Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Glody Muyeki, a prisoner at HMP/YOI Aylesbury, on 15 May 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 Glody Muyeki died on 15 May 2023 at HMP Aylesbury after being found unresponsive in his cell. The cause of his death is unknown. He was 26 years old. I offer my condolences to Mr Muyeki's family and friends.

Mr Muyeki had a history of drug misuse in prison. During his time at HMP Aylesbury, staff suspected that Mr Muyeki was under the influence of drugs on two occasions but did not take appropriate steps to monitor him. My investigation found there was no process in place to support prisoners who were believed to be under the influence of illicit substances.

At the time of Mr Muyeki's death, HMP Aylesbury had experienced an increase in the use of and presence of psychoactive substances. The Governor took steps to educate prisoners about the risks of taking drugs and reduce the supply and demand in prison.

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 **January 2024**

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Summary

Events

1. On 9 August 2021, Mr Glody Muyeki was remanded to prison charged with assault occasioning actual bodily harm. This was not his first time in prison. Mr Muyeki had spent a year on remand and on 17 August 2022, he was sentenced to 22 months in prison. Due to the time he had already served on remand, Mr Muyeki was released from prison on a conditional licence. On 24 October, Mr Muyeki was recalled to prison for breaching his licence conditions. He was also charged with conspiracy to supply class A drugs. He was sent to HMP Chelmsford. Mr Muyeki declined substance misuse support in prison.

2. On 13 April 2023, Mr Muyeki was found guilty of the supply of a Class A controlled drug (namely crack cocaine) and sentenced to four years in prison. On 25 April, Mr Muyeki transferred to HMP/YOI Aylesbury.

3. At 6.26pm on 5 May, staff found Mr Muyeki unconscious on the floor of his cell. Staff believed that Mr Muyeki was under the influence of an illicit substance. Clinical staff advised Mr Muyeki to go to hospital for further assessment, but Mr Muyeki became threatening towards staff and refused to go. Staff monitored him regularly in prison.

4. At 8.50am the next day, staff believed that Mr Muyeki was under the influence of an illicit substance again. He was initially unresponsive but when he came round, he was confused and became aggressive towards staff. Staff restrained him and took him to the segregation unit. A senior manager decided that his location in the segregation unit was inappropriate and at 10.30am, staff moved him to a single cell on A wing, a standard wing.

5. At 2.15pm, Mr Muyeki became violent towards staff, and they returned him to the segregation unit. On 9 May, staff moved Mr Muyeki back to a standard wing (E wing).

6. During the day of 14 May, staff recorded no concerns about Mr Muyeki being under the influence of illicit substances. The night officer on duty told us that staff had told him that Mr Muyeki was believed to be under the influence of drugs. Despite claiming that concerns had been raised about Mr Muyeki, the night officer did not complete any checks on him during the night.

7. At 7.10am on 15 May, an officer arrived on E wing to start her shift. She checked on Mr Muyeki and saw him sitting on the edge of his bed with his head resting on his arm. She believed he was sleeping, so she completed her checks on the wing.

8. At approximately 8.25am, another officer went to Mr Muyeki's cell to complete a routine check. When the officer entered the cell, he announced that he was going to complete the checks, but Mr Muyeki did not respond and on checking further, he realised Mr Muyeki was not breathing. The officer radioed a medical emergency code.

9. Staff attended the cell and noted that Mr Muyeki was rigid with discolouration to his skin. They continued with cardiopulmonary resuscitation (CPR) until the paramedics arrived at 8.36am. At 8.45am, the paramedics confirmed that Mr Muyeki had died.

10. The post-mortem was unable to determine the cause of Mr Muyeki's death.

Findings

11. Mr Muyeki was able to source and use illicit drugs at HMP Aylesbury.

12. At the time of Mr Muyeki's death, there was no policy in place to advise staff what they should do in the event a prisoner was found under the influence of illicit substances. As a result, on the two occasions he was found to be under the influence, Mr Muyeki did not receive appropriate support.

13. The clinical reviewer concluded that the clinical care Mr Muyeki received at Aylesbury was good and although there were some opportunities for improvement, it was equivalent to what he could have expected to receive in the community.

The Investigation Process

14. HMPPS informed us of Mr Muyeki's death on 15 May 2023.

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

16. The investigator visited Aylesbury on 15 June. He obtained copies of relevant extracts from Mr Muyeki's prison and medical records. He also visited the wing where Mr Muyeki had been living and interviewed the Head of Drug Strategy and Head of Safety. He returned to Aylesbury on 2 and 3 August and interviewed seven members of staff.

