Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Benjamin Harrison, a prisoner at HMP Rochester, on 10 May 2022

A report by the Prisons and Probation Ombudsman

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

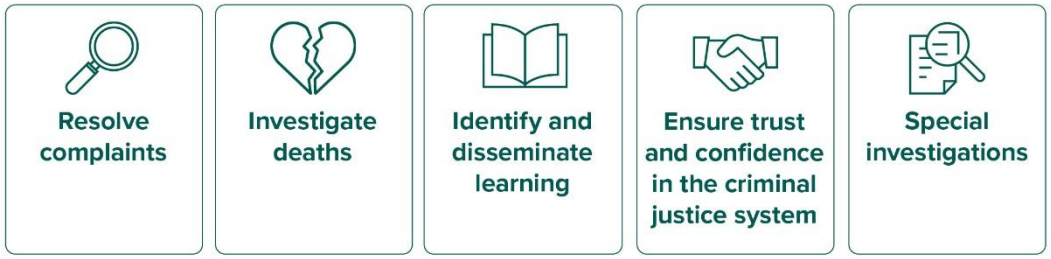
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

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

© Crown copyright, 2026

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Benjamin Harrison died of fentanyl (pain relief) toxicity on 10 May 2022 at HMP Rochester, five days after he was transferred from HMP Elmley. He was 42 years old. I offer my condolences to Mr Harrison's family and friends.

The clinical reviewer found that the clinical care Mr Harrison received was of a reasonable standard and therefore equivalent to what he could have expected to receive in the community. However, she identified some issues with the management of Mr Harrison's medication and clinical care at Elmley and in the regional policy at Oxleas NHS Foundation Trust. The healthcare team at Elmley were concerned about the combination of medications that Mr Harrison had been prescribed in the community. However, they made little progress in addressing this issue during the two months that he spent there. HMP Rochester did make some progress in the short period that Mr Harrison was accommodated there and we commend the prison's proactive approach. Sadly, Mr Harrison died before the process could be completed. The clinical reviewer also considered that Elmley should have referred Mr Harrison to a neurology service to explore his potential epilepsy.

No detailed clinical handover was provided for Mr Harrison when he transferred from Elmley to Rochester. Although this is not a policy requirement, we consider that this would have been good practice for someone with Mr Harrison's complex medication, to ensure continuity of care.

The clinical reviewer found that the healthcare provider at Elmley and Rochester do not have a formal policy in place for the use of fentanyl patches in secure settings. She noted that national guidelines advise stringent governance around the prescribing, administration and monitoring of fentanyl patches using a safety checklist. We recommend that this checklist is incorporated into Oxleas policy going forward.

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 **November 2023**

Contents

Summary

Events

1. Mr Benjamin Harrison had a long offending history and substance misuse issues. Mr Harrison had some physical health problems, including an unconfirmed diagnosis of epilepsy and chronic leg pain, for which he was prescribed medication.

2. Mr Harrison was released from HMP Elmley on 6 January 2021 and recalled on 8 March 2022. At his initial screenings, staff found that he had arrived with several prescription medications, including fentanyl patches for pain relief, which were due to be supplied every three days. Healthcare staff added Mr Harrison to the chronic pain multidisciplinary team (MDT) meeting caseload, but the next meeting was cancelled, so they referred to the local hospital for advice. They did not receive a response.

3. On 5 May, Mr Harrison was transferred to HMP Rochester and placed in a shared cell. Although no formal clinical handover took place between Elmley and Rochester, a GP quickly highlighted that Mr Harrison was being prescribed a significant amount of medication which should be reviewed.

4. At around 4.00pm on 9 May, healthcare staff at the medication hatch administered Mr Harrison a new fentanyl patch. Mr Harrison used a vape pen to smoke the patch and did so in the toilet/shower area of his cell, to conceal what he was doing from prison staff.

5. At around 8.35pm, the night patrol officer carried out the evening roll check of prisoners on Mr Harrison's wing and thought she could detect a faint odour of burning paper coming from his cell. She checked in on Mr Harrison on a few occasions but raised no concerns.

