Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ronald Meikle, a prisoner at HMP Woodhill, on 30 April 2024

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 Ronald Meikle died from synthetic cannabinoid toxicity, in his cell at HMP Woodhill, on 30 April 2024. He was 48 years old. I offer my condolences to Mr Meikle's family and friends.

Mr Meikle had a history of substance misuse and openly disclosed to staff that he used drugs while in prison. However, he declined to engage with substance misuse services at Woodhill. There were a number of occasions in the weeks before his death when prison staff found Mr Meikle under the influence of drugs. It is unclear from the records whether healthcare attended, and no referrals were made to the substance misuse service on these occasions.

With the support of the HMPPS Substance Misuse Group, Woodhill is putting steps in place to effectively reduce the supply and demand of illicit substances at the prison. However, it is clear that this is still an issue, with a significant spike in prisoners found under the influence following Mr Meikle's death. I note that a permanent drugs strategy lead is now in place and HMPPS Substance Misuse Group is continuing to support the prison.

On the morning that Mr Meikle died, two members of prison staff did not follow national guidelines when Mr Meikle had obscured his cell observation panel. I am particularly concerned that the investigation has identified a culture at Woodhill in which staff do not challenge prisoners who have blocked their observation panel, despite my office twice making recommendations on the matter in the time before Mr Meikle'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.

Adrian Usher
Prisons and Probation Ombudsman **January 2025**

Contents

Summary

Events

1. On 19 October 2011, Mr Ronald Meikle was sentenced to Imprisonment for Public Protection (IPP) for robbery and possession of a bladed article. He was given a tariff of 33 months. Mr Meikle was never released on licence and remained in prison for considerably longer than his tariff.

2. Mr Meikle had an extensive history of substance misuse in the community and in prison. Mr Meikle also had diagnoses of anti-social personality disorder and attention deficit disorder.

3. On 20 December 2022, Mr Meikle transferred to HMP Woodhill. At Woodhill, he reported using psychoactive substances (PS) on a number of occasions but declined to engage with the prison's substance misuse service.

4. Mr Meikle was in debt regularly and had short periods of isolating while at Woodhill.

5. Between 8 April and 11 April 2024, staff found Mr Meikle under the influence of drugs on several occasions. No referrals were made to the substance misuse service. Mr Meikle disclosed to his prison offender manager that he had not meant to appear under the influence but that the substance had affected him more than usual.

6. On 11 April, Mr Meikle lost his job due to a pattern of negative behaviour.

7. A few days before he died, Mr Meikle started to isolate and asked staff not to open his door. He did not provide a reason.

8. At around 9.12am on 30 April, staff found Mr Meikle unresponsive in his cell. Prison and healthcare staff attempted resuscitation. Paramedics arrived at 9.27am and confirmed Mr Meikle's death at 9.33am.

Findings

9. Mr Meikle was a frequent PS user and disclosed to one member of staff that he used drugs every day while in prison. He declined to engage with the substance misuse service while at Woodhill.

10. Prison managers have responded positively to a review conducted by HMPPS Substance Misuse Group and are working to drive improvements in relation to drug supply. However, PS and other illicit drugs remain widely available. The number of prisoners reported to be under the influence of drugs in the month after Mr Meikle died is particularly concerning.

11. When prison staff found Mr Meikle under the influence in the weeks prior to his death, they did not follow the correct process and there is no evidence that healthcare staff attended to check him or that referrals were made to the substance misuse service.

12. Staff members completing routine checks on the morning of Mr Meikle's death did not take effective action when they identified that he had blocked his observation panel. We found that there was a culture of prisoners covering their observation panels and staff not challenging this. We have made two previous recommendations about this.

Recommendations

- The Governor should ensure that there is clear guidance and training for all staff on actions to take when a prisoner appears to be under the influence of drugs and that a robust quality assurance process is introduced to monitor and ensure that staff comply with local guidance.

- The Long Term High Security Deputy Director should devise a plan of action to satisfy herself that prison staff understand local and national expectations regarding blocked observation panels, including that prisoners are always challenged, and blockages removed.

The Investigation Process

13. HMPPS notified us of Mr Meikle's death on 30 April 2024.

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

15. The investigator visited HMP Woodhill on 7 May 2024. She obtained copies of Mr Meikle's prison and medical records, CCTV and body worn video camera footage of the emergency response. She also obtained the HMPPS Early Learning Review and Ambulance Service records.

16. NHS England commissioned a clinical reviewer to review Mr Meikle's clinical care at the prison. The investigator and clinical reviewer jointly interviewed nine members of staff.

17. The investigator interviewed an additional six members of staff and three prisoners between May and July 2024.

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

19. The Ombudsman's office contacted Mr Meikle's brother and father to explain the investigation and ask if they had any matters they wanted us to consider. Mr Meikle's father wanted to know how Mr Meikle had died. Mr Meikle's brother asked several questions about Mr Meikle's physical health, which are addressed in the clinical review.

20. We shared the initial report with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

21. We also shared the initial report with Mr Meikle's family. They did not make any comments.

Background Information

HMP Woodhill

22. HMP Woodhill is a high security prison in Milton Keynes, holding primarily category B prisoners and a small number of category A prisoners. (Mr Meikle was a category B prisoner.) Central and North-West London NHS Foundation Trust provides health services, including substance misuse services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Woodhill was in August 2023. Following the inspection, the Chief Inspector of Prisons invoked the Urgent Notification (UN) process due to serious concerns. (The Urgent Notification process allows HM Chief Inspector of Prisons to directly alert the Lord Chancellor and Secretary of State for Justice if he has an urgent and significant concern about the performance of a prison.) He noted that none of the recommendations from the previous inspection in 2021 had been achieved.

