

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Michael Hamill a prisoner at HMP Moorland on 18 May 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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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.

We carry out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Michael Hamill died after cutting his neck in his cell at HMP Moorland on 18 May 2016. Mr Hamill was 41 years old. I offer my condolences to Mr Hamill's family and friends.

Mr Hamill had regularly used new psychoactive substances (NPS) at his previous prison. We did not find evidence that he had taken anything illicit at Moorland but there is evidence that his prior use had affected his mental health. We identified missed opportunities for him to work with psychological services and the substance misuse team. In our investigation into another death at Moorland this year, we identified a similar missed opportunity.

Despite these missed opportunities and although Mr Hamill had some risk factors associated with suicide and self-harm, we found little to indicate to prison staff that he was at heightened or imminent risk in the period before his death. We consider that it would have been difficult for staff at Moorland to have predicted or prevented Mr Hamill's death.

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

**Nigel Newcomen CBE**  
**Prisons and Probation Ombudsman**

**March 2017**

## Contents

Summary .....	1
The Investigation Process .....	3
Background Information .....	4
Key Events .....	6
Findings.....	11

# Summary

## Events

1. Mr Michael Hamill was recalled to HMP Leicester in March 2015 shortly after being released on licence. He had a history of substance misuse, anxiety and depression. He said he began smoking new psychoactive substances (NPS) more regularly in prison in August 2015. He was a regular user while at HMP Ranby where he was transferred in August and there are several entries in his prison record describing bizarre and paranoid behaviour.
2. In January 2016 at Ranby, Mr Hamill made cuts to his arms. On 4, 7 and 8 February, he threatened to cut his throat. These were the only incidents of self-harm in his record, and staff monitored his risk of suicide and self-harm. Mr Hamill was moved to HMP Moorland on 18 February 2016.
3. Mr Hamill had a mental health assessment and regular appointments with the prison GP. He appeared well and co-operated with a plan to reduce his dependence on prescribed medication. He was keen to work on courses identified by his offender supervisor to reduce his risk of reoffending.
4. Mr Hamill worked in the prison barber shop and does not appear to have had any issues with staff or prisoners. There is no evidence that he took NPS at Moorland and he did not self-harm. At a substance misuse assessment on 20 April, he agreed to begin individual and group work on NPS but the substance misuse worker forgot to refer him.
5. On 12 May, Mr Hamill asked an officer to remove his television because he said there was a camera inside it. The officer did not think Mr Hamill was at risk of suicide or self-harm but contacted the mental health team. They told him they would make an appointment for Mr Hamill but there is no record of this. There was no evidence that Mr Hamill's mental health deteriorated over the next few days.
6. On 18 May, Mr Hamill was found dead in his cell at morning roll count. He had made a cut to his neck. The first officer on scene radioed emergency response codes and an ambulance was called promptly. Staff did not start cardiopulmonary resuscitation because he was clearly dead. Paramedics attended very quickly and confirmed Mr Hamill had been dead for a couple of hours.

## Findings

7. Although Mr Hamill had some risk factors for suicide and self-harm, we found there was little to indicate to prison staff that he was at heightened or imminent risk in the period before his death. We consider that it would have been difficult for staff at Moorland to have foreseen or prevented his actions on 18 May.
8. Although there was evidence that Mr Hamill suffered mental health issues as a result of using NPS, a referral to the Improving Access to Psychological Therapy

programme (IAPT) did not result in an appointment before his death. A substance misuse worker did not tick a box in his medical record that would have given Mr Hamill access to individual and group work on NPS.

9. Although there is no evidence that an appointment with an IAPT counsellor or work with the substance misuse team would have prevented Mr Hamill's death, we consider they were missed opportunities to explore the long term effect on his mental health of using NPS. We note that in our investigation into a previous death at Moorland, we found that a referral to the substance misuse team had not happened as it should have done.