6. At around 11.55am, Mr Harrison's cell mate pressed the cell bell. He appeared distressed and said he thought there might be something wrong with Mr Harrison. The night patrol officer attended the cell and quickly called a medical emergency 'code blue', indicating a life-threatening situation. Officers responded and began cardiopulmonary resuscitation (CPR). An ambulance crew arrived on site at 12.20am but were unable to revive Mr Harrison. Paramedics confirmed that Mr Harrison had died at 12.41am.

Findings

7. The clinical reviewer found that the clinical care received by Mr Harrison was of a reasonable standard and therefore equivalent to that which he could have expected to receive in the community.

8. Healthcare staff at Elmley identified that Mr Harrison's medications presented certain health risks and should be reduced or changed. Although there was no quick solution, we are concerned that they did not make any progress during the two months that Mr Harrison spent at the prison. The healthcare team referred to the local hospital for advice but did not chase up a response. The clinical reviewer suggests that staff at Elmley could and should have done more within that time, to

reduce or change Mr Harrison's prescribed medications. When Mr Harrison arrived at HMP Rochester, a GP quickly highlighted that he was being prescribed a significant amount of medication which should be reviewed. We are pleased that progress to reduce Mr Harrison's medication was underway at Rochester and commend the prison's proactive approach. Sadly, Mr Harrison died before the process could be completed. The clinical reviewer also identifies that Elmley did not take any action to confirm Mr Harrison's epilepsy diagnosis and the appropriateness of his medications for it.

9. We consider that it would have been good practice to conduct for Elmley to provide a more detailed clinical handover for Mr Harrison, considering his complex needs, to ensure the transfer was safe and to enable continuity of risk management and care.

10. The clinical reviewer noted that Oxleas, the healthcare provider to Elmley and Rochester, do not have a formal policy in place on the governance arrangements for the use of fentanyl patches in a secure setting. The clinical reviewer noted that the prescribing of fentanyl patches as a controlled drug is not recommended in secure settings in accordance with national policy. However, in the exceptional event they are prescribed, The Care Quality Commission (CQC) and NHSE recommend that there should be stringent governance around the prescribing, administration and monitoring of this drug by utilising a safety checklist.

11. PSI 04/2017 states that, "In those establishments where it is authorised for use, BWVC must be deployed and set to record during a response to any reportable incident". Although some officers involved in the emergency response on Mr Harrison were wearing body-worn video cameras (BWVC), none were turned on. We have recommended that they do so in future reportable incidents.

Recommendations

- The Head of Healthcare at HMP Elmley should ensure that handovers take place for complex patients who present clinical risks and are due to be transferred, to ensure continuity of care.

- The Head of Healthcare at HMP Elmley should ensure that when new prisoners enter the establishment on high risk and complex medication, staff complete a prompt review of medication to manage any risks.

- The Head of Healthcare at HMP Elmley should ensure that when there is a query regarding a prisoner's diagnosis, the relevant referral is made to ensure it can be confirmed or other options explored.

- The Lead Pharmacist at Oxleas Trust should create clear guidelines on the safe prescription, administration and governance of Fentanyl patch prescriptions in secure settings, in accordance with the RCGP 'safer prescribing in prisons' (2019) and the guidance and checklist contained within the CQC and NHSE guidance for the 'safer use of controlled drugs' (2016).

- The Governor of HMP Rochester should remind staff to switch on their body-worn cameras during reportable incidents and that control room operators prompt staff to do so during an incident.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Harrison's prison and medical records.

14. The investigator interviewed five members of staff via video-link on 12 October 2022.

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

16. We informed HM Coroner for Mid Kent and Medway of the investigation. The Coroner gave us the results of Mr Harrison's post-mortem examination and toxicology screen. We have sent the Coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Harrison's sister to explain the investigation and to ask if she had any matters she wanted us to consider. She asked us to find out about the prescriptions Mr Harrison received at Rochester. She also asked if we had spoken to Mr Harrison's cell mate or any other prisoners, if there was a delay in entering the cell during the emergency response, and why Mr Harrison's mother learned of her son's death indirectly through someone known to her family. We have addressed these questions in our report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). Healthcare at HMP Rochester and HMP Elmley. The clinical reviewer, made a slight amendment to a recommendation in her Clinical Review in response to comments made by Healthcare at HMP Elmley, however her overall findings remain unaffected. We have provided clarification to the family by way of separate correspondence to them. The final version of the clinical review is included as an annex to this report.