24. Inspectors found that illicit drug use was widespread, with positive random mandatory drug tests at 38%, the sixth highest rate in the country. They also found that levels of self-harm were the highest in the adult male estate.

25. Inspectors cited a chronic shortage of prison officers being behind the prison's difficulties. They found that time out of cell had improved since their last inspection but that prisoners still spent too much time locked up. Staff shortages meant that work and education were routinely cancelled, and they found that prisoners were frustrated by the lack of opportunities for progression. They also found that prisoners who were acutely unwell, including those who had taken an overdose of illicit drugs, did not receive care that met the national guidelines for clinical monitoring or escalation of concerns.

26. As a result of the UN, HM Prison and Probation Service decided to temporarily reduce the prisoner population at Woodhill and the prison closed down two house units. At the time of issuing this report, these remain closed.

27. In July 2024, HMIP conducted a visit to review Woodhill's progress. They found good or reasonable progress across all but one of their concerns. Inspectors noted that the prison had successfully recruited and retained its full quota of officers, although some were still in training and levels of inexperience were high. Inspectors found that prisoners now spent more time unlocked and engaged in purposeful activity.

28. Inspectors found that violence had reduced overall. They noted that while the mandatory drug testing positive rate had decreased to 28%, this was still high. Inspectors reported that clinical monitoring of prisoners' needs were being appropriately undertaken, in line with their presentation.

Independent Monitoring Board

29. 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 May 2024, the IMB found that prisoner-on-prisoner assaults remained among the highest in the Long-Term High Security Estate. They expressed concern at the number of prisoners choosing to self-isolate and found that many prisoners were doing this due to debt or efforts to stay out of trouble. They acknowledged the vigilance of the safer custody team in implementing the safer custody policy and visiting these prisoners weekly.

30. The Board found that preventing illicit items continued to be a challenge for the prison. They found that the use of spice (a term generally describing synthetic cannabinoids – a type of PS) had increased and adapted vapes were being used as a way of taking drugs. They noted that the dedicated search team (DST) carried out searches on men and across areas of the prison, which resulted in finds of drugs and phones among other items. The Board found that there were 30 medical emergencies during one weekend in May 2024 due to spice use. The Governor and Head of Healthcare met regularly to review operations and progress. The Board found that prisoners expressed frustrations at the length of time they had to wait for psychiatrist appointments.

31. The IMB noted that the prison continued to rely on the redeployment of staff from other establishments to maintain safe staffing levels. They witnessed occasions where all officers on a wing were on detached duty, limiting the ability to develop trusting relationships.

HMPPS Substance Misuse Group

32. In November 2023, as part of Woodhill's UN, the HMPPS Substance Misuse Group (SMG) conducted a drug strategy support visit at the prison. The aim of this visit included providing a better understanding of the scale of the prison's vulnerability to the conveyance of illicit drugs.

33. They found that there was individual good work taking place, driven by the then Head of Drugs Strategy, and that the prison's security and intelligence department had a good understanding of substance misuse issues. However, they noted that the prison would benefit from specific timebound activity and a better understanding of drug strategy among all staff. They also found that there could be better alignment between security, safety and substance misuse work.

34. Their findings included:

- There were apparent knowledge gaps around illicit drugs, noticeably around the signs and symptoms of PS strains.
- HMP Woodhill utilises Enhanced Gate Security (EGS) at its entrance points for both staff and visitors. However, the search process felt rushed and chaotic, potentially undermining its effectiveness. They recommended having a manager in the EGS area, particularly at peak times.

- Some staff had an understanding what organic drugs look like, but the searching staff had less understanding of the current threat of drugs and what illicit substances look like in other forms.
- The drugs of choice within the establishment were cannabis and PS.
- While staff seemed well briefed for visits, there was no zonal patrolling.
- Having identified PS ingress through mail as a risk, the establishment had begun to photocopy mail.
- There was a general lack of awareness and understanding of the drug strategy within the establishment.
- The prison had recently relaunched its Drug Strategy meeting.
- The prison did not have (or that staff could show them) an Under the Influence (UTI) policy.

35. The SMG initially made five recommendations. These included that:

- Activity should be undertaken to raise awareness of substance misuse and drug strategy across the prison.
- A UTI protocol should be developed and introduced, setting out key roles and responsibilities. This should then be communicated to staff so that they understood the process to follow.
- Drug Strategy meetings should be used as a forum to commission and coordinate timebound activity.
- Supervision of medication administration should be reviewed to address the lack of operational support provided during dispensing times.
- The Senior Management Team should ensure close strategic alignment between Security, Safety and Drug Strategy activity.

Previous deaths at HMP Woodhill

36. Mr Meikle was the eighth prisoner to die at Woodhill since April 2021. Three of the previous deaths were from natural causes and four were self-inflicted. To the end of October 2024, there have not been any other deaths at Woodhill.