17. NHS England commissioned a clinical reviewer to review Mr Muyeki's clinical care at the prison.

18. We informed HM Coroner for Buckinghamshire of the investigation. The Coroner gave us the results of the post-mortem examination and toxicology results. We have sent the Coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Muyeki's family to explain the investigation and to ask if they had any matters, they wanted us to consider. The family asked the following questions:

    - Was Mr Muyeki managed under suicide and self-harm procedures and how was this managed?
    - What support was Mr Muyeki receiving from primary care and mental health services?
    - How was Mr Muyeki able to access illicit drugs, namely 'spice' (a psychoactive substance)?

    We have tried to answer Mr Muyeki's family's questions in this report.

20. Solicitors representing Mr Muyeki's family responded to the initial report on 19 January 2024, and provided feedback on our findings. The points raised by Mr Muyeki's family have been addressed in separate correspondence.

21. HMPPS also responded to the initial report, highlighting minor factual or grammatical errors. These have been addressed.

22. An inquest into Mr Muyeki's death concluded on 24 November 2024. A jury provided a narrative verdict which stated that '… Mr Muyeki knowingly and voluntarily ingested a synthetic cannabinoid for recreational purposes suffering fatal effects. It is possible that his death could have been prevented had there been greater levels of observation and interaction leading up to and during the night of 14 May 2023 ...'

Background Information

HMP/YOI Aylesbury

23. HMP/YOI Aylesbury takes category C prisoners aged between 21 and 27. Central and Northwest London NHS Foundation Trust provides physical and mental healthcare services. Forward Trust provides substance misuse treatment.

HM Inspectorate of Prisons

24. The most recent inspection of HMP/YOI Aylesbury was in November 2022. Inspectors expressed concern about the management of the recent change of role (from holding young adults aged 18 to 21 serving long sentences) the prison had undergone, and the impact that this had. Inspectors said that outcomes for prisoners remained insufficient and the provision of purposeful activity was poor, although the inspectors noted that the prison's new purpose needed to be taken into account when making direct comparisons with their previous inspections. However, they found that prisoners were still not treated well enough, and their needs were still not being met.

25. The inspection noted that a shortage of staff was impacting nearly all aspects of prison life. The prison was short of about 50 officers and the shortages of staff within health care were said to be so dire that it had been determined an unacceptable risk to send prisoners over the age of 40 to the prison. The inspection noted that the most apparent consequence of the shortages was the effect on the daily regime, with almost 40% of prisoners unemployed and those without activity spending up to 23 hours a day locked up, with time in the open air limited to 30 minutes a day.

26. More positively, the inspection noted that, based on their survey of prisoners, only 14% said it was easy to get drugs and 9% alcohol, compared with 29% and 26% respectively at other category C establishments. Random testing had showed that drug use had spiked in the late summer of 2022, but a coordinated approach and good targeted actions had reduced supply. The inspection noted that this was a successful area of work.

Independent Monitoring Board

27. 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 March 2022, the IMB reported that it had seen the prison coming out of the latter stages of the COVID-19 pandemic. The IMB reported that overall, the prison was reasonably safe. There had been no deaths in in prison during the reporting year.

28. The report noted that there was an issue with gang culture. This was made worse by the ages of the prisoners and was behind much of the violence that happened. The board said that the prison had a violence reduction strategy and a gang strategy to address this. They reflected that there had been fewer chances for violence during the pandemic, with prisoners locked up for much of the time. The board noted that Aylesbury had traditionally had a reputation for violence, as a

former member of the Long-Term High Security Estate (LTHSE) catering only for prisoners from 18 to 21 years old. The board commented that the reputation continued and needed to be addressed as the prison transitioned to a category C establishment.

Previous deaths at HMP/YOI Aylesbury

29. Mr Muyeki was the fourth prisoner to die at HMP Aylesbury since May 2020. Of the previous deaths, two were self-inflicted and one for which the cause is yet to be ascertained. Ten days after Mr Muyeki's death, another prisoner died, which was thought to be drug related.

Assessment, Care in Custody and Teamwork (ACCT)

30. 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 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.

31. 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.

Psychoactive Substances (PS)

32. PS (formerly known as 'legal highs') continue to be a serious problem across the prison estate. They can be 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 PS 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, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Measures to reduce supply and demand for drugs in place at Aylesbury before Mr Muyeki's death

33. On 25 April 2023, Aylesbury held a drugs amnesty, in an attempt to encourage prisoners to hand over illicit items, supported by advice about the dangers of PS use. While the initiative had some results, it was not as effective as they had hoped.