19. Mr Harrison's family received a copy of the draft report. The solicitor representing the Harrison family raised several questions that do not impact on the factual accuracy or findings of this report. We have provided clarification to the family by way of separate correspondence to them.

Background Information

HMP Rochester

18. HMP/YOI Rochester is a category C resettlement prison, holding up to 695 adult and young male prisoners. Oxleas NHS Foundation Trust provides healthcare services at the prison. Primary healthcare services are available onsite from 7.45am to 7.30pm Monday to Thursday, and 7.45am to 6.00pm from Friday to Sunday. Healthcare services were therefore not available at the time of Mr Harrison's death.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Rochester was in October 2021 and findings were outlined in a report published in February 2022. Inspectors found that patients who could not have medication in their possession attended an administration hatch to receive their medicines.

20. Inspectors found that risk assessments for whether prisoners could hold and administer their own medications were not routinely checked to ensure they were up to date. Patients were not encouraged to have medicines in possession, which did not support independent care.

21. Inspectors also reported that medication-related incidents were not reported robustly and recommended that robust governance procedures, including consistent incident reporting and investigation, should be implemented to ensure that concerns affecting patient safety are promptly addressed.

Independent Monitoring Board

22. 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 (published in September 2022), the Board reported that there is nearly always a healthcare staffing shortage at Rochester. However, core nursing responsibilities were covered, with managers stepping in as necessary.

23. The Board noted that a new healthcare manager had been employed since April 2021, and improvements had been made in their first year in post. However, 85 healthcare related complaints had been received during the reporting year, up from 58 and 56 respectively from the previous two years. The overwhelming majority of complaints related to medication issues or perceived delays in seeing the prison GP. The Board described the increase in complaints as 'concerning' and stated that they would continue to monitor the issue.

Previous deaths at HMP Rochester

24. Mr Harrison is the fourth death at Rochester since April 2018. Of the previous deaths, two were self-inflicted and the one was from natural causes. There are no similarities in our investigation findings for Mr Harrison and previous deaths.

Assessment, Care in Custody and Teamwork

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

26. As part of the process, a caremap (a 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, Management of prisons at risk of harm to self, to others and from others (Safer Custody).

Psychoactive substances (PS)

27. Psychoactive substances (PS), previously known as 'legal highs', are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of 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, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Fentanyl

29. Fentanyl is an opioid based painkiller. It is used to treat severe and long-lasting pain, for example during or after an operation or a serious injury, or pain from cancer.

30. It is possible to become addicted to fentanyl, but the prescribing doctor will explain to patients how to reduce the risks of becoming addicted.

Key Events

Background

31. Mr Benjamin Harrison had a long offending history dating back to 1996. He had significant substance and alcohol misuse issues which were linked to his offending.

32. Mr Harrison also had a history of anxiety, depression and self-harm. In March 2018 at HMP Elmley, he placed a ligature around his neck in a protest about his medication. He also reopened wounds from an earlier self-harm incident. In June 2019, Mr Harrison made a ligature to suspend himself before staff entered his cell and cut him down. Afterwards, he told staff he was frustrated about not getting the medication he needed. Staff monitored Mr Harrison under prison service suicide and self-harm prevention measures (ACCT) on several occasions, most recently in April 2022.

33. Mr Harrison was prescribed medication to treat epilepsy, although a formal diagnosis had not been confirmed. Prison staff requested emergency support on several occasions when he appeared to be experiencing seizures relating to the condition. Mr Harrison also had Hepatitis C (a viral infection affecting the liver), Deep Vein Thrombosis (a condition caused by blood clotting), self-reported Chronic Obstructive Pulmonary Disease (a lung condition), and fractured shin bones after jumping from height in 2019, for which he was awaiting an operation.

34. Mr Harrison was thought to be tampering with and diverting his prescribed medication in prison. In May 2020, while at HMP Elmley, he was found diverting prescribed Fentanyl patches and tampering with them (by trying to exchange a fake patch for a new one), which led to his prescription being stopped.

HMP Elmley (2022)

35. Mr Harrison was released from HMP Elmley on 6 January 2021. On 8 March 2022, he was recalled due to his lack of engagement, for not residing in accommodation as directed, and an increase in risk due to substance misuse.