37. In two previous investigations we made recommendations about staff challenging blocked observation panels. Woodhill responded that during daily Accommodation Fabric Checks (AFCs), staff would check that observation panels were not blocked. They also noted that they continued to publish Notices to Staff highlighting the importance of taking immediate action when staff discover that a prisoner has blocked their observation panel.

Imprisonment for Public Protection (IPP) sentences

38. Imprisonment for Public Protection (IPP) sentences were abolished in 2012. They were intended to protect the public against offenders whose crimes were not serious enough to merit a normal life sentence, but who could only be released once they had served their minimum tariff and had demonstrated to the satisfaction of the Parole Board that they had sufficiently reduced their risk.

39. As of June 2023, there were 2,909 IPP prisoners, of which 1,312 had never been released and 1,597 had been recalled to custody.

Psychoactive substances

40. The term ‘psychoactive substances’, is a broad term that refers to a drug or other substance that affects mental process. Synthetic cannabinoids and synthetic opioids (including nitazenes) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

41. PS 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 these substances 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.

Key Events

42. On 19 October 2011, Mr Ronald Meikle was sentenced to Imprisonment for Public Protection (IPP) for robbery and possession of a bladed article. He was given a tariff of 33 months. Mr Meikle was never released on licence.

43. Mr Meikle had a significant history of substance and alcohol misuse and, before arriving at HMP Woodhill, he had engaged with substance misuse teams on various occasions in custody. Mr Meikle had diagnoses of anti-social personality disorder and attention deficit disorder.

44. During his sentence, Mr Meikle moved between numerous establishments. In some instances, prison staff moved Mr Meikle due to negative behaviour or being in debt, while at other times he requested a transfer.

45. During his time in custody, Mr Meikle often chose to isolate. Before moving to Woodhill, Mr Meikle isolated for almost six months as he wanted to show to the Parole Board that he was keeping out of trouble.

46. Mr Meikle attended a Parole Board hearing in November 2022. The panel found that his behaviour had improved but he had not achieved his sentence plan targets. This included the completion of the Kaizen programme (an offender behaviour programme for adult males assessed as high or very high risk).

HMP Woodhill

47. On 20 December 2022, Mr Meikle transferred to Woodhill. In his first night interview, Mr Meikle told staff about his drug use and admitted to “liking a smoke”. At his initial health screening, Mr Meikle disclosed a history of substance misuse. He reported a diagnosis of paranoid schizophrenia (a mental health team explored this in 2021, but there was no confirmed diagnosis). Mr Meikle also shared that he had been prescribed antipsychotic medication in the past, but not currently.

48. On 21 December, a staff member from the substance misuse service visited Mr Meikle. Mr Meikle told them that he did not need any support from the team. He disclosed that he used psychoactive substances (PS) but knew how to keep himself safe.

49. On 22 December, a mental health nurse reviewed Mr Meikle. Mr Meikle told the nurse that he had a history of substance misuse and that he had used PS the previous day. The nurse sent a task to the substance misuse service, who saw him the following day. Mr Meikle accepted harm minimisation advice (a discussion with patients about the effects of illicit substances) but declined to engage further. He again admitted to using PS but said that this was not problematic. He signed a service withdrawal form.

50. On 18 January 2023, a mental health nurse conducted a welfare check with Mr Meikle. He engaged well and discussed his anger issues, paranoia and thoughts to harm others. Mr Meikle said he wanted a prescription for mirtazapine (an antidepressant), olanzapine and chlorpromazine (both antipsychotics). He explained that he had taken these medications previously and had found them

helpful. (Mr Meikle's medical records show that he had last been prescribed chlorpromazine in 2012, mirtazapine in 2021 and had never been prescribed olanzapine in custody.) He also disclosed again taking illicit substances and staff submitted an intelligence report. Staff added Mr Meikle to the psychiatry waiting list. Mr Meikle did not attend psychiatry appointments on three occasions and was not therefore assessed for or prescribed the medication he requested. (Healthcare staff recorded that Mr Meikle did not attend because he was isolating due to debt and also because he was "not interested" in attending. On one occasion they did not record why Mr Meikle did not attend.)

51. During the year, Mr Meikle spent three short periods isolating. On one of occasion, he said that he was isolating because he was under threat on the wing (in the medical records it notes that Mr Meikle was in debt). There is no record of why Mr Meikle isolated on the other two occasions. There were also several intelligence reports noting that Mr Meikle was observed cleaning other prisoner's cells. (This might indicate that he was in debt.)

52. In February and July, staff found fermenting liquid and drug paraphernalia in Mr Meikle's cell. On both occasions, healthcare staff visited Mr Meikle to discuss harm minimisation, but he declined to engage with the service.

53. In October, staff informed Mr Meikle that the Kaizen course was being paused at Woodhill (this was due to the temporary closure of certain wings). Mr Meikle said that he was disappointed by this and that he now had had no incentive to behave positively.

December 2023 – March 2024

54. In December, a Kaizen programme facilitator held a wellbeing check with Mr Meikle. Mr Meikle told him that he was under threat due to getting a particular cleaning role on the wing. He said that he was being labelled a "grass" and therefore wanted to forfeit the role. The facilitator submitted an intelligence report and told wing staff. He met with Mr Meikle on 22 further occasions. They frequently discussed Mr Meikle's frustration with his IPP sentence.