34. In an attempt to reduce the trafficking of drugs into the prison through the post (on paper impregnated with drugs), the prison photocopied all incoming post for a

period of two weeks from 2 May. Prisoners were informed of the action and told that they would receive photocopies of post during this period. Under a new contract with an external drug testing laboratory, Aylesbury sent more items for testing, which proved beneficial.

35. The prison identified that drugs were being sent to prisoners in clothing parcels. As a result, the prison changed the rules for items being sent in and restricted this to only allowing items from named suppliers.

Key Events

36. On 9 August 2021, Mr Glody Muyeki was remanded to prison charged with assault occasioning actual bodily harm (ABH). This was not his first time in prison.

37. Mr Muyeki had a prison history of self-harm, violence, racist behaviour, hostage taking, assaults on staff and gang affiliations. During his initial reception screen, Mr Muyeki was open about his drug use and told staff that he had smoked cannabis, had no desire to stop and that he did not wish to engage with the substance misuse team.

38. Mr Muyeki spent a year on remand, and, on 17 August 2022, he was sentenced to 22 months in prison. Due to the time he had already spent on remand, Mr Muyeki was released from prison on a conditional licence.

39. On 24 October, Mr Muyeki's licence was revoked, and he was recalled to prison for breaching his licence conditions. He was also charged with conspiracy to supply class A drugs. He was sent to HMP Chelmsford.

HMP Chelmsford

40. During his reception interview, Mr Muyeki said that he had previously self-harmed but had no current thoughts or intentions to harm himself. On 27 October, staff started suicide and self-harm prevention measures (known as ACCT) because Mr Muyeki told his probation officer several times that he intended to harm himself. The next day, staff found Mr Muyeki in his cell with a ligature around his neck. Mr Muyeki said that his main issues included his recall to prison and that he had not received the prescribed medication he had been taking in the community. This were later resolved. Staff placed him under constant supervision and moved him to a constant supervision cell. The next day, Mr Muyeki attempted suicide again. Staff kept him under constant supervision until 1 November.

41. Mr Muyeki remained on ACCT monitoring until 10 November. Mr Muyeki said that he was now taking medication to help with his mental health, he was in contact with his partner and raised no other concerns.

42. On 22 November 2022, Mr Muyeki transferred to HMP Highpoint. He was then returned to Chelmsford on 6 February 2023 to attend his court appearance. During his time at Chelmsford, Mr Muyeki's behaviour deteriorated. He became abusive towards staff, had fights with other prisoners (associated with gang affiliations) and isolated himself. Mr Muyeki spent time in the segregation unit (a unit where prisoners are located following a violent or other serious incident) until his behaviour improved and he returned to a standard wing. Mr Muyeki received support from the mental health team as he was not taking his medication, not leaving his cell and had not been attending the gym as usual. His presentation later improved, and he raised no further concerns. He engaged fully with the prison regime.

43. On 13 April, Mr Muyeki was found guilty of supplying a Class A controlled drug (crack cocaine) and was sentenced to four years in prison.

HMP Aylesbury

44. On 25 April 2023, Muyeki was transferred to Aylesbury.

45. During his induction at Aylesbury, Mr Muyeki told staff that he had support from his mother, partner and children. He said that he did not feel that he had any issues with gang affiliations at Aylesbury. He said that he had been diagnosed with psychosis and depression and was in receipt of daily medication. He talked about his previous drug use but declined any input from substance misuse services. Mr Muyeki was located on E wing, a standard wing, and he settled in well.

46. On 5 May, during a routine evening check, staff found Mr Muyeki unconscious on the floor of his cell. Mr Muyeki had been sick, and staff placed him in the recovery position. Staff called a code blue (indicating a prisoner is unconscious or is having breathing difficulties) and control room staff called an ambulance. Mr Muyeki regained consciousness and nursing staff and paramedics arrived at his cell. After assessing Mr Muyeki, paramedics advised that Mr Muyeki should attend hospital for further assessment. Mr Muyeki became threatening and refused to go to hospital, despite nursing staff encouraging him to go. Mr Muyeki signed a disclaimer, which confirmed that he had refused treatment. Staff suspected that Mr Muyeki was under the influence of an illicit substance. They confiscated his vape pen and sent it for testing. Paramedics advised prison and healthcare staff to monitor Mr Muyeki regularly. Healthcare staff did not refer Mr Muyeki to the substance misuse team or put in place physical monitoring as they should have done.

