Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derrick Rose-Fowler a prisoner at HMP Stoke Heath on 5 June 2015

A report by the Prisons and Probation Ombudsman
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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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 Derrick Rose-Fowler was found hanged in his cell at HMP Stoke Heath on 5 June 2015 and later died in hospital. He was 44 years old. I offer my condolences to Mr Rose-Fowler's family and friends.

Mr Rose-Fowler had been moved from Stoke Heath in May 2014 because of concerns that he was under threat from other prisoners and I am concerned that he was moved back to Stoke Heath in January 2015, without any checks as to whether his safety might still be at risk. He said that he continued to be under threat and rarely left his wing, but nothing was done to protect him or investigate his concerns.

Mr Rose-Fowler was unhappy that his pain relief medication had been changed. I am satisfied that this was an appropriate clinical decision but I am concerned that no one took any action when Mr Rose-Fowler said he was using a new psychoactive substance to compensate for his changed medication. This is another investigation into a death, where we have found that the use of NPS was a serious problem at the prison and more needs to be done at Stoke Heath and nationally to address this issue and warn prisoners of the risks.

While I consider that more should have been done to address Mr Rose-Fowler's anxieties about being at Stoke Heath, I recognise that there was little to indicate that he was at immediate risk and it would have been difficult for staff at the prison to have predicted or prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **March 2016**

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Summary

Events

1. On 4 December 2012, Mr Derrick Rose-Fowler was sentenced to six years in prison. In October 2013, Mr Rose-Fowler transferred to HMP Stoke Heath. In February 2014, he said he was in debt for drugs and was holding something for someone. Officers found a mobile phone. He spent a month in the segregation unit from March because he felt under threat. He was transferred to HMP Featherstone, but spent two months segregated before moving to HMP Risley. He settled well at Risley, but was sent back to Stoke Heath in January 2015 as the prison has a resettlement function for prisoners from Wales, where Mr Rose-Fowler was from.

2. On 6 February, the prison GP at Stoke Heath changed Mr Rose-Fowler's medication for neuropathic pain. Mr Rose-Fowler was very unhappy and complained twice. He missed appointments to discuss this with the GP. (In June, he told a nurse that he had been using a new psychoactive substance to compensate for the change in his medication.)

3. On 3 March, Mr Rose-Fowler told a nurse he was unhappy about being at Stoke Heath and was scared to leave his wing. The nurse informed security staff, but no one investigated. In April, he gave an officer a note outlining the reasons for his previous transfer from Stoke Heath and said he was still under threat. Officers told the safer custody team about the letter but they did not investigate further because Mr Rose-Fowler would not name anyone.

4. On the morning of 5 June, a nurse gave Mr Rose-Fowler some paracetamol for neck pain and an officer locked him in his cell at about 8.45am. Just before 9.00am, he rang his cell bell and asked an officer about his prison shop order, which had not arrived. However, it does not appear that Mr Fowler had ordered anything that week, as he did not have sufficient money. Shortly after 10.00am, an officer unlocked his cell and found he had hanged himself with a cord attached to the window. She radioed an emergency, went into the cell with another prisoner and removed the cord from around his neck. Other staff responded quickly. Staff tried to resuscitate Mr Rose-Fowler until paramedics arrived and took over emergency treatment. At 11.00am, the paramedics took Mr Rose-Fowler to hospital but he did not recover and died two hours later.

Findings

5. Mr Rose-Fowler was transferred from Stoke Heath in May 2014, because he refused to move from the segregation unit, apparently because he was concerned about his safety at the prison. The reasons for his move were not highlighted in his prison record and he was therefore moved back to Stoke Heath in January 2015, without any checks that there might still be a problem. After he arrived, Mr Rose-Fowler told staff that he was anxious about being there, but was not prepared to name any prisoners and they did not investigate. We consider that Stoke Heath should have done more to find out whether his fears were justified and to ensure his safety. However, we recognise that there was little to

indicate that he was at risk of suicide at the time of his death and it would have been difficult for staff to have predicted or prevented his actions.

6. Mr Rose-Fowler was upset about a change in his pain relief medication and complained about this. We are satisfied that the change was in line with clinical guidelines. However, Mr Rose-Fowler told a nurse that he had been self-medicating to relieve his pain, by using a new psychoactive substance. There is no record that the nurse warned him of the dangers or referred him to the substance misuse team.