36. At his initial health screenings, staff noted the high volume of medications Mr Harrison had been prescribed by a community GP. The healthcare team added Mr Harrison to the chronic pain multidisciplinary team (MDT) meeting caseload, to ensure there was opportunity to discuss this. *At the time of Mr Harrison's death, he was prescribed the following medications: one 50mcg fentanyl transdermal patch every three days (fast acting pain relief given as a patch that absorbs into the skin), clonazepam and pregabalin (to treat epilepsy), co-codamol (codeine and paracetamol-based pain relief), lansoprazole (to reduce stomach acid), mirtazapine (for depression), quinine sulphate (for treatment of leg cramps), and amoxicillin (an antibiotic).*

37. On 30 March, a nurse noticed that Mr Harrison had been recorded as having epilepsy but that the diagnosis was not confirmed. She noted that Mr Harrison had last seen neurologist in May 2019. She also noted that he was taking medication for his epilepsy that had not been reviewed by neurology specialists.

38. Later that day, the scheduled chronic pain multidisciplinary team (MDT) meeting had to be cancelled because no GP was available to attend. Healthcare emailed the orthopaedic team at Kings College Hospital requesting advice about Mr Harrison's prescribed medication in relation to his upcoming operation on his shin bone (which was due to take place in June). The email stated that Mr Harrison had a long history of drug-seeking behaviour, and that he had previously been weaned off all his medications but "unfortunately had them reinstated". The email concluded "Given the extremely high doses of opiates he is currently taking; we would be happy to support a reduction if you feel this will improve the likelihood of a positive outcome from surgery". From the evidence we have reviewed, it does not appear that Elmley received a response to the email.

39. On 8 April, staff observed that Mr Harrison seemed to be under the influence of drugs or alcohol in his cell. An officer recorded that Mr Harrison was "lying on his bed moaning and unable to speak, in a zombie-like fashion".

40. On 24 April, Mr Harrison made superficial cuts to his left arm which were dressed by a nurse. He told staff that that he made the cuts in response to not being given a fentanyl patch earlier in the day, after his other one had allegedly fallen off in the shower.

41. Staff began monitoring him under ACCT procedures. They closed it two days later when they were satisfied that the risks had reduced.

42. On 3 May, a nurse assessed Mr Harrison after staff observed that he appeared to be under the influence of drugs or alcohol. Mr Harrison told staff that he had smoked psychoactive substances (PS) earlier that day.

43. On 4 May, Mr Harrison was observed to be under the influence of drugs or alcohol for the third time and a nurse went to assess him. No concerns were raised, but the nurse asked officers to complete hourly rousing observations to ensure that he was conscious. Officers completed the checks, and no concerns were raised.

HMP Rochester

44. On 5 May, Mr Harrison was transferred to HMP Rochester and placed in a shared cell with another prisoner. Mr Harrison arrived wearing a fentanyl patch, which he had been given at Elmley two days earlier.

45. The reception nurse completed Mr Harrison's initial health screening. He noted Mr Harrison's substance misuse history and referred him to the substance misuse team for a triage assessment. The same day, a prison GP reviewed Mr Harrison's medications and recorded that he was a complicated patient. The GP noted that the chronic pain team at Elmley recommended that the extremely high dosage of opioids needed to be reduced slowly, however no formal clinical handover took place between Elmley and Rochester. He agreed that Mr Harrison's medication should be reduced and that an appointment should be made to discuss the approach. Healthcare staff invited Mr Harrison to a Complex Case Review meeting (a multidisciplinary meeting between prison and healthcare staff to discuss complex patients) planned for 18 May.

46. On 6 May, a nurse completed Mr Harrison's second reception screening assessment. Mr Harrison told the nurse that he had been sectioned under the Mental Health Act five years prior. He also said that a bipolar diagnosis was being explored for him and that he wanted to see the mental health team. She referred Mr Harrison to the mental health team for further assessment.

47. That same day, Mr Harrison should have been given a new fentanyl patch to replace the one he arrived with. However, Rochester did not have any in stock at the prison's pharmacy and had to order it in. (We have found no evidence to suggest that this delay had an adverse impact on Mr Harrison.)

48. On the evening of 8 May, Mr Harrison's cellmate told the police that he had observed Mr Harrison become excited because he was due to be prescribed a new fentanyl patch.

