Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Daniel Bates, a prisoner at HMP Northumberland, on 24 October 2021

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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.

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

Mr Daniel Bates died from the effects of a combination of methadone, mirtazapine, amitriptyline (which he was not prescribed) and a synthetic cannabinoid (PS) on 24 October 2021 while a prisoner at HMP Northumberland. He was 39 years old. We offer our condolences to Mr Bates' family and friends.

There is no evidence that Mr Bates intended to take his life at the time of his death. Prison staff had reminded him of the risks of using illicit substances and he was given support to live drug-free. His death appears to have been the result of an accidental overdose.

It is troubling that Mr Bates was able to access and use illicit substances, including PS, with apparent ease at Northumberland.

I am concerned about the number of deaths we have investigated in which PS has played a part and about the availability of PS across the prison estate. Northumberland will need to ensure that local initiatives are implemented and developed further to reduce the availability of drugs. HM Inspectorate of Prisons have also expressed concern about the availability of illicit drugs at Northumberland.

I share the clinical reviewer's concerns about the assessment of Mr Bates' prescribed antidepressants.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **January 2023**

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Summary

Events

1. In October 2020, Mr Daniel Bates was remanded into prison custody at HMP Durham. In January 2021, he received a five-year extended determinate sentence. In February, Mr Bates was transferred to HMP Northumberland.

2. Mr Bates had a history of illicit substance misuse and received methadone treatment therapy throughout his stay at Northumberland. He was also epileptic and had anxiety and depression, for which he was prescribed medication.

3. In April, staff monitored Mr Bates under suicide and self-harm prevention procedures, known as ACCT, for three days, after he disclosed that he had taken an overdose of tablets. After this, Mr Bates appeared to settle into prison life.

4. On the morning of 24 October, an officer found Mr Bates unconscious on the floor of his cell. He radioed a medical emergency code blue and was assisted by further prison and healthcare staff. They established that there were clear signs of rigor mortis and concluded that Mr Bates had been dead for some time.

5. A post-mortem test showed that Mr Bates died as a result of the effects of a combination of methadone, mirtazapine, amitriptyline (which he was not prescribed) and synthetic cannabinoids (PS).

Findings

Substance misuse

6. Mr Bates had a history of substance misuse. He worked with substance misuse services at Northumberland and appeared to want to remain drug-free while in custody. However, we are concerned that he was able to obtain illicit drugs with apparent ease at Northumberland.

7. Although Northumberland has taken some steps to address its drug supply issues, Mr Bates' death is a stark reminder that more needs to be done to reduce the availability and detection of drugs and alcohol. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority to address.

Clinical care

8. The clinical reviewer found that Mr Bates' antidepressants were not reviewed despite him making several applications for a doctor's appointment.

Recommendations

- The Governor should ensure that the key drug issues at HMP Northumberland are identified, that the local drugs strategy is appropriately reviewed and revised, where

appropriate, to address them and that staff are aware of its contents and their responsibilities.

- The Head of Healthcare at HMP Northumberland should ensure that requests made by prisoners for GP appointments and medication reviews are actioned appropriately.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from Mr Bates' prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Bates' clinical care at the prison.

12. The investigator and clinical reviewer jointly interviewed six members of staff. The interviews were completed by video and telephone because of the restrictions imposed due to the COVID-19 pandemic.

13. We informed HM Coroner for Northumberland North of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent him a copy of this report.

14. The PPO's family liaison officer contacted Mr Bates' next of kin, his girlfriend, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Bates' girlfriend asked about the circumstances that led to his death, including what medication he was prescribed.

15. Mr Bates' girlfriend received a copy of the initial report. She pointed out two factual inaccuracies. This report has been amended accordingly.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). They identified no factual inaccuracies in the report. All recommendations were agreed.

Background Information

HMP Northumberland

17. HMP Northumberland is a Category C training prison that holds up to 1,348 men and is managed by Sodexo Justice Services. Spectrum Community Health CIC provide the healthcare services.

HM Inspectorate of Prisons (HMIP)

18. The most recent inspection of HMP Northumberland was in September 2020. Inspectors found that the healthcare department had responded well to the COVID-19 pandemic, maintaining all essential processes in spite of staffing problems. A survey of prisoners found that a quarter said that it was easy to obtain drugs. The prison had prioritised this longstanding problem and was taking steps to reduce the supply of drugs. These included using drug dogs and a device to detect illicit substances concealed in incoming mail and responding quickly to intelligence reports. Inspectors found that these measures had resulted in an increase in drug finds at the prison.

