PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Erlestoke in May 2014

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the investigation report into the death from a drug overdose of a man in May 2014 at HMP Erlestoke. He was 45 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received in prison was conducted. The prison cooperated fully with the investigation.

The man was sentenced to five years and 11 months in prison in December 2011 for violent offences. He suffered from mental health problems which affected his behaviour. Prison mental health staff reviewed him frequently and provided support.

In September 2013, the man was transferred to Erlestoke. He continued to have frequent contact with mental health services. Staff noted that his behaviour had improved and recorded no major concerns.

In May 2014, the man spent time around the wing and spoke to staff and other prisoners. He went back to his cell at lunchtime. Later that afternoon, officers found him unresponsive in his cell. They radioed for an emergency ambulance and attempted to resuscitate him. Shortly afterwards, paramedics attended and pronounced him dead.

A post-mortem report concluded that the man died from the toxic effects of heroin. It is not clear when and where he took the heroin and I am satisfied that Erlestoke could not have predicted or prevented his death. The investigation found that an opportunity to check his welfare was missed when his cell was unlocked earlier in the afternoon. However, we cannot say whether this would have changed the outcome.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **February 2015**

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SUMMARY

1. The man was sentenced to five years and 11 months in prison in December 2011 for violent offences. He had been in prison before. He had a history of mental health problems, and had previously abused alcohol and drugs.

2. The man moved between a number of prisons during his sentence. His mental health problems included obsessive compulsive disorder (OCD) and attention deficit hyperactivity disorder (ADHD), which affected his behaviour. Mental health staff reviewed him frequently and supported him. They had some success in helping him manage his behaviour.

3. In September 2013, the man transferred to HMP Erlestoke. He continued to have frequent contact with mental health services. Staff noted that his behaviour had improved and recorded no major concerns.

4. On a morning in May 2014, the man spent time around the wing and spoke to staff and other prisoners. He went to his cell at lunchtime and was locked in over the lunch period till around 1.30pm. During the afternoon, prisoners went to see him but left him as he appeared to be sleeping. At around 5.00pm, another prisoner and an officer took food to his cell as he had not collected his dinner. They also thought that he was asleep and left his meal in the cell.

5. At around 5.45pm, officers went to check the man as they had not seen him on the wing that afternoon. The officers found him unresponsive and radioed for an emergency ambulance. The officers attempted to resuscitate him but shortly afterwards paramedics arrived and pronounced him dead.

6. A post-mortem report concluded that the man died from the toxic effects of heroin. Staff and police found no drugs in his cell after his death, and we do not know where he got heroin from or when he took it. Intelligence information suggested that another prisoner had supplied him with heroin the day before he died, but the prison and police investigations could not verify this.

7. We are satisfied that Erlestoke could not have predicted or prevented the man's death. There was no evidence that he took an overdose of heroin on purpose. However, an officer missed a possible opportunity to check on his welfare when he unlocked his cell in the afternoon. We cannot say whether this would have changed the outcome.

8. The clinical reviewer concluded that the standard of healthcare the man received at Erlestoke was at least equivalent to that which he could have expected to receive in the community. We make one recommendation about unlock procedures.

THE INVESTIGATION PROCESS

9. The investigator issued notices to staff and prisoners at HMP Erlestoke informing them of the investigation and inviting anyone with relevant information to contact him. One prisoner responded.

10. NHS England commissioned a clinical review of the man's clinical care in prison.

11. The investigator obtained copies of the man's medical records and relevant extracts from his prison record. He visited the unit at Erlestoke where the man lived. He and the clinical reviewer interviewed staff and prisoners. He gave the Governor initial feedback about the preliminary findings of the investigation.

12. We informed HM Coroner for Wiltshire & Swindon of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation. She said that the Coroner had initially told her that her son died of a heart attack. She said that he was not a drug user and tried to keep healthy by going to the gym and eating well. He had been looking forward to his release in August. She asked the following questions:

    - How did he get drugs? Did he inject the heroin?
    - Could his death have been self-inflicted? Did he mean to take an overdose?

14. The man's family received a copy of the draft report. The solicitor representing the family wrote to us and raised a number of questions and we have provided clarification by way of separate correspondence to the solicitor. The prison has also submitted an action plan detailing what they have done to address the issue we raised and this is included at the end of the report.

HMP ERLESTOKE

15. HMP Erlestoke is a medium secure prison near Devizes in Wiltshire. It holds around 500 men. Great Western Hospitals NHS Foundation Trust provides health services at the prison, and sub-contracts mental health services to Wiltshire Mental Health Partnership NHS Trust. Healthcare staff are on duty from Monday to Friday. There is an out-of-hours service at night and at weekends. Three GPs from a local practice run a clinic each weekday.

