Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Declan Carr, a prisoner at HMP Humber, on 28 August 2023

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO

WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Declan Carr was found hanged in his cell on 28 August 2023 at HMP Humber. He was 26 years old. I offer my condolences to Mr Carr's family and friends.

Mr Carr's was the fourth self-inflicted death at Humber since January 2020. Up to the end of 2023, there had been one self-inflicted death since Mr Carr's death. Mr Carr had been recalled to prison in June 2023 and arrived at HMP Humber on 16 August. Mr Carr had a history of substance misuse and self-harm but denied any current thoughts of self-harm.

The investigation found that staff had few meaningful conversations with Mr Carr in the 11 days he was at Humber. He did not have a keyworker and there are few records of the induction he received. The Governor has provided the investigation with an update on the current issues being faced in delivering aspects of the regime and the changes made since August 2023 to ensure delivery of keywork, and induction is addressed.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **April 2024**

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Summary

Events

1. Mr Carr was released on conditional licence from HMP Wealstun on 1 June 2023. He had been in prison since 21 February 2022, serving 876 days in prison for burglary. On release, Mr Carr continued to use drugs and so he was recalled to prison, arriving at HMP Hull on 12 June.

2. Mr Carr had a history of self-harm in prison dating back to 2015 and had attempted to hang himself in 2018. He was most recently on suicide and self-harm monitoring (known as ACCT) in February 2023, after he deliberately set fire to his cell, but he told staff that this was to facilitate a move off the wing and not an act of self-harm.

3. During his reception screen, Mr Carr denied thoughts or intentions of harming himself but told staff that he was withdrawing from drugs and alcohol and had used spice (a psychoactive substance) daily since his release. He was placed on a five-day alcohol detoxification programme and referred to the prison's drug and alcohol service.

4. On 19 June, Mr Carr told a nurse he was having troubling thoughts about his friend who had died from a drug overdose in front of him. He denied any thoughts of self-harm, but the nurse referred him to the mental health team. At a mental health assessment, Mr Carr denied any thoughts of self-harm. He declined any further support from the mental health team.

5. On 16 August, Mr Carr transferred to HMP Humber.

6. At his initial health screen, a nurse recorded that Mr Carr had a history of self-harm, but that he appeared mentally and physically well, with no issues with illicit drugs. Mr Carr denied any thoughts of self-harm.

7. At approximately 5.43am on 28 August, a night operational support grade (OSG) conducted a routine check on Mr Carr. The OSG saw Mr Carr standing at the left side of the door. He tapped on the door, but Mr Carr did not respond. The OSG initially had no concerns and continued with the routine check. However, he returned to Mr Carr's cell a few moments later to check on him and attempted to gain a response. When Mr Carr did not respond, the OSG asked for other staff to attend.

8. An officer arrived at the cell and could see him standing at the left side of the door, with both feet on the ground. At 5.51am, the officer radioed a medical emergency code and for more staff to attend.

9. Staff entered the cell and found that Mr Carr had ligatured from ventilated brickwork above the cell door. They cut the ligature and started cardiopulmonary resuscitation (CPR). The night orderly officer arrived and noted clear signs of death and advised the staff to stop CPR. Paramedics arrived at approximately 6.20am and confirmed that Mr Carr had died at 6.27am.

10. The post-mortem and toxicology report found traces of psychoactive substances in Mr Carr's body.

Findings

11. Although Mr Carr had a history of self-harm in prison dating back to 2015, there were no obvious indications that his risk of suicide had increased in the days before his death. There were no indications that he was suspected of using drugs while at Humber.

12. However, there is little evidence in Mr Carr's prison record that staff had meaningful contact with him during his time at Humber. He had not been allocated a key worker and records of the induction he received were incomplete. It is difficult to see how staff would have identified any signs of his increased risk of suicide given this.

13. The clinical reviewer concluded that the care Mr Carr received at Humber was of a reasonable standard and at least equivalent to what he could have received in the community.