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 report for the year to December 2021 the IMB noted that the presence of illicit drugs, production of illicitly brewed alcohol, and attempts to smuggle banned items, remained a constant challenge. However, they recorded that the prison operated a thorough and responsive security policy. The prison had deployed a number of preventative measures to interrupt the supply of illicit substances.

Previous deaths at HMP Northumberland

20. Mr Bates was the tenth prisoner to die at Northumberland since October 2019. Of the previous deaths, five were from natural causes and four were self-inflicted. There has been one further death from natural causes at Northumberland since Mr Bates' death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

21. Mr Daniel Bates had been to prison a number of times. Most of his offences were linked to substance misuse.

22. On 20 October 2020, Mr Bates was remanded to HMP Durham, charged with theft, robbery, and possessing a bladed article. He had last been released from custody in December 2019.

23. During his initial health screen, Mr Bates told staff that he was taking medication for epilepsy, he had a history of drug and alcohol misuse and had been under the care of the community substance misuse team. A drugs screen noted that Mr Bates tested positive for methadone, cocaine, and cannabinoids. Mr Bates said that he had no mental health problems, although he had experienced a lot of trauma as a child and had emotional regulation difficulties. The nurse noted that Mr Bates engaged well during his screen and referred him to the mental health team (for emotional regulation support) and the substance misuse team.

24. A prison GP assessed Mr Bates and noted he was currently prescribed methadone (for opiate withdrawal), as well as levetiracetam (for epilepsy) and mirtazapine (for anxiety and depression). The GP reminded Mr Bates of the danger of using illicit substances while he was taking methadone.

25. The next day, a member of the substance misuse team visited Mr Bates and gave him harm reduction advice. This included thoroughly discussing the risks of substance misuse.

26. On 29 November, staff placed Mr Bates on “gold” level of the Incentive and Earnings Privilege (IEP) scheme, after noting that he was a positive role model to other prisoners. (The IEP scheme is designed to encourage good behaviour in prisons.)

27. On 22 January 2021, Mr Bates attended court and received a five-year extended determinate sentence for robbery and possession of a bladed article.

HMP Northumberland

28. On 15 February, Mr Bates was transferred to HMP Northumberland. Prison staff interviewed him in Reception and recorded no concerns.

29. A Healthcare Assistant (HCA) completed Mr Bates’ initial health screen. She recorded that Mr Bates was prescribed medication for epilepsy, anxiety and depression, and methadone.

30. On 16 February, a member of the substance misuse team contacted Mr Bates on his in-cell telephone and completed a substance misuse induction interview with him. He reminded Mr Bates of harm reduction, tolerance levels and the danger of using illicit substances.

31. A nurse saw Mr Bates that day and completed his secondary health screen. Mr Bates said that he had no thoughts of suicide or self-harm and no mental health

problems, although he said that he experienced low mood. Mr Bates tested negative for illicit substances.

32. On 17 February, a nurse conducted a substance misuse assessment. She noted that Mr Bates showed no signs of intoxification or of drug withdrawal. Mr Bates said that he wanted to "remain stable" for now and reduce his methadone dose gradually. She created a secondary methadone care plan for Mr Bates, which included a review every 13 weeks. Mr Bates collected his medication each morning from the medication hatch.

33. From February to October, Mr Bates received ten one-to-one substance misuse support sessions. Each session identified issues and problems and focused on him getting a suitable job to make meaningful use of his time in custody. While Mr Bates had hoped to get a job in the prison kitchen, this was not possible as he was taking opiate substitute medication. The prison careers service assisted Mr Bates to explore other work opportunities and gave him distraction packs to help occupy his time.

34. On 18 February, a prison GP reviewed Mr Bates' antidepressants. Mr Bates said that he was happy with the medication. The GP noted that Mr Bates' mood was stable, he had no symptoms of anxiety or self-harm and was sleeping well.

35. During April, Mr Bates asked for his methadone dose to be reduced. A plan was put in place to support this and his prescription was changed accordingly. (Mr Bates' methadone dose was subsequently reviewed and changed regularly.)

36. On 12 April, staff started suicide and self-harm procedures, known as ACCT, after Mr Bates told them that he had taken an overdose of 54 ibuprofen and 10 paracetamol tablets. He reported that he had vomited straight afterwards. He was taken to hospital for examination. After the examination, the hospital doctor discharged Mr Bates as no tablets were found in his system.