HM Inspectorate of Prisons

16. The most recent inspection of Erlestoke was in September and October 2013. The Inspectorate found it to be a safe, well-led and effective prison. They noted a vigorous approach to reducing the supply of illicit drugs. Mandatory drug tests suggested that the prison was tackling illicit drug use, although nearly half of prisoners the Inspectorate surveyed said it was easy to get drugs in the prison.

Independent Monitoring Board

17. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent published report for the year to 31 March 2013, the IMB was concerned about the illicit use of prescribed medication in the prison. The IMB noted that staff carried out regular compliance checks to minimise this.

Previous deaths at HMP Erlestoke

18. The man was the first prisoner to die at Erlestoke since 2010.

KEY EVENTS

19. The man was remanded to prison in July 2011 and went to HMP Exeter. On 8 December, he was sentenced to five years and 11 months in prison for violent offences. His conditional release date was 11 August 2014. He had a number of convictions and had been in prison before. He had a history of alcohol and drug misuse.

20. The man had mental health problems, including obsessive-compulsive disorder (OCD, an anxiety disorder) and attention deficit hyperactivity disorder (ADHD, a psychiatric disorder). Although mental health specialists diagnosed these conditions as far back as 2007, prison healthcare staff initially had difficulty treating him effectively. His behaviour towards staff was often aggressive and abusive and he found it difficult to control his obsessive behaviours.

21. After time spent at HMP Channings Wood and HMP Erlestoke, the man arrived at HMP Portland in July 2012. At his initial health screen at Portland, a nurse noted that he had high risk mental health issues and referred him to mental health services. After this, he had frequent mental health reviews. Staff reviewed and amended his medication as necessary, and worked with him to reduce the symptoms of his OCD and ADHD.

22. On 13 December, a nurse reviewed the man on the wing after officers said that he had fallen and hurt his back. She recorded that he had been sick and incontinent. He told her that he had fallen earlier that morning because of a trapped nerve in his back. He said that he had taken a substance, but would not say what it was.

23. The nurse reviewed the man again twice during the day. She took his clinical observations, which were normal. Officers told her they believed that another prisoner had given him an ecstasy tablet that morning. (There is no further information available about this.) The next day, a prison GP reviewed him. He told her that his back was still painful and she gave him paracetamol. She had no further concerns.

24. Over the following months, the man had frequent contact with mental health services at the prison. Although he continued to struggle with behaviours related to his OCD and ADHD, staff recorded no major concerns about his health.

25. On 12 September 2013, the man told a psychologist that he was suffering from panic attacks, and was worried that he had a serious illness. The psychologist noted that healthcare staff had taken his medical observations and performed an electrocardiogram (a test to monitor heart activity) the previous day, the results of which were normal. He reassured him and gave him advice to help him relax.

26. The man transferred to Erlestoke on 19 September. Healthcare staff recorded no concerns at his initial health screen. A prison GP re-prescribed

his medication for OCD and ADHD. He lived on Wessex Unit, a residential wing.

27. On 24 September, a community mental health nurse reviewed the man. He told the nurse that a specialist had diagnosed him with bi-polar disorder (a depressive illness) two years before. There is no evidence in the records to confirm this diagnosis. The nurse referred him for a mental health assessment.

28. On 3 October, a counsellor assessed the man. He told the counsellor that he wanted to resolve his anxiety, paranoia and obsessive behaviours. Over the following months, the counsellor and the nurse reviewed him frequently. They had some success in helping him to manage and reduce his ritual behaviours. His general behaviour also improved.

29. The man took a voluntary drug test on 13 October, which was negative. (He took a further four voluntary drug tests at Erlestoke. All of the results were negative.)

30. While living on Wessex Unit, the man started a job as a cleaner and used the gym frequently. Staff recorded that he usually had a good attitude. Although improved, his ritual behaviour and anxiety continued, which sometimes caused him to become angry. The counsellor and nurse continued to support and advise him.

31. On 7 February 2014, the man told the nurse that his grandmother had suffered a stroke the previous week. Although he reported feeling well, he asked a nurse to take his blood pressure for reassurance. The nurse took his clinical observations, which were normal. On 27 March, he told the nurse that his grandmother had died. He had some concerns about this, but told the nurse that he was generally feeling good.

32. On 15 April, a prison GP reviewed the man after he raised concerns about his health. He told her that his grandmother had died from a stroke and said he had a family history of cancer. She took his medical observations, which were normal, and referred him for a Wellman check (full medical tests). The test results revealed no physical health concerns.