The Investigation Process

14. HMPPS notified us of Mr Carr's death on 28 August 2023.

15. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

16. The investigator visited Humber on 7 September 2023. He obtained copies of relevant extracts from Mr Carr's prison and medical records, CCTV and body worn video camera (BWVC) footage and Mr Carr's prison telephone calls. A copy of the HMPPS Early Learning Review was also obtained.

17. The investigator interviewed seven members of staff at Humber on 9 November 2023.

18. NHS England commissioned a clinical reviewer to review Mr Carr's clinical care at the prison. Transcripts of interviews carried out by the investigator were shared with him.

19. We informed HM Coroner for Hull of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

20. The Ombudsman's family liaison officer contacted Mr Carr's mother to explain the investigation and to ask if she had any matters, she wanted us to consider. Mr Carr's mother asked whether her son had been subject to suicide or self-harm monitoring (ACCT) in the six months before his death. This is answered within our report. A copy of our report was shared with Mr Carr's mother, but no response to our findings was received.

21. An inquest was opened into Mr Carr's death on 5 September 2023 with a final inquest hearing on 29 September 2025. A jury noted failures in Mr Carr's care but said that they were not causative to his death. The cause of death was found to be hanging and synthetic cannabinoid intoxication.

Background Information

HMP Humber

22. HMP Humber is a large category C resettlement prison in East Yorkshire, holding up to 1,082 adult males. Healthcare services are provided between 7.00am and 8.30pm, there is no healthcare cover at night.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Humber was a scrutiny visit in November 2020, during the pandemic. Inspectors reported that the full induction programme had been suspended throughout the pandemic and now consisted only of a short face-to-face meeting with wing staff and access to a set of laminated information sheets to read. None of those that inspectors spoke to on the Reverse Cohort Unit on F wing said that they had received this written information, and there was no assessment of prisoners' understanding of the information. A member of the chaplaincy visited all new arrivals but, beyond that, the level of engagement with prisoners provided through the induction programme was poor.

24. Inspectors found that only 37% of prisoners who had been managed under ACCT procedures said that they felt cared for by staff, but that this was at odds with most of the documentation they reviewed and the generally positive feedback they received from prisoners during their visit. However, inspectors considered that the lack of Listener support during the pandemic and the unusually high use of anti-ligature clothing may have contributed to this perception.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2022 and published in June 2023, the IMB reported that HMP Humber had continued to be a safe place for prisoners and extremely well managed throughout the pandemic. The Governor and SMT appeared to have given all possible consideration to moving forward in their planning of a revised alternative regime, in order to maintain the safety of everyone within the establishment, both staff and prisoners and at the same time trying to attain a high level of purposeful activity for prisoners. There had been an overall reduction in self-harm, prisoner-on-prisoner violence and prisoner-on-staff violence.

Previous deaths at HMP Humber

26. Mr Carr was the eleventh prisoner to die at Humber since January 2020. Four of those deaths were self-inflicted. Up to the end of 2023, there had been one self-inflicted death since Mr Carr's death.

27. As a result of the number of self-inflicted deaths, Humber is receiving support and monitoring from HMPPS headquarters.

28. In our previous investigation into the death of a prisoner at Humber in June 2022, we raised concerns about the delivery of the keyworker scheme. At that time, Humber was experiencing major staffing shortages and was in the early stages of recovery from being a COVID-19 outbreak site. The Governor said that while in a slightly better place regards staffing, the prison was now facing fresh challenges affecting delivery of some areas of the regime, such as induction and key work.

Assessment, Care in Custody and Teamwork

29. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

30. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key worker scheme

31. The key worker scheme provides prisoners with an allocated officer that they can meet regularly to discuss how they are and any day-to-day issues they would like to address. Improving safety is a key aim of the scheme. All adult male prisoners should have around 45 minutes of key work each week, including a meaningful conversation with their allocated officer.

32. In 2023/24, due to exceptional staffing and capacity pressures in parts of the estate, some prisons are delivering adapted versions of the key work scheme while they work towards full implementation. Any adaptations, and steps being taken to increase delivery, should be set out in the prison's overarching Regime Progression Plan which is agreed locally by Prison Group Directors and Executive Directors and updated in line with resource availability.