37. At his ACCT assessment and first ACCT case review the next day, Mr Bates apologised and said that he felt embarrassed about taking an overdose. Mr Bates said his actions were triggered by a bad phone call with his girlfriend. This, coupled with the imposed restricted regime (due to COVID-19) and the lack of work opportunities, made him "lose the plot". Mr Bates said that he hoped he would still be able to maintain a relationship with his daughter and planned to phone her later that day. Members of the mental health team at the review asked Mr Bates about his mental health. He said that he was okay and aware of the support available. He said that he understood that his actions meant that he would no longer be allowed to keep his epilepsy medication in his cell. When asked why he had used ibuprofen and paracetamol as opposed to his prescribed medication (mirtazapine and levetiracetam) that he kept and administered himself, Mr Bates said that he had not thought about it. He said that the tablets he used were given to him by another prisoner, who had since been released.

38. The ACCT review panel provided Mr Bates with in-cell distraction packs and contact details for the Samaritans. It was agreed to review Mr Bates' ACCT monitoring on 15 April, after he had spoken to his daughter.

39. Noting Mr Bates' recent actions, prison security intelligence reported that in recent weeks, there had been a spate of prisoners from Houseblock 9 who said that they had taken tablets to be taken to hospital. This trend had raised suspicion from staff as it mainly related to prisoners who did not normally cause any issues. The security intelligence suspected that there were prisoners on the unit who were asking other prisoners to go to hospital to collect packages for them. Monitoring of this situation was to continue.

40. On 15 April, staff held a multidisciplinary ACCT case review and agreed to stop ACCT monitoring. Mr Bates denied that he had been pressured to go to hospital and said that he had no thoughts of self-harm. The review panel reminded him of the support that could be offered to him if he was being bullied.

41. On 17 April, the prison mail room intercepted a letter, addressed to Mr Bates, that was soaked in an illicit substance. This information was passed to the security team.

42. On 1 May, a Prison Custody Officer (PCO) saw Mr Bates for a key worker session. Mr Bates reported that he was doing well on Houseblock 9 and was settled. He said that he intended to apply for a job in the kitchens or as a wing cleaner. Mr Bates said that he had no mental health concerns and continued to be supported by the substance misuse team.

43. On 7 June, security intelligence noted that they had received anonymous information which highlighted that Mr Bates was illicitly brewing alcohol with another prisoner and selling this for vapes and canteen. Staff recorded that they would monitor Mr Bates.

44. On 8 June, Mr Bates told a nurse that he had sleep problems and aching limbs, which he associated with the reduction in his methadone. He asked for his methadone dose to be increased. This was agreed.

45. On 17 June, prison staff found 12 litres of illicitly brewed alcohol in Mr Bates' cell. As a consequence of his negative behaviour, Mr Bates appeared at a disciplinary hearing and his IEP was downgraded to standard.

46. On 29 June, a PCO completed a key worker session with Mr Bates who reported that he was well, felt safe and had no concerns. He acknowledged that he had done wrong in brewing alcohol.

47. On 13 July, Mr Bates referred himself to the mental health team. He did not record a reason for this. On 16 July, a member of the mental health team contacted Mr Bates who said that he thought he had a personality disorder.

48. On 22 July, a nurse from the mental health team assessed Mr Bates. Mr Bates disclosed that he had had two seizures in the last few months, the last of which occurred around three weeks earlier. He asked for his epilepsy medication be reviewed. He also said that his mirtazapine no longer worked, his mood was low, and he had problems sleeping. He had no thoughts of self-harm and denied using illicit substances. The nurse noted that he had no concerns about Mr Bates' mental health. He recorded that Mr Bates had engaged well, did not display evidence of a thought disorder, and did not appear distracted by perceptual disturbances. He

noted that Mr Bates would be discharged from the mental health team's caseload and that his issues should be addressed by the healthcare team. (Mr Bates later submitted an application to the prison GP.)

49. On 11 August, Mr Bates told his substance misuse support worker that he wanted to be moved to Houseblock 5 because he feared for his safety. He said that the alcohol that had been found in his cell had been stored for another prisoner. Mr Bates said that he had been blamed for its confiscation and was expected to pay debts to another prisoner on the wing as a result. He said that he had tried to pay off the debt, but it had doubled each week. (Mr Bates did not disclose the amount of the debt or name the prisoner to whom he owed the debt).

50. The next day, an officer spoke to Mr Bates to check on his wellbeing. He noted that Mr Bates was "very noncommittal" and said he just wanted to move to Houseblock 5 as he knew several prisoners who lived there. When asked directly if he feared for his safety, Mr Bates said that he felt safe and refused the offer of a separate regime for his safety on Houseblock 9. The officer noted that Mr Bates appeared to get on well with other prisoners and no recent issues had been raised about his behaviour.