7. There was a prompt emergency response when Mr Rose-Fowler was found hanged. While there was no significant delay in calling an ambulance, the local policy does not require the control room to call an ambulance immediately, when an emergency code is used, as national instructions require. The prison did not follow the national policy when returning Mr Rose-Fowler's property to his mother.

Recommendations

- The Governor should ensure that appropriate security alerts are entered on prisoners' records when they are moved from Stoke Heath for safety or security reasons so that other prisons can take this into account and reassess the situation when a return to Stoke Heath is proposed.
- The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.
- The Governor should ensure that prisoners who admit to using new psychoactive substances are referred to drug treatment services and warned about the dangers and risks to health.
- The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.
- The Governor should ensure that families are asked how they want a deceased prisoner's property to be returned.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Stoke Heath informing them of the investigation and asking anyone with relevant information to contact her. One prisoner asked to speak to her when she was visiting the prison.

9. NHS England commissioned a clinical reviewer to review Mr Rose-Fowler's clinical care at the prison.

10. The investigator visited Stoke Heath on 11 June 2015. She obtained copies of relevant extracts from Mr Rose-Fowler's prison and medical records.

11. The investigator interviewed eight members of staff and six prisoners at Stoke Heath in July and August. The clinical reviewer joined her for interviews with three members of healthcare staff. One officer provided written answers to questions.

12. We informed HM Coroner for Shropshire, Telford and Wrekin of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report. Prison and medical records are in the name of Mr Derrick Fowler but, at his family's request, the coroner agreed to refer to Mr Fowler as Mr Rose-Fowler. We have therefore used that name.

13. One of the Ombudsman's family liaison officers contacted Mr Rose-Fowler's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know how her son was able to able to hang himself in his cell, and about the emergency response. She asked why he had been moved back to Stoke Heath after such a short time at Risley, especially as he was adamant that he did not want to return. His mother said that his letters before his death did not suggest he was feeling suicidal and she wanted to know whether Mr Rose-Fowler was having problems in the prison that would explain his actions. His mother was unhappy about communication with the prison after her son's death and that they had not followed her wishes about returning his clothes.

14. Mr Rose-Fowler's family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact upon the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Stoke Heath

15. HMP Stoke Heath is a medium security prison in Shropshire holding up to 745 adult and young adult men. It is in the process of becoming a resettlement prison for Wales and about 60% of its prisoners are from Wales. Primary care services are provided by Shropshire Community Health NHS Trust and secondary mental health services by South Staffordshire NHS Foundation Trust.

HM Inspectorate of Prisons

16. The most recent inspection of Stoke Heath was in April 2015. Inspectors reported that prisoners in crisis said they felt well supported, although access to Listeners (prisoners trained by Samaritans to provide confidential support to other prisoners) was inadequate. Levels of violence were high and likely to be linked to the high availability of alcohol and drugs, including new psychoactive substances. Inspectors considered that the prison needed to do more to challenge the behaviour of perpetrators of violence and threats and support victims, who did not always receive sufficient support.

17. Inspectors assessed relationships between staff and prisoners as good. Most prisoners said staff treated them with respect although the personal officer scheme was ineffective. Some prisoners were unhappy about the GP changing pain relief medication. Inspectors found that the practices were clinically sound and showed positive clinical governance but consultation with individual patients and explanations about the changes could have been better. The healthcare complaint system was not well advertised or managed and some complaints were answered by the clinician who was the subject of the complaint.

Independent Monitoring Board

18. 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 April 2015, the IMB commended the prison GP for taking action to reduce the prescription of unnecessary medication, which had led to him receiving abuse from some prisoners. The IMB was concerned that a number of prisoners got into debt and then sought a move to the segregation unit for their own safety. The IMB noted that the role of the personal officer appeared to have been lost and needed to be reinstated.

Previous deaths at HMP Stoke Heath

19. There has been one other self-inflicted death at Stoke Heath, in the last four years – in March 2013. In the investigation into that death, we found that the prison did not investigate allegations of bullying.

Assessment, Care in Custody and Teamwork

20. Assessment, Care in Custody and Teamwork (ACCT) is the is the care planning system the Prison Service uses for supporting and monitoring prisoners assessed as at risk of suicide and self-harm. The purpose of the ACCT process

is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary case reviews involving the prisoner. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

New Psychoactive Substances

21. NPS are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.

22. As well as emerging evidence of dangers to both physical and mental health, there are also links to suicide or self-harm. Trading in these substances, while in prison, can lead to debt, violence and intimidation.