Key Events

33. On 21 February 2022, Mr Declan Carr was remanded to HMP Hull charged with burglary and sentenced to 876 days on 21 March. He was transferred to HMP Wealstun on 4 April.

34. Mr Carr had a history of self-harm in prison and had attempted suicide by hanging in 2018. His last period of monitoring under suicide and self-harm prevention procedures was at the end of February 2023, at Wealstun, after he set fire to his mattress in order to fill his cell with smoke to his cell. Mr Carr said that he had not intended to harm himself but wanted to move wings because he was in debt for vapes. He was released on conditional licence from Wealstun on 1 June 2023.

35. On 8 June, Mr Carr's licence was revoked after he failed to comply with his licence conditions, and he was misusing drugs. He was given a standard recall, meaning that he would serve the rest of his prison sentence (and he would not be released until 14 August 2024).

36. Mr Carr arrived at Hull on 12 June. During the reception process he denied any thoughts or intentions of harming himself but said that he was withdrawing from drugs and alcohol and had been using Spice (a psychoactive substance) daily. He was placed on a five-day alcohol detoxification programme and staff referred him to the prison's drug and alcohol service.

37. On 19 June, a nurse reviewed Mr Carr's progress with his detoxification. During the review, Mr Carr spoke about his friend who had died from a drug overdose and that it was troubling him, although he denied any current thoughts of self-harm. She referred Mr Carr to the mental health team.

38. A nurse completed a mental health assessment with Mr Carr on 23 June. She recorded that Mr Carr had previous contact with mental health services in 2020 at Hull and Wealstun, during a period of drug induced psychosis, but that Mr Carr had been discharged from their care due to lack of engagement. Mr Carr again spoke about his friend who he said had died in front of him and told her that it kept him awake at night. However, he said that he felt positive that things would improve and again denied any thoughts of suicide or self-harm. Mr Carr said that he did not want any input from the mental health team, and she reassured him that he could refer himself again if he changed his mind.

39. On 16 August, Mr Carr was transferred to Humber. Prior to his transfer, Mr Carr had told staff that he had no concerns about moving to HMP Humber.

40. A nurse completed a health screen with Mr Carr on his arrival. He recorded that Mr Carr had previously self-harmed, but this had been 'a long time ago'. Mr Carr told him that he had not drunk alcohol in the last three months or taken any drugs. The nurse recorded that Mr Carr appeared mentally well and had no issues with illicit drugs (despite records from Hull outlining his significant substance misuse treatment and history) and no mental health issues. The nurse identified no relevant issues, and Mr Carr denied any current thoughts or intent to harm himself. The nurse identified no other issues and did not refer Mr Carr to the mental health or substance misuse teams.

41. An unknown officer completed Mr Carr's first night documentation and recorded limited information. A cell sharing risk assessment (CSRA) was completed which highlighted that Mr Carr had previously intentionally set fire to his cell and had previous self-harm markers on his record, as well as markers for racism and violence. Mr Carr was identified as being unsuitable to share a cell and was given a single cell on the induction wing. That evening, Mr Carr made three telephone calls to his mother between 7.19pm and 7.28pm, nothing of concern was raised.

42. On 17 August, a chaplain from the prison chaplaincy department spoke to Mr Carr as part of the induction process. He told Mr Carr about how to access religious services and how to contact chaplaincy staff. Mr Carr raised no concerns and told him that he had no specific religious beliefs. This was the last entry in Mr Carr's prison record before his death. There is no evidence that Mr Carr received an appropriate induction as the induction paperwork was incomplete.

43. That day, a nurse completed a secondary health screen with Mr Carr. Mr Carr said that he had no family history of chronic health issues. He raised no other issues. This was the last entry in Mr Carr's medical record before his death.

44. Prison staff told the investigator that in August 2023, prisoners at Humber were allocated a keyworker within the first 24 hours, but a keyworker might not see the prisoner within the first 36 days (as an average). There is no evidence that Mr Carr was allocated a keyworker during his time at Humber.