55. On 28 December, Mr Meikle told staff he was being targeted. He said he would be assaulted if he was not taken off the unit with immediate effect. He isolated behind his door for the next three days. Intelligence reports suggest that Mr Meikle was isolating due to being in debt. Staff did not move Mr Meikle off the unit, make a referral for a debt support plan or place him on a Challenge Support & Intervention Plan (CSIP, a tool used to manage and support prisoners at risk of violence or who present a risk of violence to others).

56. On 3 January 2024, Mr Meikle met his prison offender manager (POM). He told her that he had some debt on the wing due to an issue with his canteen allowance. He told her he was then unable to pay for Spice (a type of PS) and chose to isolate to avoid getting into conflict.

57. Mr Meikle told his POM that he was a functional spice user and used drugs daily with no intention to stop. (She submitted an intelligence report.) During this discussion, she gave Mr Meikle a copy of his parole report. She explained that probation practitioners had not decided whether they would recommend release,

but that they would like to see the completion of Kaizen, or if this was not possible, the maintenance of current behaviour. Mr Meikle was frustrated by this and walked out, telling her that he would not have any contact with her and not to come and see him again.

58. On 5 January, Mr Meikle received a negative incentive warning. He went on to receive 16 further negative incentive warnings until he died. Some of these were for appearing under the influence, some for being found with suspected PS substance residue, one was for vaping at work while others were for not complying with the regime.

59. On 8 January, Mr Meikle received a positive result from his mandatory drug test (MDT) for synthetic cannabinoids. On 11 January, staff charged him with a prison disciplinary offence. He was found guilty and given a reduction in privileges.

60. Staff also reviewed Mr Meikle's level on the Incentives Policy Framework (IPF) Scheme (which aims to encourage and reward responsible behaviour in prisons), downgrading him from enhanced status to standard. No referral was made to the substance misuse service.

61. On 16 January, Mr Meikle, along with three other prisoners, ran into a cell and barricaded the door. An intelligence report suggested that Mr Meikle may have been involved due to being in debt to one of the prisoners. During a search following this incident, staff found an improvised weapon in Mr Meikle's cell. The next day, staff downgraded him from standard to basic on the IPF Scheme (meaning a more severe reduction in privileges, including access to an in-cell television and money to spend in the prison shop). (Staff charged Mr Meikle but did not proceed with the hearing due to a lack of evidence and the reporting officer not being available.) On 31 January, he was upgraded to standard.

62. On 17 January, Mr Meikle approached a mental health nurse and asked for a psychiatrist appointment. Staff added Mr Meikle to the psychiatry waiting list. Mr Meikle did not see the psychiatrist before he died. (The Head of Healthcare told us that there was a significant waiting list for the psychiatrist at the time, due to a limited staff resource. She told us that since Mr Meikle's death they have increased their psychiatry provision.)

63. On 7 February, Mr Meikle discussed his drug use again with his POM. He shared that he regarded himself as a horrible person when not under the influence. She did not submit an intelligence report and told us that she did not submit an intelligence report every time Mr Meikle discussed his drug use. (Her notes of her appointments with Mr Meikle were recorded on a probation IT system that wing staff cannot access.)

64. On 19 February, Mr Meikle started working in the off-wing laundry.

65. On 7 March, Mr Meikle met his POM and his community offender manager (COM). They informed him that Kaizen would not be removed from his sentence plan, in response to a request he had a made a few weeks earlier. Mr Meikle expressed that he felt he had done enough programmes. He told them he would not engage with them or his upcoming oral hearing and left the room. He also said that he was

having issues in receiving the correct pay. He said that this was causing him issues on the wing as he had bills to pay and that he was at risk on the wing as a result.

66. On 11 March, Mr Meikle was frustrated that he could not attend work in the laundry after attending chapel that morning. Staff then observed lots of prisoners coming and going from his cell. Intelligence assessments note that it is likely that Mr Meikle was using the laundry to traffic items, possibly to pay off a debt or for personal use.

67. On 14 March, Mr Meikle spoke with a member of the Safer Custody team about his ongoing debt. Mr Meikle did not share who he owed money to but said he wanted to move to a different wing. Staff told Mr Meikle that this would be unlikely but if he was under serious threat he could isolate. He replied that this was not the kind of thing he did and that he would rather "walk around with a tool [weapon]" than isolate.

68. Later that day, a GP reviewed Mr Meikle. Mr Meikle said that he had a migraine and felt stressed. The GP prescribed him propranolol (medication used to treat several conditions, including anxiety), stating that they would trial this and then have a review. There is no evidence that a review took place.

69. On 19 March, the Dedicated Search Team (DST) searched Mr Meikle's cell and found a vape cap with suspected PS residue. This was seized and sent for external testing. The results, which came back after Mr Meikle's death, detected synthetic cannabinoids in the vape cap.

70. On 20 March, a member of the substance misuse service spoke to Mr Meikle following the find in his cell. Mr Meikle said that this was not PS. He said that he had never denied using PS and was well aware of the risks involved. Mr Meikle again declined to engage with the substance misuse service and the staff member gave him harm minimisation advice.

71. On 21 March, Mr Meikle had a keyworker session. During this session he said he would like to transfer out of Woodhill as it was "pissing him off" and he would ideally like to move closer to home. His keyworker informed his prison offender manager.

April 2024

72. In April, Mr Meikle made applications to different prison departments in which he said that he wished to appeal his sentence and that he would like to temporarily transfer to a London prison so he could see his family.