## **Recommendations**

- **The Head of Healthcare should ensure that:**
  - **staff understand and operate the correct procedures for referring prisoners to the Improving Access to Psychological Therapy programme;**
  - **all referrals are actioned within a specific timeframe; and**
  - **appropriate management checks of the above are in place.**
- **The Governor should ensure prisoners who use new psychoactive substances are referred to drug treatment services.**

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Moorland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. Another investigator, who was visiting the prison on 23 May, collected copies of relevant extracts from Mr Hamill's prison and medical records. The investigator reviewed CCTV on 28 June in the prison. She also listened to recordings of Mr Hamill's telephone calls in the ten days before he died.
12. NHS England commissioned a clinical reviewer to review Mr Hamill's clinical care at the prison.
13. The investigator interviewed five members of staff, two jointly with the clinical reviewer, on 28 June.
14. We informed HM Coroner for South Yorkshire East of the investigation who sent us a copy of the post mortem report. We have given the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Hamill's mother to explain the investigation. We regret that Mr Hamill's mother's questions were not effectively communicated to the investigator before we issued the initial version of this report. We have apologised to Mr Hamill's mother and have answered her questions in separate correspondence.

# Background Information

## HMP Moorland

16. HMP Moorland in South Yorkshire holds up to 1,000 men. Nottinghamshire Healthcare NHS Trust runs healthcare services at the prison, including primary care, mental health and substance misuse services. The prison does not have an inpatient facility or full time nursing cover.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Moorland was in February 2016. Inspectors reported that the impact of NPS posed a severe threat to the stability of the prison. Despite some positive initiatives, the number of prisoners who said it was easy to get drugs at Moorland had increased from 28% to 48% since the last inspection. There were several acute health incidents every day due to NPS and the environment was increasingly violent. Staff and prisoners told inspectors that the prison was becoming more unsafe due to intoxicated NPS users and the violence associated with related bullying and debt. Inspectors concluded there was an unacceptable lack of an integrated approach to NPS across the whole prison.
18. Health services were reasonable but the number of incidents involving NPS and other emergencies had curtailed some clinics. Specialist mental health services were good but primary mental health services were more limited. Services for prisoners with substance misuse issues had improved due to better integration with the psycho-social team.

## Independent Monitoring Board

19. 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 February 2016, the IMB reported that a reduction in staff had impacted negatively on safety in the prison. Drugs, especially NPS, and violence were a major concern and bullying and debt had spiralled. The Board observed that a growing number of prisoners appeared to have significant mental health issues.

## Previous deaths at HMP Moorland

20. Mr Hamill's is the third apparently self-inflicted death at Moorland in 2016. In our investigation into the previous self-inflicted death, we identified a similar missed opportunity to refer the prisoner for work on NPS.

## New psychoactive substances (NPS)

21. NPS, previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of

such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

22. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
23. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

## Key Events

24. On 17 January 2014, Mr Michael Hamill was sentenced to three years and one month in prison for sexual assault and threats to harm a member of his family. He was released on licence in March 2015 but recalled to HMP Leicester in May 2015 after he attacked a member of staff at his hostel while under the influence of NPS.
25. On 19 May 2015, Mr Hamill received a further sentence for the assault at the hostel. On 3 August, Mr Hamill was transferred to HMP Ranby. On four occasions, between August 2015 and January 2016, he was found to be under the influence of NPS.
26. On 25 January 2016, Mr Hamill made several deep cuts to his right forearm with a razor blade. Staff began suicide and self-harm monitoring procedures known as ACCT. Mr Hamill said he had smoked NPS, which had made him paranoid that he was under threat from other prisoners. He said his actions were a cry for help and he did not want to die. This was the first time he had harmed himself.
27. On 28 January, he admitted taking NPS again and had to be helped back from the exercise yard to his cell. On 29 January, he told his substance misuse worker that he had started smoking NPS more regularly in August 2015 (about three or four times a week) but now smoked them two or three times a week. The next day, officers had to carry Mr Hamill back to his cell because he could not walk after smoking NPS again. On 1 February, he told his substance misuse worker that after smoking NPS on 30 January, he had experienced extreme anxiety and paranoia.
28. On 4 February, Mr Hamill threatened to cut his throat. He admitted that he had taken NPS again. An officer contacted the substance misuse team who said that he was on the list to attend the NPS awareness course.
29. On 7 February, Mr Hamill threatened to cut his throat with a razor blade. On 8 February, Mr Hamill held a razor to his throat and threatened to cut himself if he was not moved to a different house block. Staff began ACCT monitoring and moved Mr Hamill to the segregation unit where Mr Hamill said he felt much less paranoid. On 17 February, the ACCT was closed after Mr Hamill said he felt able to return to a standard wing.
30. On 18 February, Mr Hamill was transferred to HMP Moorland. His person escort record, which accompanied him from Ranby, noted he had been subject to ACCT monitoring and had a history of violence and misuse of NPS.
31. On 19 February, at an initial health screen, Mr Hamill gave a history of alcohol and substance misuse, anxiety and depression. Mr Hamill refused a nurse's offer to refer him to the substance misuse team. She referred him to the mental health team.
32. On 20 February, Mr Hamill told an officer that he was feeling anxious. The officer spent some time talking to him and offered Mr Hamill a Listener (prisoners trained by The Samaritans to offer confidential peer support) and the Samaritans