45. Between 18 August and 28 August, nothing was recorded about Mr Carr in either prison records or healthcare records at Humber. There is no evidence that he had any meaningful contact with any other member of staff, agency or department, or that he was provided with any further induction. Mr Carr was moved from the induction unit to M wing, a standard wing, on 22 August.

46. Between 17 August and 25 August, Mr Carr telephoned his brother twice and his mother a further five times, nothing of concern was raised during these calls.

47. During the late afternoon on 27 August, CCTV shows Mr Carr walking back to his cell after collecting his evening meal. He does not speak to anyone and after returning to his cell his door is closed. That night, an Operational Support Grade (OSG) was on night duty working between L and M wing.

48. At 10.10pm, CCTV shows movement underneath Mr Carr's cell door and the cell light is on. The light remains on for the remainder of the night, but no further movement is seen. The OSG had no reason to check Mr Carr during the night.

49. At approximately 5.33am on 28 August, the OSG began the early morning routine check on L wing then moved to M wing. He reached Mr Carr's cell at 5.43am. When he looked through the cell door observation panel, he said that he saw Mr Carr standing to the left side of the door, so he tapped on the door, but Mr Carr did not respond. Although he was not initially concerned and began to continue the checks, after walking halfway along the landing, he decided to go back to Mr Carr's cell and check on him again. He again tried to get a response from Mr Carr and when he did not get one, he called the communications room and asked patrol staff to come to M wing so that the cell could be opened to check on Mr

Carr. He told control room staff that he could see the side of Mr Carr's face, but he was not responding.

50. An officer arrived on M wing at 5.50am, and the OSG told him that he had been unable to get a response from Mr Carr during the routine check. The officer made his way to Mr Carr's cell and, as he approached, he activated his Body Worn Video Camera (BWVC). He tried to get a response from Mr Carr. He said that he could see Mr Carr at the left side of the door, and both of his feet were on the ground. At 5.51am, he radioed the communications room and requested further staff to attend M wing and then called a medical emergency code blue (indicating a prisoner is unconscious or is having breathing difficulties). The control room called for an ambulance.

51. The officer entered Mr Carr's cell and found that Mr Carr had ligatured from ventilated brickwork above the cell door using torn bed sheets. He immediately cut the ligature and, with the help of the OSG, moved Mr Carr onto the floor and began CPR. Two more officers were the first staff to respond and brought a defibrillator to the cell. (HMP Humber does not have 24-hour healthcare cover, so no nursing staff were on duty at this time.)

52. A Custodial Manager (CM) responded to the code blue. On his arrival at the cell, he said that it was clear from Mr Carr's presentation that he was dead, and he instructed the officer to stop CPR. Paramedics arrived at approximately 6.20am and completed their own observations. At 6.27am, the paramedics confirmed that Mr Carr had died.

Contact with Mr Carr's family

53. The prison appointed an officer as their family liaison officer (FLO) and, along with deputy governor, visited the home of Mr Carr's mother on the morning of 28 August, to inform her of her son's death. The officer remained in contact with Mr Carr's mother, offering advice and support. A further visit was made to Mr Carr's mother by the officer on 5 October.

54. The prison contributed towards funeral expenses in line with national policy.

Support for prisoners and staff

55. After Mr Carr's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team and Trauma Informed Management (TRiM) practitioners also offered support. Local Samaritans were also contacted as part of the postvention measures.

56. The prison posted notices informing other prisoners of Mr Carr's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

Post-mortem report

57. A post-mortem report gave Mr Carr's cause of death as hanging. Findings from the toxicology indicated the presence of spice in Mr Carr's system. The report states that while not directly linked to the cause of death, its use might have impaired Mr Carr's cognition at the time. (The toxicology report does not draw any conclusions about how recently Mr Carr might have used Spice before his death.)