9 May

49. At around 2.00pm, the mental health team completed a paper-based triage for Mr Harrison, in response to the referral made on 6 May. After the assessment, a nurse planned to write to Mr Harrison to request further details about the exploration of a bipolar disorder diagnosis in the community.

50. At 3.58pm, healthcare staff at the medication hatch administered Mr Harrison a new fentanyl patch (the only one he received at Rochester). According to the cellmate, Mr Harrison returned to the cell, removed the patch and began to dismantle his vape pen. He said that Mr Harrison had placed the patch on to the heating element of the vape pen and, using scrunched up tissue paper, heated this to cause the paper to ignite. This then caused the patch to heat up and release the fumes and chemicals from the patch. The cellmate told police that he saw Mr Harrison inhaling the fumes that were being produced from the patch, which influenced his behaviour, and he became intoxicated. (We requested an interview with the cellmate, but the prison was unable to facilitate this.)

51. At dinner time that day, the cellmate had to rouse Mr Harrison so that he could collect his meals. He said that Mr Harrison used the patch on the vape pen consistently throughout the day and inhaled the fumes in the toilet/shower area most of the time, to conceal what he was doing from prison staff.

52. At around 8.35pm, an Operational Support Grade (OSG) carried out the evening roll check of prisoners on Mr Harrison's wing. She thought she could detect a faint odour of burning paper coming from Mr Harrison and the cellmate's cell. In interview, she told us that she could see Mr Harrison lying on his bed, but the cellmate told her that he was ok. She told the cellmate that she would come back to check on them once she had finished her roll check.

53. At around 9.15pm, the OSG returned to the cell to check on Mr Harrison. The cellmate asked her to turn off the cell night light. At this point, Mr Harrison jumped up from his bed but, according to the OSG, looked a bit wobbly. He asked her if the light could stay on for another 20 minutes, to which she agreed. She asked Mr Harrison if he was ok, to which he replied that he was fine. As she was observing another prisoner on an ACCT, she continued to check in on Mr Harrison at regular intervals because she was suspicious that he might be under the influence. On at

least two to three occasions, she saw him sitting on the edge of his bed talking to his cellmate and raised no concerns.

54. At around 10.00pm, the cellmate pressed his cell bell and asked the OSG to dim the lights in his cell. She looked across at Mr Harrison and noted he was lying on his bed and appeared asleep. She asked the cellmate if Mr Harrison was ok, and he said he was just asleep. She turned the night light off. However, the television remained on as the cellmate had started watching a film.

55. At around 11.55am, the cellmate pressed the cell bell. He appeared distressed and told the OSG that he thought there might be something wrong with Mr Harrison. When she arrived at the cell, the cellmate told her he had finished watching his film and was about to turn the television off when realised that Mr Harrison had not moved for a while and was lying face down on the bed.

Emergency response

56. The OSG asked the cellmate to try and physically rouse Mr Harrison by shaking him by the shoulder, which he did. He became distressed at this point because Mr Harrison remained unresponsive. He told her that he thought Mr Harrison may have been sick and said he felt cold to the touch.

57. At 11.58pm, the OSG called a medical emergency 'code blue', indicating a life-threatening situation. She waited for the arrival of another officer before entering the cell, having assessed the security risks. More staff arrived in around one to two minutes and entered the cell straight away. They were closely followed by a Custodial Manager (CM).

58. Officers began cardiopulmonary resuscitation (CPR) and used a defibrillator (a device that can give a high energy shock to someone who is in cardiac arrest), which indicated no shock was advised. An ambulance crew arrived on site at 12.20am and noted that prison staff were completing effective CPR, which they took over.

59. At 12.41am, paramedics confirmed that Mr Harrison had died. After Mr Harrison's death, staff found drug paraphernalia including a vape pen in his cell.

Contact with Mr Harrison's Family

60. At around 8.50am on 10 May 2022, Mr Harrison's sister telephoned HMP Rochester and said that her family had been made aware of her brother's death via a family relation. The relation was told by another prisoner on the same wing as Mr Harrison. She spoke to the Head of Operations and Family Liaison Officer (FLO) and asked if he could telephone again later that morning, once Mr Harrison's mother had joined her at her home.