73. On 8 April, Mr Meikle attended work in the laundry. A prison instructional officer wrote in Mr Meikle's prison record that she believed he was under the influence of drugs. She spoke to Mr Meikle about this, but he denied being under the influence.

74. A Kaizen programme facilitator spoke to Mr Meikle that afternoon about his decision to de-select from the Kaizen programme. Mr Meikle confirmed again that he did not want to continue.

75. On 9 April, Mr Meikle attended an art session. He was quiet and slow to engage and requested to go back to the wing. An officer facilitated this, and he was

escorted back. (Mr Meikle's behaviour might have indicated that he was under the influence of drugs, although no one recognised or recorded this at the time.)

76. On 10 April, laundry staff noted that Mr Meikle was displaying signs of being under the influence. An officer recorded on Mr Meikle's prison record that healthcare staff were due to come and check him. However, there is no evidence in Mr Meikle's medical records that healthcare staff attended.

77. On 11 April, prison staff decided to remove Mr Meikle from his job in the laundry. This was due to a pattern of poor behaviour and negative incentive warnings.

78. That morning, Mr Meikle attended an art session but appeared to be under the influence and staff sent him back to the wing.

79. In the afternoon, Mr Meikle met his POM and informed her he would de-select from the Kaizen programme. He told her that he had been bulled into doing Kaizen and that as an IPP prisoner he did not have to. They discussed Mr Meikle's request to move out of Woodhill to a London prison to have visits from his family. She informed him that she had no reason to facilitate a move for Mr Meikle to another establishment as he could achieve his sentence plan at Woodhill. She went on to explain to him that Woodhill was the closest category B prison to London for which he met the criteria. Mr Meikle told her that he would do what he needed to transfer out of Woodhill. She reiterated that in the absence of Kaizen, maintained behaviours would put him at better standing and Mr Meikle said he would think about this.

80. On the same day, DST conducted an intelligence-led cell search. They found a pair of staff gloves and a suspected PS vape cap. The vape cap was sent off for external testing. The results, which came back after Mr Meikle's death, indicated that synthetic cannabinoids were present.

81. During this cell search, staff noted that Mr Meikle appeared to be under the influence of drugs. They recorded in his prison record that they contacted healthcare staff, who confirmed that he seemed to be under the influence but that he refused for clinical observations to be taken. There is no record of this in Mr Meikle's medical records and no referral was made to the substance misuse service.

82. Mr Meikle subsequently attended an IPF review board and staff downgraded him from standard to basic. On 25 April, he was upgraded back to standard following a period of more settled behaviour.

83. On 16 and 17 April, a number of calls were made from Mr Meikle's PIN phone. (All prisoners' telephone calls are recorded. Prison staff listen to some at random and others are listened to if security staff have intelligence that information about the safety of individuals or the prison might have been discussed. No one listened to Mr Meikle's calls until after his death.) Mr Meikle made some of these calls to his brother. Other prisoners made five calls to one number (which we believe was a virtual landline which diverts calls to mobile telephone numbers), telling their contacts that they were using the phone as a courtesy because of debts Mr Meikle owed.

84. On 19 April, an officer conducted a keyworker session. Mr Meikle said he had regular contact with family and friends and that his debt on the wing was under control.

85. On 24 April, Mr Meikle met his POM. During this meeting, she shared a report she had written for the Parole Board which detailed Mr Meikle's withdrawal from Kaizen. They discussed the number of times that Mr Meikle had recently been under the influence of drugs. Mr Meikle said he had no intention to take more PS than usual or to be noticeably under the influence, but the substance had affected him more on those occasions. (She did not submit an intelligence report.)

86. On 27 April, an officer opened Mr Meikle's door and asked him why he had not come out to spend association time with other prisoners. He told the investigator that Mr Meikle responded that he did not wish to be out that day. Mr Meikle said he was fine but wanted to stay in his cell. He did not make an entry in Mr Meikle's prison records or the observation wing book.

87. A prisoner told the investigator that Mr Meikle began to isolate on 27 April. Before this, Mr Meikle had asked him for help with paying his debts. He said that he declined to help Mr Meikle. He told the investigator that he had paid Mr Meikle's debts three times before and did not want to do this again.

88. On 28 April, Mr Meikle wedged plastic cutlery under his door to make it harder to open the door. An officer asked him the reason for this. Mr Meikle did not give a reason but said that staff should not open his door. He said that he did not feel safe having his door open. (No one made an entry in the observation wing book about Mr Meikle's isolation at any time before he died.)

89. A Supervising Officer (SO) asked a peace promoter (a prisoner who helps to mediate issues with prisoners) to speak to Mr Meikle to ensure that he was not isolating due to debt. The SO informed the investigator that Mr Meikle told the prisoner that he just wanted some peace behind his door.

90. Another SO told the investigator that he recalled Mr Meikle being out of his cell on 28 April, as he remembered racing him along the landing back to his cell. Other staff members said that Mr Meikle did not come out of his cell at all that day.

91. On 29 April, Officer A submitted an intelligence report about his conversation with Mr Meikle from the previous day and recorded this in Mr Meikle's prison records. No entry was made in the wing observation book.