Findings

Mr Carr's risk of harm

58. Mr Carr had a history of self-harm in prison dating back to 2015 and had attempted suicide by hanging in 2018. He was most recently on suicide and self-harm monitoring in February 2023, after he deliberately set fire to his cell, but told staff that this was to facilitate a move off the wing and not an act of self-harm.

59. When he arrived back into prison custody on 8 June, Mr Carr denied any thoughts or intent to harm himself. However, he did have factors known to increase the risk of suicide including having been recalled, illicit drug and alcohol use and previous suicide attempts and self-harm. Mr Carr's phone calls to family in the days before his death did not reveal particular concerns and his outward presentation did not raise any concerns with staff.

Meaningful contact

60. Mr Carr had been at Humber for 11 days when he died. In that time, there were very few entries in his prison record and little evidence that staff had had much meaningful contact with him. There are no key work entries in Mr Carr's record and his induction paperwork was incomplete.

61. The investigator was told that in August 2023, the expectation was that a prisoner entering Humber would be allocated a keyworker within 24 hours, although they might not be seen for a keywork session for up to 36 days. Mr Carr had not been allocated a key worker by the time he died.

62. In our previous investigation into the death of a prisoner at Humber in June 2022, we raised concerns about the delivery of the keyworker scheme. At that time Humber was experiencing major staffing shortages and was in the early stages of recovering from a COVID-19 outbreak. In August 2023, the target for staffing at Humber was 194, and the prison had 211 staff in post, (this figure does not account for non-effective staff, those on sick leave, restricted duties, annual leave or those training).

63. The Governor told us that Humber had transitioned to a resettlement prison during the pandemic and now experienced the highest levels of prisoner 'churn' (the number of prisoners arriving and leaving across a period) across all prisons in Yorkshire. She said that this was affecting processes like induction. She accepted that at the time Mr Carr arrived at Humber, the induction process was not being delivered well.

64. The Governor said that since August, the induction process had been reviewed, resulting in clear improvement plans. There had also been improved quality assurance of the induction process. Key work had now been ringfenced within the Regime Management Plan (RMP) with three staff now available to deliver keywork in the morning and afternoon.

65. The lack of entries in Mr Carr's records, the apparent lack of meaningful contact with him by staff and the incomplete induction paperwork suggest it would have

been difficult for staff to identify signs of Mr Carr's suicide risk or indeed to have known anything much about him at all. However, given the work underway to improve both the induction process and the delivery of key work at Humber, we make no recommendation. The Governor will want to closely monitor both areas to ensure improvements continue.

Mr Carr's substance misuse

66. Mr Carr had a history of substance misuse and on his recall to prison he said that he had been using both Spice and alcohol daily. At Hull, he received good substance misuse support and treatment.

67. When he arrived at Humber on 16 August 2023, Mr Carr said that had had not had any alcohol of drugs for the last three months. He had been successfully detoxed at the time of his transfer from HMP Hull. A nurse concluded that he did not have any current issues with illicit drugs and did not refer him to the substance misuse team. There are no reports of Mr Carr being suspected of using illicit drugs after his recall.

68. The toxicology report identified that Mr Carr had Spice in his system when he died, although we do not know how recently. During his time at Humber, Mr Carr was located in a single cell. He had little interaction with other prisoners and received no visits. He had little money in his spending account and had only purchased vapes from the canteen during the short time he was there. No drug paraphernalia or illicit substances were found in his cell after his death.

69. The clinical reviewer noted that although Mr Carr had an extensive reception screen assessment when he arrived at Humber, this would have been better informed if the nurse had access to information about Mr Carr's substance misuse care from HMP Hull. She considered that although Mr Carr had completed treatment at Hull, a summary of the interventions that the drug and alcohol team had delivered to Mr Carr there should have been handed over to the substance misuse service at Humber to ensure they were aware of Mr Carr's substance misuse issues and to enable him to be monitored if needed.

70. The clinical reviewer has made a recommendation about this issue which we do not repeat here, but which the Head of Healthcare will wish to address.

71. The clinical reviewer concluded that the clinical care Mr Carr received at Humber was of a reasonable standard and at least equivalent to what he could have expected to receive in community.

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