telephone (a cordless telephone with a direct line to The Samaritans) but he declined them.

33. On 23 February, Mr Hamill saw an offender supervisor. She said Mr Hamill communicated well with her and appeared to be planning for his release. He was willing to work on his index offence. He said he was taking legal advice about whether to challenge the decision to recall him to prison. She was not concerned because Mr Hamill seemed quite stable. The officer who was present said that Mr Hamill did not appear to have any issues on the wing.
34. On 24 February, a nurse examined Mr Hamill after he reported feeling unwell in the night. She said Mr Hamill appeared quite anxious and she noted in his medical record that she would ask the mental health team to refer him to IAPT (the Improving Access to Psychological Services programme). On 25 February, a worker from the national careers service referred Mr Hamill to the mental health inreach team at his request.
35. On 10 March, Mr Hamill asked to see a chaplain. He said he was feeling anxious and asked whether he could have an appointment with the doctor to review his medication.
36. On 11 March, a mental health nurse completed a mental health assessment. Mr Hamill said he had smoked NPS every other day at Ranby and had become paranoid. He said he felt clearer in his mind and better focused now he had stopped taking them. The nurse said Mr Hamill did not appear in crisis and arranged to see him again in three weeks. (The nurse was absent on sick leave at the time of the interviews and has since retired. He was not interviewed.)
37. A prison GP reviewed Mr Hamill's medication on 21 March. He said he noticed Mr Hamill was on diazepam, which is not usually given in prison unless prescribed by a psychiatrist. The GP renewed the prescription and made an appointment for Mr Hamill with the visiting psychiatrist.
38. On 22 March, Mr Hamill told a nurse and a healthcare assistant that he was hearing voices, felt anxious and thought that there was a conspiracy between staff and prisoners to kill him. The healthcare assistant spoke to the mental health nurse and made Mr Hamill an appointment with a prison GP. The nurse did not go and see Mr Hamill. He wrote on the medical record that he thought Mr Hamill would benefit from activity. He chased up Mr Hamill's gym induction and said he would see him as planned on 1 April.
39. Mr Hamill saw a prison GP that afternoon. Mr Hamill said he had smoked a lot of NPS at Ranby and it had made him paranoid. He had also self-harmed which he said was out of character. Mr Hamill said he had some thoughts that officers were out to get him but was not hearing voices. He said he had no thoughts of self-harm but was feeling low and subdued.
40. They discussed Mr Hamill's prescription for diazepam. The GP said he expected Mr Hamill to be resistant but he was pleasant, rational and happy to try to reduce his dose. He prescribed Mr Hamill paroxetine (an anti-depressant) for his low mood. He cancelled Mr Hamill's appointment with the psychiatrist and noted that

the mental health nurse would follow up how Mr Hamill was feeling at their scheduled appointment.