61. At 10.00am, the FLO telephoned Mr Harrison's mother (who was with his sister) and told them that Mr Harrison had died. He told the family that he would have preferred to tell them in person; however, as the news had already been shared with them, it was important that he provided as much information as possible in order not prevent any further distress.

62. The FLO explained to the family that Kent Police had told the prison that they would be going to the family home to deliver the news to Mr Harrison's mother. He told us that he was shocked to find out that they had not done so when the family called. When he spoke to the police, they said the contact details for Mr Harrison's Next of Kin were incorrect and they had attended the wrong address. The FLO explained that if the police had told prison staff that they had not been able to contact the family as agreed, the prison would have made arrangements to visit the family home themselves, as quickly as possible. He agreed that he and a colleague would visit the home of Mr Harrison's mother that afternoon, around 2.00pm.

63. At 2.00pm, the FLO visited Mr Harrison's mother's home to discuss what had happened and answer any initial questions. Rochester contributed to the costs of Mr Harrison's funeral in line with Prison Service instructions.

Support for prisoners and staff

64. After Mr Harrison's death, the Governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

65. The prison posted notices informing other prisoners of Mr Harrison's death and offering support.

Post-mortem report

66. The toxicology screening found an elevated level of fentanyl in Mr Harrison's blood. The post-mortem concluded that, on the balance of probability, Mr Harrison's death was due to fentanyl toxicity.

Findings

Clinical care

67. The clinical reviewer found that the clinical care received by Mr Harrison was of a reasonable standard and therefore equivalent to what he could have expected to receive in the community.

Medication risk management

68. The clinical reviewer noted that when Mr Harrison arrived at HMP Elmley in March 2022 he had been prescribed several medications in the community that, when combined, increased the risk of respiratory and central nervous system (CNS) depression. She highlights that the combination of fentanyl, pregabalin, mirtazapine and clonazepam must be prescribed with caution, particularly for those with substance misuse problems. Mr Harrison's medications had been prescribed by a community GP, and it was not the first time he had been prescribed that combination. During a previous period in prison, he had been successfully weaned off the same combination. We are unable to comment on the actions of community-based healthcare services, which are outside of the PPO's remit.

69. We found that healthcare staff at Elmley identified the risks and the challenges around reducing Mr Harrison's medication in the prison environment. They contacted the orthopaedic team at Kings College Hospital for support on how they could approach it. Unfortunately, the prison did not make any progress on reducing the medications during the period that Mr Harrison was at Elmley. The clinical reviewer suggests that staff could and should have done more within that time, to reduce or change his prescribed medications.

70. The clinical reviewer found that some of Mr Harrison's medications were for epilepsy, which had not been confirmed with a diagnosis. She highlights that Elmley should have referred Mr Harrison to a neurology service to explore the potential epilepsy and appropriateness of his medications for it.

71. We are pleased that when Mr Harrison arrived at Rochester, a GP quickly identified that he was being prescribed a significant amount of medication which should be reviewed. Mr Harrison was added to the Complex Case Review meeting agenda for 18 May and invited to attend (this was the first meeting following his arrival). We note that the meetings were attended by the Chronic Pain Management Service, so would have been particularly helpful for Mr Harrison. The clinical reviewer noted that the personalised approach was in line with the Royal College of General Practitioners (RCGP) guidance for 'safer prescribing in prisons' (2019). After the initial meeting, Mr Harrison's care was due to be discussed every two weeks. Sadly, Mr Harrison died before he could attend the first meeting.

72. Mr Harrison spent only five days at HMP Rochester, and they were unable to make any further progress on reducing his medication and addressing his longer-term care needs.

Clinical handover

73. Mr Harrison had significant substance misuse needs. He was prescribed a range of medications and was found under the influence and requiring intervention in the two days before he transferred to Rochester on 5 May. His medication combination presented specific health risks that were known to the healthcare team at Elmley. While they flagged the high amount of opioid based medications Mr Harrison was taking, they did not supply any further information. We consider that it would have been good practice to conduct a more detailed clinical handover for Mr Harrison, considering his needs, to ensure the transfer was safe and to enable continuity of care planning. Rochester did not have any fentanyl patches in stock at the prison's pharmacy and had to order it in. A formal handover would have enabled Rochester to order a patch in advance of Mr Harrison's arrival.