23. In July 2015, we published a Learning Lessons Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

24. On 21 March 2010, Mr Derrick Rose-Fowler was sentenced to five years in prison for possession of an offensive weapon and possession of class A drugs with intent to supply. He had a history of substance misuse including LSD, crack cocaine, benzodiazepines and heroin. In 2012, he was released on licence but later that year was arrested for and then convicted of wounding with intent to cause grievous bodily harm. While on remand, he told nurses that he had attempted suicide by hanging 27 years previously. On 4 December 2012, he was sentenced to six years in prison. His new release date was January 2016.

25. In May 2013, while at HMP Altcourse Mr Rose-Fowler complained of back pain from an injury suffered at work and said he needed stronger pain relief than naproxen. A GP noted that Mr Rose-Fowler had numbness down his right arm from an accident and referred him for a hospital neurology review.

26. On 25 October 2013, Mr Rose-Fowler transferred to Stoke Heath. In December, a GP referred him to the mental health team after he said he was anxious and depressed. The GP suggested counselling and prescribed an antidepressant.

27. Prison intelligence reports from the start of 2014 indicated that Mr Rose-Fowler was taking and dealing drugs. On 21 February, Mr Rose-Fowler told staff he had been forced to hold something in his cell on behalf of another prisoner because he was in debt. Officers searched his cell and found a mobile phone. Mr Rose-Fowler told a nurse that he was using drugs every day and had got into a lot of debt. He told a drugs worker he wanted to go to a therapeutic community to address his drug problems.

28. On 28 March, Mr Rose-Fowler went to the prison healthcare centre to have a cut on his head treated, which he said he had banged on a table. Afterwards, he refused to go back to his wing, said he needed protection and asked to go to the segregation unit. A manager agreed to segregate him for his own protection. He stayed in the segregation unit for several weeks and refused to return to a wing. On 16 April, he told a nurse that he had cut his eyebrow himself, so that staff would know that he was at risk on the wing. On 2 May 2014, because he continued to refuse to go back to a wing, Mr Rose-Fowler was taken to HMP Featherstone.

29. In August 2014, Mr Rose-Fowler was taken to the segregation unit at Featherstone after he threatened to take a GP hostage and smashed up his cell. He told staff he had been using black mamba (a new psychoactive substance) and cannabis for the previous six weeks. He refused to leave the segregation unit and asked for a transfer. On 15 October, he took a handful of antibiotic tablets, barricaded his cell and said he would start a dirty protest. He told staff that his “head had gone” and he was supported under ACCT suicide and self-harm prevention procedures. At a review a week later, Mr Rose-Fowler said he had not been trying to kill himself. He agreed to transfer to HMP Risley, but said that he felt he would soon end up in the segregation unit there. Officers noted an alert on his prison record (NOMIS) that he was, “Not to return to Featherstone.” No reason was given.

30. On 22 October, Mr Rose-Fowler transferred to Risley and staff at Risley ended ACCT supervision a few days later. Mr Rose-Fowler said that he had no thoughts of suicide or self-harm and had swallowed the tablets to get a transfer out of Featherstone. He said that he had cut his wrists when he was ten years old. Mr Rose-Fowler said he wanted to move near his family, when he was released. At the time, they were living in Wales. He appeared to settle well on a standard wing at Risley.

31. In January 2015, a prison GP referred Mr Rose-Fowler for a scan because of his continuing neck, back and arm pain. The hospital arranged an appointment for 24 February.

32. As part of a reconfiguration of the prison estate, Stoke Heath took on the role of a resettlement prison for prisoners being released to their home areas in Wales. As a result, on 29 January 2015, Mr Rose-Fowler was moved back to Stoke Heath to help resettlement work before his release in January 2016. His outstanding appointment for a scan was not regarded as sufficiently serious to hold up the move. When Mr Rose-Fowler arrived at Stoke Heath, he was allocated a cell on A Wing.

33. At the time of his transfer, Mr Rose-Fowler was being prescribed co-codamol, ibuprofen (both pain relief medications), lansoprazole (to reduce stomach acid), mirtazapine (an antidepressant) and pregabalin (for neuropathic pain – caused by damage to the nervous system). The appointment for a scan was cancelled.

34. On 4 February, Mr Rose-Fowler told a GP that he had been injured in 2012 when an engine block fell on his head and he had numbness in his right arm. He told the GP why he had been moved from Stoke Heath some months earlier and said he was worried about being around other prisoners at Stoke Heath and thought they were talking about him. He said that he could not work because he suffered from anxiety. The GP spoke about the benefits of work for his mental health but Mr Rose-Fowler then walked out of the appointment. The GP referred him to a physiotherapist.