47. Prison staff submitted a security intelligence report and recorded that this was the first time that Mr Muyeki had been suspected of using drugs in the past 12 months. It said that in a previous intelligence report submitted at Chelmsford, it was alleged that he had been holding over 100 sheets of paper impregnated with spice in his cell. (There is no substantive information to confirm this, and Mr Muyeki was never found in possession of drugs or indicated as being under the influence at Chelmsford.) The report also noted that Mr Muyeki had been placed on the basic regime, which meant that he had minimal time out of his cell, was unemployed and was yet to receive a visit at Aylesbury.

48. At 8.50am on 6 May, staff called a code blue after Mr Muyeki was again suspected of being under the influence of an illicit substance. When staff entered his cell, he was initially unresponsive and there was a large amount of vomit around him. As he became responsive, he was confused and became aggressive towards staff. Prison staff restrained him and took him to the segregation unit. Staff removed more vape pens and capsules from his cell. Mr Muyeki did not wish to be referred to the substance misuse team.

49. The duty manager over the weekend of 5-7 May was responsible for authorising prisoners being sent to segregation unit. He spoke to a Custodial Manager (CM), who told him that healthcare staff had requested that Mr Muyeki was taken to the segregation unit to detox from drugs, as they were concerned about the amount of drugs he had taken and the level of his intoxication. The duty manager said that the reasons given were not sufficient for placing someone in the segregation unit. He said that he was not prepared to have a prisoner in segregation solely for the purpose of detoxing.

50. The duty manger instructed staff to look for more suitable spaces around the prison. Staff found a suitable cell on A wing, a standard wing. Staff explained to Mr Muyeki that he would be moving to a cell on A wing, as it was believed that he could be concealing drugs in his cell on E wing. They told him that his property would be collected and searched before being given to him on A wing. Nothing was found during the search, and at 10.30am, Mr Muyeki was moved to A wing.

51. At 2.15pm, Mr Muyeki became violent when he was told that staff on E wing were still in the process of clearing his cell. Staff restrained him and returned him to the segregation unit. During the restraint, Mr Muyeki bit two members of staff and, due to his poor behaviour, he was held in the segregation unit, pending a disciplinary hearing. The duty manager said that he went to the segregation unit to check on the staff and Mr Muyeki and signed the relevant paperwork. He said that Mr Muyeki did not appear to be under the influence of drugs at that time.

52. On 7 May, a member of the chaplaincy team spoke to Mr Muyeki. He said that his partner had told him their daughter had been admitted to hospital, and as a result, he had used illicit substances over past few days. Mr Muyeki said that he did not have a contact number for his partner as he did not have access to his address book. She said that she would try and verify the situation. She discovered that Mr Muyeki had not spoken to his partner and his daughter was not in hospital.

53. Mr Muyeki remained in the segregation unit until 9 May, when he returned to E wing.

54. On 14 May, an officer was on duty on E wing and spoke to Mr Muyeki during the afternoon and asked him about his recent drug use. Mr Muyeki told him that it had been a mistake, he was doing fine and that he was happy as he was due to get his television back. He said that Mr Muyeki asked him why he was concerned, and he told Mr Muyeki that the types of substances he had taken were dangerous. Mr Muyeki thanked him for asking and said that he would not be touching anything anymore. Staff returned Mr Muyeki's television and there were no recorded concerns about him being under the influence of drugs at any point during that day or when locked in his cell that evening.

55. That evening, an Operational Support Grade (OSG) arrived on E wing to start his night shift. He told the investigator that the officer had given him a handover and said that Mr Muyeki had been under the influence of an illicit substance (the officer refutes this). The OSG conducted a routine check on Mr Muyeki at 9.00pm and had no concerns. He did not go to Mr Muyeki's cell again during the night.

56. At 5.10am on 15 May, the OSG completed a routine check. CCTV shows him arriving at Mr Muyeki's cell. He looked through the observation panel then turned the cell light on and continued to look into the cell for a few moments, before closing the observation panel and walking away, leaving the cell light on.

57. At around 5.35am, the OSG returned to Mr Muyeki's cell and looked into the cell for a few seconds, before switching off the cell light and walking away. He said that he could not recall why he had gone back to the cell and did not provide any reasons for his actions. (The prison is conducting an internal investigation into his actions during his shift on 14 and 15 May.)