51. On 30 August, Mr Bates told healthcare staff that he no longer wanted to reduce his methadone dose as he was "not sleeping and felt anxious". This information was passed to the substance misuse team.

52. On 2 September, Mr Bates was moved to Houseblock 2.

53. On 7 September, the prison GP prescribed Mr Bates naproxen after he complained of having back pain.

54. On 10 September, Mr Bates told a key worker that he had settled well in Houseblock 2. He was still waiting for a job but had no immediate concerns. Mr Bates was placed on the workshop waiting list for catering and barbering work.

55. On 13 September, Mr Bates asked for his mirtazapine medication to be reviewed. It was noted in his medical record that he had been added to the waiting list to see the GP.

56. On 14 September, Mr Bates' new substance misuse worker introduced herself. Mr Bates raised no concerns.

57. On 26 September, Mr Bates again asked for his mirtazapine to be reviewed. It was noted that he was already on the waiting list to see the GP for a medication review. (We found no evidence that a GP reviewed Mr Bates' mirtazapine before his death.) That day, Mr Bates asked to restart his reduction in methadone, and it was agreed that this would start from 28 September.

58. On 29 September, Mr Bates told the substance misuse team that he no longer wished to reduce his methadone.

59. That evening, members of Mr Bates' family contacted the prison and told them that his father had died. A prison chaplain visited Mr Bates in his cell to break the news to him. Mr Bates said that his girlfriend had already told him. The chaplain offered support and facilitated two compassionate phone calls for Mr Bates to speak to his

brother and girlfriend. The next morning, the chaplain again offered support to Mr Bates.

60. On 1 October, Mr Bates was allocated a job in a workshop and was moved to a new cell on the ground floor. At his key worker session on 4 October, a PCO noted that Mr Bates was happy that he had a job and felt safe on the wing.

61. On 12 October, security intelligence reports noted concerns that Mr Bates was brewing alcohol for the weekend. Wing staff were told to "keep a watchful eye" on him.

62. That day, Mr Bates asked a member of the substance misuse team if his methadone dose could be increased as he was struggling to sleep following the death of his father. He also said that he had stomach cramps. Mr Bates' methadone dose was subsequently increased.

63. At his substance misuse review meeting on 18 October, Mr Bates said that he was happy with his increased dose of methadone.

64. On 21 October, a PCO completed a key worker session with Mr Bates, who said that he felt safe, had no thoughts of self-harm and enjoyed his job.

65. At around 8.25pm on 23 October, an Operational Support Officer (OSO) started his night duty. He had no concerns about any of the prisoners.

66. In a statement written after Mr Bates' death, a prisoner stated that at around 11.30pm, he had heard a prisoner shouting out of his window to another prisoner. The first prisoner was alleged to have shouted that Mr Bates was "coughing and throwing up". (Both of these identified prisoners were released from prison custody shortly after Mr Bates' death.) The OSO told us that the night was very quiet with no concerns throughout.

24 October

67. CCTV footage shows that at 5.39am, the OSO started his roll check of the wing, which he completed by 5.50am. He told us that when he checked Mr Bates' cell, he looked through his observation panel and had no concerns. He patrolled the wing landings again at around 6.35am and said that he heard nothing untoward. On completion of his duties at around 7.05am, he handed over to PCO A.

68. Around 9.00am, PCO A and a colleague unlocked prisoners on the second-floor landing for association and to collect their medication. At around 9.50am, the officers proceeded to the ground floor landing, where Mr Bates' lived, to unlock prisoners who needed to collect medication. When PCO A arrived and unlocked Mr Bates' cell, Mr Bates did not respond or come out of his cell. He therefore went into his cell to check on him. He found Mr Bates lying flat on his back, unconscious, on the floor.

69. PCO A immediately radioed a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties). PCO A, who had recent first aid training, checked Mr Bates and tried to get a response from him. Mr Bates showed no signs of life, his skin was mottled, and he appeared to have rigor mortis.

70. Two more PCOs responded to the emergency within ten seconds. PCO B told us that when she entered the cell, she saw Mr Bates on the floor in a supine position, with his head towards the back of the cell. He was white, his eyes were open, and he was unresponsive to officers calling his name. Both officers checked Mr Bates for signs of life by checking his neck and wrist for a pulse. None were found. Mr Bates' body was stiff, cold and too rigid to be placed in the recovery position. PCO B and her colleague confirmed that rigor mortis was present. They did not therefore attempt resuscitation.

71. At 9.52am, a nurse and an HCA arrived at the cell. The nurse noted that any resuscitation attempt would be futile.

72. At 10.12am, ambulance paramedic staff arrived. They agreed with prison and healthcare staff's assessment and confirmed Mr Bates' death at 10.20am.