92. Officer A contacted Safer Custody and asked for the paperwork to complete in relation to Mr Meikle isolating. (Local guidance is that when an individual has been isolating for 72 hours a referral form should be completed and submitted to the Safer Custody team.) He explained to the investigator that Safer Custody told him to complete this by 30 April.

93. Later that day, Mr Meikle told Officer A that his in-cell computer terminal (used for making prison applications) was not working and he could not place an order with the prison shop. The officer asked if this was to do with paying someone back, but Mr Meikle replied that he just wanted his order. The officer explained that he would

take him out to the kiosk on the other wing if he had the time. (He told us that he did not have time that afternoon.)

94. At 4.53pm, Officer B went to Mr Meikle's cell door. He told the investigator that Mr Meikle asked him to deliver a letter to another prisoner that he had written on the prisoner's behalf. The officer delivered the letter and Mr Meikle asked if the prisoner had given him a vape cap in return. The officer said he had not, and Mr Meikle said he would settle this the next day. The officer said that he did not believe Mr Meikle to be under the influence of drugs at this time. At 5.00pm, he returned to Mr Meikle's cell to deliver his food.

Events of 30 April 2024

95. The following account has been drawn from staff statements, interviews, body worn video camera (BWVC) footage, CCTV footage and ambulance service records.

96. At 5.00am on 30 April, an Operational Support Grade (OSG), the night patrol officer, conducted a routine check. This was his first night shift and the first time that he had conducted a routine check unsupervised.

97. The OSG went to Mr Meikle's cell door and knocked three times. The observation panel in the cell door was blocked and he was unable to see into the cell. On the third knock, he told the investigator that he heard a grunt from Mr Meikle's cell. He took no further action at that time to challenge Mr Meikle about the blocked observation panel.

98. At 7.15am, Officer C conducted a routine check. Due to staffing pressures that morning, she told the investigator that she was on her own doing the check for both sides of the unit. (There was meant to be an additional member of staff there for the routine check.) At 7.28am, she opened the observation flap and stood by Mr Meikle's cell for a few seconds. She could not recall what she saw at Mr Meikle's cell but told the investigator that she counted someone in the cell. She could not remember whether the observation panel was covered.

99. At 8.26am, a prisoner went to Mr Meikle's cell. He informed the investigator that he had gone to give Mr Meikle a vape, as he knew Mr Meikle did not have much money. The observation panel was covered with a curtain, and he knocked multiple times. He thought that Mr Meikle was asleep and then left the wing to attend an appointment.

100. At around 9.11am, Officer D was helping engineers who were checking that phone ports on the wing were working. They arrived at Mr Meikle's cell, and he knocked on the door but did not get a response.

101. Officer D opened the observation flap but saw that the panel was blocked. He told the investigator that he was not able to see into the cell at all. He shook the handle of the door which helped to loosen the item and then saw Mr Meikle lying on the floor on his back next to the bed. He immediately opened the cell door and radioed a medical emergency code blue (used to indicate when someone is unresponsive or not breathing). He noted that Mr Meikle looked pale, a bit blue and his eyes were very dark. He explained that there was blood coming out from one of his ears.

102. Officer A and a SO arrived at the cell around 30 seconds later. The SO directed staff to start cardiopulmonary resuscitation (CPR), which Officer D did immediately. At 9.14am, two members of healthcare staff, who were on the wing dispensing medication, arrived at the cell. A minute later, they were joined by the healthcare team leader, who directed the officers to continue CPR. Healthcare staff noted signs of rigor mortis but described Mr Meikle as not being cold to touch.

103. At 9.25am, a GP arrived and was followed by paramedics at 9.27am. The GP noted that rigor mortis was present. At 9.33am, paramedics and the GP confirmed that Mr Meikle had died.

Contact with Mr Meikle's family

104. Woodhill appointed two family liaison officers (FLOs). At 3.15pm on 30 April, they arrived at Mr Meikle's brother's address. He was not home and so they decided to call him.

105. Mr Meikle's brother informed the FLOs that he did not live at the address. He asked several times whether his brother was dead and said he did not want to meet them. They therefore broke the news of Mr Meikle's death over the phone. Mr Meikle's brother asked that his father was contacted and the FLOs travelled to his father's address that afternoon. They offered ongoing support.

106. The prison contributed toward the cost of Mr Meikle's funeral in line with national policy.

Support for prisoners and staff

107. After Mr Meikle's death, a prison governor chaired a debrief for all 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. The majority of staff we spoke to felt well supported. However, one member of staff involved in the emergency response told the investigator that while there was support on the day, no-one checked up on him for around two to three weeks following the incident.

108. The prison posted notices informing other prisoners of Mr Meikle'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 Meikle's death. A prisoner told the investigator that senior officers came to see him following Mr Meikle's death and he was offered good support.

Post-mortem report

109. The report of the post-mortem examination concluded that the cause of Mr Meikle's death was acute ADB-BINACA toxicity (ADB-BINACA is a synthetic cannabinoid). This resulted in acute cardiorespiratory depression.

Findings

Drug strategy at HMP Woodhill

110. In April 2024, two weeks before Mr Meikle's death, the HMPPS Substance Misuse Group (SMG) conducted a follow up visit to review the recommendations implemented from their initial visit. Overall, they found that the Drug Strategy Leads (DSL) at Woodhill had worked hard to implement the initial recommendations. They noted that while some of the recommendations were still ongoing, SMG believed there was evidence of improvement in the delivery of the drug strategy across the establishment. They set out that once the establishment had successfully recruited a full time DSL (the lead at the time was interim due to the departure of the previous DSL), SMG would continue to offer their support where required.