41. On 1 April, the mental health nurse saw Mr Hamill as planned. Mr Hamill had still not completed a gym induction despite the nurse having put him on the list. The nurse said he felt strongly that Mr Hamill needed to be occupied to help his mood. Mr Hamill told her he was keen to be occupied and was finding it difficult doing nothing. Mr Hamill said he was keen to reduce his medication and have talking therapy. The nurse noted that Mr Hamill could be referred to IAPT once the GP had managed his medication. Mr Hamill said he had no thoughts of self-harm.
42. On 4 April, Mr Hamill refused to continue taking paroxetine. He was added to the waiting list to see the GP.
43. On 18 April, the offender supervisor visited Mr Hamill at work in the prison barber shop. They discussed a new sentence plan and she told him she would email his offender manager, which she did that afternoon.
44. The offender supervisor said that Mr Hamill was coherent and clear. He did not appear to be under the influence of any substance. She said she had seen references in his record to paranoid symptoms but had not seen any signs of this. Mr Hamill was properly dressed, clean, appeared to be eating normally and made good eye contact. He was pleasant and polite and seemed well-motivated to work on his offending behaviour.
45. On 20 April, a substance misuse worker assessed Mr Hamill. Mr Hamill said he had started smoking NPS in custody and it had made him behave erratically. He described it as a 'bad experience'. He agreed with Mr Hamill that he should attend group work to focus on NPS awareness and a one-to-one session to focus on coping strategies and triggers.
46. On 28 April, Mr Hamill asked a prison chaplain if he could light a candle in the prison chapel for his mother. He said he was anxious and worried about a conversation they had during a visit the previous day. She said Mr Hamill was carrying a lot of guilt for the problems his behaviour had caused. He wanted to change but was afraid of failure.
47. On 3 May, a prison GP saw Mr Hamill again. He said Mr Hamill seemed fine and was coping with the reduction in his diazepam. He said he had stopped taking paroxetine because he did not like the side effects and agreed to try sertraline (another antidepressant) instead. The GP planned to review Mr Hamill's medication in one month and to ask the mental health nurse about his referral to IAPT. There are no medical records to indicate he did so.
48. On 12 May, Mr Hamill rang his cell bell and asked an officer to take his TV away because he thought there was a camera in it watching him. The officer removed the television and then returned to Mr Hamill's cell and asked him if he wanted to have a chat. Mr Hamill was upset and tearful and said he was worried about his future. He said he had seen his offender supervisor recently and therefore his future was on his mind. The officer said Mr Hamill was a bit lower in mood than usual and he considered opening an ACCT. He asked Mr Hamill whether he felt

suicidal or like harming himself. Mr Hamill told him he did not and the officer said he believed him.

49. The officer telephoned the mental health team because he was concerned that Mr Hamill thought there was a camera in his television. He thought it might indicate a mental health problem. He spoke to a female member of the mental health team whose name he could not remember. She told him that Mr Hamill was known to them and she would make an appointment for someone to see him. There is no record of this conversation in Mr Hamill's medical record.
50. On 16 May, Mr Hamill submitted a general application asking for a meeting with his offender supervisor and the mental health nurse because he had not had a follow up appointment as promised. The application was stamped as received by the answering department on 17 May.
51. On 17 May, Mr Hamill telephoned his mother twice. There is nothing in either of these calls or any of the other calls he had made to his mother since 10 May to indicate he intended to take his own life.

### **18 May 2016**

52. At about 6.03am, the night patrol officer checked Mr Hamill during morning roll count. She said he was lying in bed covered in blood. She radioed a code red to indicate heavy blood loss. She called Mr Hamill's name and banged on his door but he did not respond. She then radioed a code blue to indicate a prisoner unconscious or in breathing difficulty.
53. An officer was walking to the gate when he heard the code red followed by the code blue. When he arrived at Mr Hamill's cell, he saw Mr Hamill lying on his bed with blood everywhere. The night patrol officer was outside the door. He went into the cell immediately. He said it was obvious that Mr Hamill had died. The custodial manager arrived next and radioed for an ambulance. (Analysis of CCTV timings and the ambulance records show that the control room had already called an ambulance in response to the emergency codes called by the night patrol officer.)
54. The custodial manager wanted to start cardiopulmonary resuscitation but the officer told her that Mr Hamill was clearly dead. There was rigor mortis present and he was cold to touch. The blood in the cell was sticky and clotted. He said he thought Mr Hamill had been dead for some time.
55. Moorland does not have 24 hour healthcare cover and no nurses or doctors were on duty.
56. Paramedics arrived and said they could not find a wound. They put a defibrillator on Mr Hamill but found no signs of life. They told the officer that Mr Hamill had been dead for at least two hours.
57. The clock on the CCTV of the incident was wrong. It showed that the officer arrived two minutes ten seconds after the night patrol officer found Mr Hamill unresponsive. The custodial manager arrived 15 seconds later and both entered the cell. Paramedics arrived two minutes 49 seconds later.