35. The next day his offender supervisor met Mr Rose-Fowler. He noted that Mr Rose-Fowler had moved from Stoke Heath the year before, after being found with a mobile phone and being in debt and that he might have problems again.

36. From 6 February, a GP began to reduce Mr Rose-Fowler's prescription of pregabalin, from 300mg per day to 50mg over the next six weeks. The GP prescribed nortriptyline, an antidepressant sometimes used for neuropathic pain. The change was part of a wider review of prescribing practice at the prison, partly to reduce the availability and misuse of opiate-based medication and other medication that is often traded in prisons. Mr Rose-Fowler was one of many prisoners whose medication the GP reviewed and changed.

37. On 17 February, Mr Rose-Fowler refused to go to a scheduled art class because he said he had mental health issues. An officer spoke to the healthcare team, who advised him to refer Mr Rose-Fowler to them.

38. On 19 February, Mr Rose-Fowler made a written complaint about the changes to his prescription. The GP replied to the complaint on 25 February and said he

had referred Mr Rose-Fowler for a scan of his neck. The GP said he was happy to discuss his medication if Mr Rose-Fowler made an appointment to see him.

39. On 20 February, the GP requested an MRI scan and the hospital arranged an appointment for 31 March. As there were insufficient staff for all the hospital escorts arranged that day, the prison cancelled the appointment and re-arranged a scan for 27 April.

40. On 3 March, a nurse from the mental health team saw Mr Rose-Fowler as a result of the officer's referral on 17 February. She remembered Mr Rose-Fowler from his last stay. Mr Rose-Fowler said he was upset about being at Stoke Heath and should not have been moved from Risley, where he was settled and happy. He said he was worried about his safety, did not want to leave the wing and was unhappy about the changes to his medication.

41. The nurse submitted a security report about Mr Rose-Fowler's concerns. The security assessment of the report noted that the problems he had experienced at the prison in April 2014 had not been recorded in any detail and there were no specific prisoners listed on his record that he needed to be kept separate from. The information was referred to the prison's safer custody team. On 11 March, a member of the team recorded the information in a "Tackling Bullying Behaviour" form, which was logged on a database but the team took no further action at the time.

42. On 6 March, Mr Rose-Fowler addressed a second complaint about his medication to "the Manager of Healthcare". He said he was in constant pain and asked for a second opinion. The mental health nurse replied and said that they would discuss it when they next met on 26 March. Mr Rose-Fowler did not attend that appointment and the nurse did not see him again until 23 April. There is no record that they discussed the complaint.

43. On 9 March and 13 April, Mr Rose-Fowler did not attend appointments with the GP, who he had asked to review his medication. In March and April, he also missed three physiotherapy appointments and four appointments with the nurse. No reasons were recorded, but it appears that he was scared to leave his wing.

44. On 20 April, Mr Rose-Fowler wrote a note about his previous problems at Stoke Heath and gave it to an officer. In the note, he said that he felt constantly paranoid at being back in Stoke Heath and had not left the wing, as the problems he had before had not gone away. He said that he had to be looking over his shoulder all the time. He had applied for a job on the wing because he did not want to go anywhere else in the prison. The officer noted in the observation book that two managers had told him that Mr Rose-Fowler should write a statement naming those he was having problems with, but Mr Rose-Fowler had just shrugged his shoulders when told him this.

45. On 22 April, Mr Rose-Fowler did not attend his appointment with the nurse, the fifth in a row he had missed. She spoke to an officer on A Wing about this and the officer said Mr Rose-Fowler had problems with other prisoners and was not attending any activities off the wing. She saw him the next day. He told her that he was having issues with the same prisoners as when he was last at Stoke Heath and did not feel safe leaving the wing. She agreed to see him on A Wing

for future appointments. She told us that she thought that he was okay if he stayed on the wing. Mr Rose-Fowler told the nurse that he wanted the GP to review his medication. She told him that he had an appointment on 28 April. Mr Rose-Fowler did not attend the appointment and did not see the GP again.