58. At 7.10am, Officer A arrived on E wing to start her shift. She said that she received a handover from the OSG, and he told her that the only notable occurrence from the previous evening was Mr Muyeki, who had been suspected of being under the influence of drugs. She said that no other information was provided, and she was not aware of any documentation relating to the incident.

59. After receiving the handover, Officer A went to check on Mr Muyeki. She looked in through the observation panel and saw Mr Muyeki sitting on the edge of his bed, with his head resting on his arm, which was resting on the board at the foot of the bed. She said that she thought Mr Muyeki was sleeping so she made no attempt to gain a response from him. She then completed a routine check, handed over the information given to her by the OSG to other staff that had arrived for duty, before going across to D wing to begin her shift.

60. At approximately 8.25am, Officer B attended Mr Muyeki's cell with the intention of completing the daily cell fabric check. He said that when he entered the cell, he announced that he was going to complete the checks and Mr Muyeki was sitting at the foot end of the bed, leaning over to his left with his head facing over the edge of the bed board resting on his left arm. He said that as he conducted his checks, Mr Muyeki did not respond. He called out to Mr Muyeki and asked him if he was all right and what he was looking for on the floor. He said at that point he saw his colleague passing the cell and asked her to assist him with checking Mr Muyeki. He said that he leaned over toward Mr Muyeki and tapped on his shoulder, while calling out to him. He said that it then became apparent that Mr Muyeki appeared not to be breathing, he looked closer and said that he saw a large amount of saliva and blood around Mr Muyeki's mouth. He called a code blue immediately.

61. Staff attempted to place Mr Muyeki in a recovery position on his bed, but Mr Muyeki was stiff. Staff lifted Mr Muyeki onto the floor and began CPR.

62. Nurses attended the cell. Mr Muyeki was lying on the floor, attached to a defibrillator. One nurse said that Mr Muyeki appeared rigid with discolouration to his skin. Staff continued with CPR until paramedics arrived at 8.36am. Staff briefed the paramedics, who took over Mr Muyeki's care. At 8.45am, the paramedics confirmed that Mr Muyeki had died.

Contact with Mr Muyeki's family

63. A prison manager was appointed as the prison family liaison officer (FLO). She identified that Mr Muyeki had given his partner as his next of kin and no other contacts were listed. However, there was a 'no contact alert' against Mr Muyeki's partner so she liaised with the police liaison officer.

64. After careful consideration and in the absence of anyone else to contact, the FLO called Mr Muyeki's partner at 10.15am and informed her of his death.

65. The FLO remained in contact with Mr Muyeki's partner and Mr Muyeki's family and arranged for the family to visit Aylesbury.

66. The prison contributed to Mr Muyeki's funeral costs in line with prison policy.

Support for prisoners and staff

67. After Mr Muyeki's death, a 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 local Samaritans were also contacted to offer support.

68. The prison posted notices informing other prisoners of Mr Muyeki'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 Mr Muyeki's death and also issued information regarding the dangers of psychoactive substances.

Post-mortem report

69. The post-mortem was unable to establish the cause of Mr Muyeki's death.

70. The toxicology report found the presence of a psychoactive drug in Mr Muyeki's system. While it is likely that Mr Muyeki's death was due to its toxic effects, due to the nature of the drug, there was no data on its potential toxic levels.

Actions taken after Mr Muyeki died

71. The prison took a number of actions in response to Mr Muyeki's death including:

- Educating prisoners about the risks associated with PS use, publishing information notices and staff from the drug rehabilitation services providing sessions to inform prisoners.
- Moving to an intelligence led searching process and away from random searching to deal with the intelligence that was received around illicit drugs.
- Weekly analyst meetings (WAM) were held between the security department and the safer prisons team, which looked at knowledge gaps and discussed those prisoners who were of concern. Threats posed by illicit drugs were discussed with the Governor monthly, and disruption tactics based on the intelligence were also discussed.
- Aylesbury had moved away from having dedicated search teams and were supporting residential staff to pro-actively challenge and search individuals on residential units. HMPPS Standards Coaching team supported Aylesbury to assist with the capability and confidence of newer staff.
- On 13 July, the prison issued a Community Notice, reminding prisoners that parcels were received and processed at the Governor's discretion, and only approved delivery suppliers could deliver their parcels.
- 51 intelligence led searches were carried out between May and July 2023.