33. A nurse reviewed the man at a planned mental health review on 15 May. He recorded that he was bright in mood. They discussed his future medication regime and his plans for accommodation after he was released from prison. The nurse recorded no concerns about him.

Events leading up to the incident

34. In May, an officer unlocked the man's cell at 8.39am. He came out of his cell around one hour later. He spoke to at least two other prisoners around the unit. He went outside to exercise at 10.07am. He went back to his cell later in the morning and came out occasionally to speak to Prisoner A and to have a drink. The prisoner told the investigator that the man came to his cell to give him advice about his sentence. He said that he had appeared his usual self. The other prisoner did not want to speak to the investigator.

35. At around 11.30am, the man helped an officer bring the lunch trolley to the unit. Around 30 minutes later, another prisoner came to his cell. He waited outside for him and then went inside with him for around a minute. CCTV shows that shortly afterwards two other prisoners arrived. Prisoner B went into the cell briefly and left holding a container. The other two prisoners then left. Prisoner B returned around two minutes later holding two containers. He gave the man one and left; the man closed his door.

36. Prisoner B told us that the man had given him his lunch that day, because he was training in the gym and needed extra protein. He had brought him his dessert from the servery in return and that is what was in the container he gave him. The other two prisoners could not remember speaking to the man. None of the prisoners said they had any concerns about him or noticed anything different about him.

37. Over the next few minutes, the man opened his door twice but stayed in his cell. An officer looked through the cell door observation panel at 12.11pm, and locked the door for the lunch period.

38. An officer unlocked the man's cell at 1.32pm, but did not speak or see him. Over the following hours, some prisoners looked through the door observation hatch, but no one went inside. A prisoner told us that he went to see him twice, but he was lying on his bed and looked asleep so he did not go in. Another told us that he went to buy cigarette papers from him. He also thought that he was sleeping and did not disturb him.

39. Just before 5.00pm, Officer A looked through the observation hatch on the man's door. Around five minutes later, he and a prisoner came back with the man's dinner. The officer told us that he had not collected his meal that evening, and a prisoner had volunteered to take it to him, as they were friends. He was still lying in his bed and appeared asleep, so they left the food in the cell for him. The prisoner told us that when they were in the cell the officer thought he had heard him speak and went towards the bed to find out what he was saying. However, the officer did not mention this and said that he had thought he was asleep.

40. At 5.35pm, officers locked the cells. Officer B looked through the observation hatch on the man's door to count the prisoners on the unit and said he seemed to be asleep.

41. At 5.44pm, Officer B went back to the man's cell with two other officers and opened the door. He told us that as he and the other officers on the wing had not seen the man out of his cell for a few hours, they decided to check on him. He tried to speak to him, but he did not respond. Officer C touched his arm, which was cold. He tried to rouse him but he could find no signs of life. He had been lying face down on his bed and when he turned him onto his back, he saw that his face was discoloured.

42. Officer A radioed a code blue emergency call (which indicates circumstances when a prisoner is unconscious or has respiratory problems). Control room staff called an ambulance immediately. The officers placed the man on the floor and Officer C started cardiopulmonary resuscitation (CPR). Two more officers arrived shortly afterwards and helped with the resuscitation attempt. Officer C told us he tried to give him rescue breaths using a facemask, but a liquid was coming out of his nose and mouth. The officers continued giving chest compressions.

43. Paramedics arrived at 6.00pm and moved the man to the corridor outside the cell. They helped the officers with CPR but could not find any signs of life, and pronounced him dead at 6.17pm.

44. An officer sealed the cell at 6.24pm. A Police Constable arrived at the prison at around 7.15pm. He searched the man's body and the cell, but found nothing concerning. The prison's healthcare manager accompanied the PC and accounted for the man's prescribed medication. At around 8.30pm, staff sealed the cell again.

Support for staff and prisoners

45. The Governor debriefed staff involved in the emergency response before they left the prison and ensured they were offered support. Officer B did not attend the debrief meeting, but another member of staff took him home. He received support over the following days.

46. Additional Listeners (volunteer prisoners trained by the Samaritans to provide emotional support to fellow prisoners) went to Wessex Unit to support prisoners after the man's death. Staff reviewed those being monitored as at risk of suicide or self-harm in case they had been adversely affected by the news.

Family Liaison

47. A governor and a prison family liaison officer visited the man's family that evening to inform them of his death. The family liaison officer remained in contact with the family. In line with national guidance, the prison contributed to the funeral costs.