Contact with Mr Bates' family

73. At around 10.35am, the prison appointed family liaison officers (FLOs). At 11.20am, due to the COVID-19 restrictions, one FLO telephoned Mr Bates' next of kin and broke the news to her. He offered condolences and support. Northumberland contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

74. The prison posted notices informing other prisoners of Mr Bates' 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 his death.

75. After Mr Bates' death, the staff involved in the incident were given the opportunity to discuss any issues arising and were also offered support by the staff care team.

Post-mortem report

76. The post-mortem toxicology examination detected levetiracetam, methadone, mirtazapine, amitriptyline, and PS in Mr Bates' system. The pathologist concluded that the effects of a combination of methadone, mirtazapine, amitriptyline, and PS caused Mr Bates' death. They recorded that it was likely that the drugs acted together to lead to a loss of consciousness, coma, and death.

Inquest

77. The Coroner's inquest held on 21 November 2023,determined the medical cause of death to be the effects of a combination of methadone, mirtazapine, amitriptyline and spice. The Coroner concluded that the death was due to misadventure (an unintended or accidental outcome of a deliberate act).

Findings

Substance misuse and the drug strategy at Northumberland

78. When Mr Bates arrived at Northumberland, staff were fully aware of his substance misuse history and he received regular monitoring and support for his prescribed methadone. The clinical reviewer found that this was appropriately adjusted throughout his time in prison to manage his symptoms.

79. While there was some suspicion that Mr Bates might have been involved in the use and supply of drugs and alcohol on the wing, there was no evidence that he was under the influence of illicit substances at Northumberland.

80. Post-mortem toxicology testing established that Mr Bates died from the combined use of methadone, mirtazapine, amitriptyline and PS. He had not been prescribed amitriptyline and so obtained this and PS illicitly.

81. While we do not know if this was a one-off occasion, it is nonetheless troubling that Mr Bates was able to access amitriptyline and PS in prison, particularly during the COVID-19 lockdown when restrictions were in place on prisoner and visitor movement.

82. Despite this, we are satisfied that Mr Bates was reminded of and was aware of the potentially fatal risks of substance misuse. While Mr Bates had some risk factors for suicide and self-harm, including a previous overdose and the recent death of his father, there is nothing to suggest that he wanted to take his life or harm himself. It appears that his death was the accidental result of substance misuse.

83. In April 2019, HM Prison and Probation Service (HMPPS) issued a national instruction that all prisons should review their drug strategies. HM Inspectorate of Prisons (HMIP) expressed concern at the easy availability of drugs at Northumberland when they completed their inspection in August 2017. Since then, Northumberland has made efforts to ensure support for prisoners with substance misuse issues and to reduce the supply and demand for illicit substances. It revised its drug strategy in line with HMPPS guidance. We note that in their scrutiny visit in September 2020, HMIP found that Northumberland had had some success in trying to reduce the supply of drugs into the prison. Northumberland further reviewed their drugs strategy in November 2021. Nevertheless, we are concerned by the ease with which Mr Bates was able to obtain illicit drugs. He had a history of substance misuse and there is evidence that he was involved in the supply of illicit substances. It is apparent that the prison must continue to work hard towards reducing supply and demand.

84. We are satisfied that Northumberland has an appropriate drug strategy in place and that measures introduced to tackle drug supply appear to be having an impact. However, it is important that the prison continues its efforts to prevent the supply of, and demand for, illicit substances and that it keeps its drug strategy under regular review to ensure it is tackling the key issues.

The Governor should ensure that the key drug issues at HMP Northumberland are identified, that the local drugs strategy is appropriately reviewed and

revised, where appropriate, to address them and that staff are aware of its contents and their responsibilities.

Clinical care

85. Mr Bates was prescribed antidepressants when he arrived at Northumberland. In July, he reported that his antidepressants were not working, and made two further requests for his antidepressant dose to be reviewed. On both occasions, it was noted that Mr Bates was on the waiting list to see the prison GP but there is no evidence that he was seen by the prison GP or that his mirtazapine dose was reviewed before he died. While the clinical reviewer found that Mr Bates' methadone management was satisfactory and equivalent to that he could expect to receive in the community, she considered that the lack of review of his antidepressants was a missed opportunity to support Mr Bates' mental health and wellbeing. We make the following recommendation:

The Head of Healthcare at HMP Northumberland should ensure that requests made by prisoners for GP appointments and medication reviews are actioned appropriately.

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Canary Wharf, London E14 4PU

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