72. Following Mr Muyeki's death and the death of another prisoner 10 days later, also from suspected PS use, Aylesbury asked for support from HMPPS' National Drug Strategy team. The Substance Misuse Group (SMG) visited Aylesbury on 14 June.

The diagnostic team made five recommendations to improve the prison's drug strategy. The SMG found that:

- The Drug Strategy Lead was working hard to implement a sound strategy, however due to ongoing issues with staffing resources and other operational tasks, a significant percentage of staff were unaware of the strategy or understood how their involvement was a driver for positive outcomes and success.

- Aylesbury had a number of challenges and the presence and demand for drugs continued to be a serious threat. This was potentially compounded by a sense of frustration from prisoners that staff had not been prepared or received training to move from working with young offenders to category C adults.

- Aylesbury did not offer Opiate Substitute Treatment (OST) and therefore it was likely that prisoners that had ongoing or hidden opiate addictions did not receive a sufficient level of support and would be at risk of self-medicating.

- The prison needed to recognise substance misuse as a key driver for increased violence, self-harm, bullying and debt, and doing so would enable the Senior Management Team to positively address the observations made by the SMG.

Findings

Mr Muyeki's substance misuse support

73. Mr Muyeki had a history of drug use. The post-mortem report showed that he had taken synthetic cannabinoids at Aylesbury, which he had obtained illicitly.

74. Mr Muyeki had been open about his use of drugs, cannabis in particular, when he entered prison. He told staff that he had no wish to stop using drugs and did not wish to engage with substance misuse services.

Monitoring prisoners under the influence of illicit substances.

75. When Mr Muyeki was found under the influence of an illicit substance on 5 and 6 May 2023, staff did not refer him to the substance misuse team or put in place additional monitoring as they should have done.

76. We asked the Head of Drug Strategy at Aylesbury whether there was a system in place for monitoring prisoners believed to be under the influence of drugs. She said that an instruction to staff had been issued on 12 May 2023, which set out what staff needed to be aware of in a prisoner who might be under the influence of drugs and a monitoring form to be completed in with healthcare staff. However, the document was withdrawn because some concerns were raised about its content, and she was unable to say whether this was before or after Mr Muyeki's death. She said that regardless of whether the form was in place or not, the expectation was that staff would contact a member of the healthcare team if they had concerns, so that a nurse could see the prisoner and advise on the appropriate treatment and level of observations needed.

77. On 22 May 2023, after Mr Muyeki's death, prison managers re-issued a revised Notice to Colleagues (NTC). The NTC provided advice to staff on the symptoms to be aware of in someone who might be under the influence and the actions that should be taken. A further NTC was issued on 12 June 2023, informing staff that a monitoring pack for the purpose of observing a prisoner who was believed to be under the influence of an illicit substance has been introduced. The NTC confirmed that 'If Healthcare staff deem that the prisoner needs to be subject to monitoring, they will advise staff, set the observation levels, and record this within the monitoring pack. They will review the prisoner after 2 hours to see if they need to remain on monitoring.'

78. Aylesbury have taken steps to ensure that proper monitoring of prisoners believed to be under the influence of illicit substances is now in place. For this reason, we make no recommendation.

Clinical care

79. The clinical reviewer concluded that overall, the care Mr Muyeki received at Aylesbury was equivalent to what he could have expected to receive in the community. The clinical reviewer did, however, identify some areas of concern.

80. While there appears to be a record in Mr Muyeki's medical notes about the primary care team undertaking physical health monitoring on the 5 and 6 May, there is no

evidence that he was referred to the substance misuse team or that physical monitoring was put in place.

81. At the mental health risk assessment on the 10 May, an action on Mr Muyeki's medical record requested that a blood test was completed due to him being prescribed antipsychotic medication, in line with National Institute for Health and Care Excellence (NICE) guidelines. There is no evidence that he was referred to the primary care team for a blood test.

82. The Head of Healthcare will wish to consider this.

Governor and Head of Healthcare to note

Resuscitation

83. Resuscitation Council (UK) guidelines state that staff should consider whether CPR efforts would be successful and, in the patient's, best interests. The guidelines state that, 'resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile'. The guidelines define examples of futility as including the presence of rigor mortis. Rigor mortis normally sets in between two and six hours after death. When staff found Mr Muyeki, his body was stiff indicating the presence of rigor mortis and that he had been dead for some time.

84. We understand the wish to continue resuscitation until death has been formally recognised, but trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. The Governor and Head of Healthcare will wish to consider this.

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