111. SMG's findings included that the large majority of the staff spoken to had recently received some form of drug strategy awareness information or training. However, they also noted that the Under the Influence (UTI) Protocol was not fully followed and some staff were unable to provide details of the basic requirements expected of them when dealing with a prisoner under the influence. (There were some occasions on which Mr Meikle appeared to be under the influence of drugs and was not assessed by healthcare staff, or the events were not reported as required.)

112. Despite improvements, there are clearly still issues with the drug supply at Woodhill. In May 2024, there were 253 individual reports of prisoners being under the influence or suspected to be in possession of substances, a very significant increase on the previous month when there were 38 reports. (The Head of Drug Strategy recognised that this was a very large increase. He said that he was unsure whether the increase could be partly attributed to officers reporting more rigorously than previously or whether they were now more vigilant to prisoners under the influence of drugs.) Mr Meikle told a staff member that he used PS every day and two prisoners we spoke to as part of this investigation told us that drugs were freely available.

113. In response to the significant increase in prisoners being found under the influence following Mr Meikle's death, the prison put together an action plan. Actions included issuing a Governor's Order around how to deal with those under the influence, targeted cell searching, discussing prisoners with multiple cases of being under the influence at the Safety Intervention Meeting (SIM) and training related to the use of naloxone medication. (Naloxone reverses effects of opioid overdose.) Two letters were sent to all prisoners to highlight the risks of PS. An operational staff briefing about PS took place in May. SMG also attended the prison in May to deliver a workshop to upskill staff about the use of PS.

114. We found that an intelligence report suggested Mr Meikle may have been using the laundry to traffic items either to pay off a debt or for personal use. A staff member working in the laundry told us that while prisoners are searched coming off and onto the unit, these searches are not effective, and they often do not find items that prisoners have on them. The Head of Security told us that staff were not always searching prisoners effectively enough during movements. He told us that staff have raised that there is not sufficient time to effectively search prisoners when they

leave the wing. He said that they have recently held a security fair for all staff which included training on searching.

115. Woodhill has now appointed a permanent DSL, who started in July 2024. Their priority will be to ensure that the SMG recommendations are fully implemented. We understand from SMG that they aim to provide more sustained support to Woodhill, as they will be doing for all HMIP Urgent Notification sites. As such, we do not make a recommendation at this time.

Substance misuse provision

116. Mr Meikle had an extensive history of substance misuse and openly told staff that he used drugs. Upon arrival to Woodhill, healthcare staff promptly referred him to the substance misuse service. Mr Meikle declined all support and went on to sign a service withdrawal form.

117. The substance misuse service continued to try to engage with Mr Meikle and visited him on a number of occasions giving harm minimisation advice. Each time, Mr Meikle declined to engage with the service, saying that he was aware of the risks and did not think his usage was problematic.

118. In April 2024, prison staff recorded that Mr Meikle was under the influence on three separate days. The Woodhill Illicit Substance Misuse guidance sets out that staff should contact the healthcare team to assess the patient as well as making a referral to the substance misuse service. None of these incidents were noted in Mr Meikle's medical record and no referrals were made to the substance misuse service. On one of these occasions, operational staff recorded that healthcare staff had seen Mr Meikle, but there was no note of this in his medical record.

119. There were no entries in the wing observation book on any of the days Mr Meikle was found under the influence and Woodhill could not provide any illicit substance misuse logs for Mr Meikle. (The illicit substance misuse log is a document detailing (i) the actions taken when a staff member is concerned that someone has taken illicit substances (ii) a section to document that a prisoner has been seen by healthcare staff and (iii) a section to document regular welfare checks taken on the prisoner.)

120. The Head of Substance Misuse told the investigator that her team often identify prisoners who were found under the influence from the daily briefing, rather than through referrals to the service. She explained that there is a mismatch of reporting, in which some prisoners had been referred but were not on the briefing sheet, while others were on the briefing sheet but had not been referred to the service. The investigator found through interviews that while prison staff knew that healthcare should be contacted when a prisoner was under the influence, some staff were not always clear on all the associated actions to follow.

121. Since Mr Meikle's death, Woodhill have updated their Illicit Substance Misuse guidance. On 8 May 2024, the Governor issued a notice to staff to ensure they were aware of the immediate steps that they must take if a prisoner was suspected of being under the influence. This includes informing healthcare staff, commencing 15-minute welfare checks, recording the incident in the wing observation book, submitting an intelligence report and referring the prisoner to the substance misuse

service. These instructions have also been added to Woodhill's Local Security Strategy.

122. Woodhill has also initiated a process by which the illicit substance misuse logs are now submitted to the DSL after completion so that they can keep them for future reference. The DSL informed us that he (or his replacement) will start taking a sample of the logs to quality assure these. The Governor will want to assure herself that this quality assurance process is in place.

123. Our experience (as demonstrated in the following section) tells us that Governors' orders to staff are rarely sufficient to drive cultural or behavioural changes across staff groups, and that more targeted action is generally required to embed the learning. We make the following recommendation:

The Governor should ensure that there is clear guidance and training for all staff on actions to take when a prisoner appears to be under the influence of drugs and that a robust quality assurance process is introduced to monitor and ensure that staff comply with local guidance.