### **Contact with Hamill's family**

58. An officer and the duty governor drove to Mr Hamill's mother's house and broke the news of her son's death. The officer maintained contact with Mr Hamill's mother. The prison offered financial assistance with Mr Hamill's funeral in line with national policy.

### **Support for prisoners and staff**

59. After Mr Hamill's death, the Governor 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 also offered support.
60. The prison posted notices informing other prisoners of Mr Hamill's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Hamill's death.

### **Post-mortem report**

61. The cause of Mr Hamill's death was:
- "1a hypovolaemic shock [blood loss]  
1b incised wound on neck  
2 Emphysema."

The toxicology analysis for Mr Hamill did not identify the presence of any illicit substances.

# Findings

## Assessment of risk

62. Prison Service Instruction (PSI) 64/2011 lists a number of risk factors and potential triggers that might increase a prisoner's risk of suicide and self-harm. Mr Hamill had some factors that increased his risk including previous self-harm, use of NPS, anxiety and depression. At Ranby, Mr Hamill cut his arms on 25 January and threatened three times to cut his throat on 4, 7 and 8 February. Mr Hamill admitted to frequent use of NPS at Ranby and his record shows numerous occasions when he was incapable as a result. He did not have a history of self-harm before 25 January and he blamed this behaviour on his use of illicit drugs. There is no evidence that Mr Hamill took NPS at Moorland or that he continued his self-harming behaviour.
63. On 22 March and 12 May, Mr Hamill twice reported paranoid thoughts that people wanted to harm him at Moorland. A prison GP examined him on 22 March and did not think that Mr Hamill was psychotic. An officer was not concerned Mr Hamill was at risk of self-harm or suicide on 12 May but was worried enough about his mental state to telephone the mental health team. There is no record of this in Mr Hamill's medical record and he was not given an appointment before he died. Mr Hamill did not appear to be in crisis at the time and we have seen no evidence of deterioration in his mental state in the days before his death.
64. We consider that there was little to indicate that Mr Hamill was at imminent and heightened risk of suicide at the time of his death. We consider it would have been difficult for staff at Moorland to have predicted or prevented his actions.

## Mental health and substance misuse

65. Mr Hamill complained of paranoid thoughts and anxiety on a number of occasions at Moorland. He was referred to IAPt on 24 February but had not received an appointment by the time he died nearly three months later. The medical records indicate some confusion about who was following up Mr Hamill's referral. Talking therapy plays an important role in reducing anxiety and uncovering underlying mental health issues that are not obvious in the snapshot view of a GP appointment. There is also abundant evidence in his medical record that Mr Hamill's symptoms were linked to previous heavy use of NPS. It is especially important that prisoners with this profile receive appropriate support given the emerging role of these substances in the deterioration of mental health and their links to suicide or self-harm.
66. On 20 April, a substance misuse worker agreed to refer Mr Hamill for individual and group work on NPS. However, he forgot to tick the correct box on Mr Hamill's medical record. Again, this was a missed opportunity to examine the long term effects of NPS on Mr Hamill. It is disappointing that not one but two opportunities to identify that Mr Hamill's deterioration in mental health were not taken at Moorland. We make the following recommendations:

**The Head of Healthcare should ensure that:**

- **staff understand and operate the correct procedures for referring prisoners to the Improving Access to Psychological Therapy programme;**
- **all referrals are actioned within a specific timeframe; and**
- **appropriate management checks of the above are in place.**

**The Governor should ensure prisoners who use new psychoactive substances are referred to drug treatment services.**

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