Post-mortem

48. A consultant histopathologist completed a post-mortem examination. He gave the cause of death as drug toxicity. Toxicology results showed significant levels of morphine in the man's blood and urine. He concluded that the presence of additional metabolites (substances produced during digestion or other bodily processes) suggested that the man probably used illicit heroin, rather than morphine. His report did not determine how or when he took the heroin. He noted that using heroin depresses the body's central nervous system (which controls breathing and keeps the heart beating), and increases the risk of respiratory depression (breathing problems).

ISSUES

Clinical care

49. The clinical reviewer concluded that the standard of clinical care the man received at Erlestoke was equivalent to that which he could have expected to receive in the community. He noted that the assessment and management of his mental health needs was of a high standard.

50. We agree with the clinical reviewer's assessment of the man's care at Erlestoke. He had frequent mental health reviews, and healthcare staff gave appropriate support and advice to help him manage his mental health problems.

Drug use

51. In his post-mortem report, the consultant histopathologist concluded that the man died from the toxic effects of heroin. Although he had used amphetamines (stimulant drugs) in the past, there is little evidence that he had habitually used drugs during his current sentence. In December 2012, staff at Portland thought that he had taken ecstasy, but there was no drug test to confirm this. An intelligence report submitted at Portland in February 2013 suggested that he was concealing drugs, including heroin, in his cell. However, there is no further information recorded about this.

52. We found little evidence to suggest that the man was involved in drugs at Erlestoke. He took five voluntary drug tests between October 2013 and April 2014, and the results were all negative with no indication of drug use. Staff we spoke to were surprised that he had died from using heroin. They had no concerns that he had been using drugs before his death. Prisoners who lived with him on Wessex Unit had no concerns about him. Some said that they had heard rumours about him taking drugs, but these were after his death.

53. An officer who worked on the unit told us that the man did not like people who used drugs. Evidence from his mental health reviews supports the officer's view. He told mental health staff a number of times that he was worried about drug use on the unit.

54. On 27 May, an officer submitted a security intelligence report about alleged drug supply to the man. A prisoner on Imber Unit had told the officer that another prisoner had said that he had supplied him with heroin the day before he died. The prison's security department reviewed the intelligence report and shared it with the police. Prison officers searched the cells of prisoners identified in the report, but found nothing. Police officers also searched his cell and reviewed CCTV evidence, but found nothing suspicious. The PC told us that there was not enough evidence to identify who supplied him with heroin. There was no evidence to bring criminal charges or that he was the victim of a crime.

55. We are satisfied that staff at Erlestoke could not have predicted or prevented the man's death. Staff and prisoners we spoke to had no concerns about him. His personal officer had almost daily contact with him. He told us that the man liked to spend time on his own but did not think that he had any problems. He could think of no reason why he would want to take drugs, and had no concerns that he wanted to harm himself.

56. Unfortunately, we have been unable to find any further evidence of why the man decided to take heroin, or whether this was an isolated incident with tragic circumstances. There is no evidence to suggest that he overdosed on purpose. He did not appear to have any concerns at Erlestoke, and he was managing his mental health problems effectively. He often spoke to staff and other prisoners about his plans after he was released from prison. Although a security intelligence report suggested that another prisoner had supplied him with heroin, we cannot be certain where he got this from, or when and where he took it. Prison staff and police found no drugs or drug-taking equipment in his cell, and CCTV evidence was inconclusive.

Unlocking prisoners

57. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead". Prison Service Instruction 10/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

58. When Officer C unlocked the man's cell after lunch on 18 May, he did not wait to get a response from him. While we cannot say whether this would have changed the outcome, it meant that staff missed an opportunity to check on his wellbeing. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

59. Prison Service Instruction (PSI) 03/2013 says that a code blue emergency call should be used in a medical emergency, including when a prisoner has chest pain, has difficulty breathing or is unconscious. It directs that medical emergency is called over the radio network and an ambulance must be called immediately.

60. When officers found the man unresponsive in his cell on 22 May, Officer A quickly radioed a code blue which meant that an ambulance was called without delay. We are satisfied that his actions were appropriate in the circumstances, and that Erlestoke has a suitable emergency protocol reflecting current Prison Service requirements.

61. The clinical reviewer concluded that that emergency treatment was appropriate and commended the actions of those involved. We consider that the emergency treatment was appropriate.

RECOMMENDATION

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A notice to staff was issued on 1 December 2014 to remind all staff of the importance of receiving a response from each prisoner confirming his well-being at each unlock period. Short term assurance tests will be completed, findings will be discussed at the safer custody meetings.	complete	