Blocked observation panels

124. An HMPPS Safety Briefing on Observation Panels, issued in February 2018, says that local safety measures should explain what staff should do if the occupant of a cell cannot be seen due to the panel being covered or blocked. It goes on to say that when staff discover that a panel has been blocked and the prisoner does not comply with instructions to remove the blockage, they must take immediate action to remove the obstruction and check on the prisoner's welfare.

125. In March 2023, Woodhill issued a notice to staff setting out that all staff are to perform a visual welfare check during roll checks as well as when unlocking for movements in the morning and afternoon. This notice to staff was in direct response to a PPO investigation. In a further notice to staff, issued in June 2023, clear instructions were given about actions to take where staff discover an obscured observation panel.

126. When the OSG conducted his roll check on the morning of 30 April, he found that Mr Meikle had covered his observation panel. He told us that he heard a grunt from the room after knocking three times. He said that he was told by another officer (who he was shadowing that night) that if he could not see the prisoner he should knock on the door and get a verbal response. This was his first night shift and the first time he had completed these checks unsupervised. He told us he now knows that he needs to ask the prisoner to unblock their observation panel and knows what to do if the prisoner does not respond or remove the blockage.

127. When Officer C conducted her roll check, she told us that she could not remember what she saw in Mr Meikle's cell and could not recall if the observation panel was covered. It is very likely, given it was covered two hours before and two hours after, that the observation panel was covered at this time. Woodhill has conducted a fact-finding investigation to decide if more formal action is needed. We are awaiting the outcome of this.

128. Officer C informed the investigator that where observation panels are covered, she either listens to hear whether someone is inside or looks through a crack in the door. She explained that roll checks and welfare checks were distinct and that at a roll check she is just checking that someone is in the cell rather than checking that someone is breathing. She said that she knows that covered observation panels are meant to be challenged but found that a lot of staff did not challenge at this time in the morning due to the abuse they might receive if they did.

129. We found through our investigation that there is a culture of prisoners blocking their observation panels and evidence to suggest this is not always challenged.

130. In previous investigations at Woodhill, we have made recommendations about challenging blocked observation panels. The prison previously stated that when staff conducted accommodation fabric checks, which are completed daily, they would check for blocked observation panels. They also said they had continued to publish notices to staff highlighting the importance of taking immediate action when a cell panel has been obscured. It is clear that these actions have not resolved the issue. We therefore make the following recommendation:

The Long Term High Security Deputy Director should devise a plan of action to satisfy herself that prison staff at Woodhill understand local and national expectations regarding blocked observation panels, including that prisoners are always challenged, and blockages removed.

Governor to note

Debt management

131. Prison records, intelligence reports and phone calls made by other prisoners indicate that Mr Meikle was regularly in and out of debt to other prisoners. Given that we know that Mr Meikle regularly used drugs while at Woodhill, it is likely that the debt was connected to his substance misuse.

132. Mr Meikle spoke to a member of the Safer Custody Team in March 2024 and explained he was in debt but did not say to whom. The staff member said that if Mr Meikle was under serious threat he could consider isolating, something which Mr Meikle declined. There is no evidence that any other action was taken or that Mr Meikle was placed on a debt support plan (in line with the process at Woodhill).

133. In mid-April, Mr Meikle lost his job, and we understand from a prisoner that before isolating a few days before he died, Mr Meikle asked for help with paying off his debts. It is likely therefore that he was in debt when he died. Officers who spoke to Mr Meikle the weekend before he died told us that he did not mention being in debt. However, wing staff we spoke to as part of this investigation were not always clear about the actions they should take when they suspect someone may be in debt.

134. In June 2024, Woodhill introduced a debt management strategy to identify, manage and support prisoners who are in debt. It provides specific guidance to ensure staff effectively manage prisoners who are in debt and to support collaborative working with prisoners to prevent future debt. This includes a designated custodial manager in the safety team with responsibility for monitoring the effectiveness of the policy in

reducing and managing custodial debt. We are satisfied that Woodhill has an appropriate strategy to manage and support prisoners who are in debt.

Self-isolation strategy

135. Mr Meikle was isolating at the time of his death. At Woodhill, the Isolating Individuals Strategy sets out that a prisoner who is isolating should be referred to Safer Custody after 72 hours. Officers told us that they intended to submit the isolating paperwork to Safer Custody the morning that Mr Meikle died.

136. There are conflicting accounts of when exactly Mr Meikle began to isolate. One prisoner told us that he believed Mr Meikle stayed behind his door from the Thursday before his death (25 April), while an officer said that Mr Meikle started to isolate from the Sunday (28 April). We therefore do not know exactly when Mr Meikle began to isolate.

137. Woodhill has a comprehensive self-isolating policy with clear instructions on what do when an individual begins isolating. This includes noting this in the wing observation book and conducting five-minute intervention conversations to check-in with the individual. There are no entries about Mr Meikle made in the wing observation book in the week before he died. While it appears that some staff did interact with Mr Meikle during this time, there is only one entry within his prison record over this period. The Governor will want to ensure that all staff understand how to recognise when a prisoner is isolating and act in line with local policy.

Inquest

138. The inquest into Mr Meikle’s death concluded on, and found that Mr Meikle’s death was drug related (PS toxicity).

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