Fentanyl patches

74. Mr Harrison was prescribed fentanyl patches to help with his chronic leg pain. His family told us that they were concerned he had been given more fentanyl patches than he was prescribed. After a thorough review of the relevant documentation, we found that staff at Elmley and Rochester gave fentanyl patches to Mr Harrison every three days, in line with directed use. We have found no evidence to suggest that Mr Harrison was given more than one patch every three days. At Rochester, Mr Harrison only received one Fentanyl patch (on 9 May) due it being a controlled drug and issues with stock.

75. The clinical reviewer found that Oxleas, the healthcare provider to Elmley and Rochester, do not have a formal policy in place on the governance arrangements for the use of fentanyl patches in a secure setting. At both Elmley and Rochester, Mr Harrison had to hand over his old Fentanyl patch before he could be given a new one. However, there was no formal policy in place for healthcare staff to ensure the control measure was consistently followed. The clinical reviewer noted that, on balance, there was no evidence to suggest this was not followed, but we consider it important that there are clear guidelines for staff to refer to in these circumstances, to reduce any risks.

76. The clinical reviewer noted that the prescribing of fentanyl patches as a controlled drug is not recommended in secure settings in accordance with the RCGP (2019) guidelines. However, in the exceptional event they are prescribed, The Care Quality Commission (CQC) and NHSE recommend in their guidance for 'safer use of controlled drugs' (2016) that there should be stringent governance around the prescribing, administration and monitoring of this drug by utilising a safety checklist. We recommend that this checklist is incorporated into Oxleas policy for secure settings. We make the following recommendations:

The Head of Healthcare at HMP Elmley should ensure that handovers take place for complex patients who present clinical risks and are due to be transferred, to ensure continuity of care.

The Head of Healthcare at HMP Elmley should ensure that when new prisoners enter the establishment on high risk and complex medication, staff complete a prompt review of medication to manage any risks.

The Head of Healthcare at HMP Elmley should ensure that when there is a query about a prisoner's diagnosis, the relevant referral is made to ensure it can be confirmed or other options explored.

The Lead Pharmacist at Oxleas should create clear guidelines on the safe prescription, administration, and governance of Fentanyl patch prescriptions in secure settings, in accordance with the RCGP 'safer prescribing in prisons' (2019) and the guidance and checklist contained within the CQC and NHSE guidance for the 'safer use of controlled drugs' (2016).

Emergency response

77. National policy guidance on entering cells during the night state is set out in National Security Framework 24/2011. Paragraphs 5.17 and 5.18 state that in an emergency, where there is or appears to be an immediate danger to life, a cell may be unlocked without the authority of the Duty Manager and with only one officer present. It also says that night staff should not take action that they feel would put themselves or others in unnecessary danger.

78. In interview, the OSG told us that when she realised Mr Harrison was unresponsive, she radioed a medical emergency code blue without hesitation. However, after completing a dynamic risk assessment, she opted to wait for help from officers before entering the cell because she was a lone female officer and could be vulnerable in a cell accommodating two men. We are satisfied that this was a reasonable assessment, in the circumstances. The assessment did not have a significant impact on the timing of the emergency response for Mr Harrison. Other officers arrived in around one to two minutes.

79. Overall, we consider that the emergency response by was prompt and appropriate.

Body-worn camera

80. PSI 04/2017 Use of Body Cameras states that, "In those establishments where it is authorised for use, BWVC must be deployed and set to record during a response to any reportable incident".

81. We found that some of the officers involved in the emergency response for Mr Harrison were wearing body-worn video cameras (BWVC) but none of the cameras were turned on. Although we recognise why officers might forget to activate their cameras in these difficult circumstances, BWVC footage is an important source of evidence which helps the PPO and other bodies investigate deaths in custody and identify learning that might prevent deaths in future. We make the following recommendation:

The Governor of HMP Rochester should remind staff to switch on their body-worn cameras during reportable incidents and that control room operators prompt staff to do so during an incident.

Inquest

82. The inquest into Mr Harrison's death concluded on 7 June 2024, and found that Mr Harrison died an accidental death after inhaling fumes from a transdermal fentanyl patch.

Prisons & Probation Ombudsman
Independent Investigations

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