46. On 27 April, Mr Rose-Fowler was taken to hospital for his outstanding scan. The results, sent on 5 May, showed that there was some narrowing of the canal within which the spinal cord sits towards the base of the neck, caused by wear and tear, and some little bony growths, which stabilised the joint. A GP explained that the scan showed the canal was slightly narrower at a particular point, but there was no evidence of pressure on a nerve. The GP said that patients can have normal scans but still have pain (which can be influenced by other things such as stress and anxiety). He did not think there was any need to change Mr Rose-Fowler's medication as a result of the scan.

47. Mr Rose-Fowler used to sketch pictures from photographs and prisoners paid him an ounce of tobacco for each picture. The prison told us that they had allocated Mr Rose-Fowler to activities three times. At first, he was enrolled for daily art classes but only attended twice: once in February and once in March. He did not attend a week-long first aid course from 16 March. He was then given a gardening job but went only twice in 16 days.

48. On 2 June, the mental health nurse had an appointment with Mr Rose-Fowler who said he was fine and had no problems on the wing. He said he talked to staff and other prisoners on the wing. She said that for most of their session, he had talked about the future and what he intended to do when he was released in January 2016. He said he wanted to live with his mother, but she no longer lived in Wales, which was originally his intended release area. She said she would let his offender supervisor know about this.

49. Mr Rose-Fowler told the nurse that he wanted a second opinion about his pain medication and said he was self-medicating to cope with the pain by smoking black mamba (a new psychoactive substance). She said he could get a second opinion when a locum GP covered for the GP. In her note of their appointment, she wrote that there was no obvious evidence of any mental health illness. Mr Rose-Fowler's concerns were prison-related and he was aware of how to get support. She noted that she did not feel he needed further input from the primary mental health team. She did not mention his use of NPS or consider referring him to the substance misuse team.

50. The nurse told us that Mr Rose-Fowler was no different from the other times she had seen him. She said that he had been worried that a prisoner who was in the prison's induction unit, who he had trouble with when he was last at Stoke Heath, might move to A Wing. He would not tell her the prisoner's name.

51. The nurse e-mailed Mr Rose-Fowler's offender supervisor. He said that on 1 June he had taken over from the previous offender supervisor, who had last seen Mr Rose-Fowler on 5 February. She told him about Mr Rose-Fowler's preferences about his release area and that someone who had previously caused him trouble was back in the prison again. He said that he would see Mr Rose-Fowler soon.

52. An officer said that, on 4 June, Mr Rose-Fowler complained of pain in his lower back that went up to his neck. The officer thought a nurse had told him he would need to see the GP, as she could not give him anything for the pain unless the GP prescribed it. The officer said she had called the healthcare centre several times that morning and spoken to a nurse, who said she would find out what was happening and call back. Another officer also called the healthcare centre about Mr Rose-Fowler. He said that he was told that a nurse would review him during the teatime medication round.

53. The medical records show that Mr Rose-Fowler collected mirtazapine as usual at the beginning of June. He refused nortriptyline from 29 May to 3 June but started again on 4 June. At 4.10pm, a nurse saw Mr Rose-Fowler and emailed the doctor noting that he was complaining about a bad neck. She booked an appointment for two weeks later, but asked the GP to see him earlier. (The GP replied by email the next morning, prescribed an ibuprofen gel and brought the appointment forward by seven days.)

54. At Stoke Heath prisoners complete an order form on Fridays for goods such as tobacco and other items from the prison shop. They receive their orders (known as canteen) the following Thursday. On Thursday 4 June, there was no canteen delivered for Mr Rose-Fowler. He pressed his cell bell three times that afternoon, at 5.26pm, 5.35pm and 5.46pm. We do not know who answered the bells, but an officer remembered talking to Mr Rose-Fowler about his canteen. Mr Rose-Fowler said he had placed an order, but nothing had arrived. The officer told him that if a mistake had been made, he would be able to get a 'smoker's pack' (usually issued to new prisoners). He declined this and said he did not like the brand of tobacco in the packs. The officer said Mr Rose-Fowler made a lot of noise about his canteen order not arriving.

55. About 8.05am on Friday 5 June, officers unlocked prisoners on Mr Rose-Fowler's landing to go to work or to collect their medication from the ground floor medication hatch. Mr Rose-Fowler spent some time on the landing and in the cell next to him, talking to two prisoners. He went to the medication hatch and asked a nurse for paracetamol for his neck pain. She gave him two tablets. Mr Rose-Fowler went back to a prisoner's cell. The prisoner told us that he was upset about his medication and not getting his canteen order.

56. Prisoners who were not going to work or the gym were locked up again around 8.45am. Prisoner cleaners stayed out of their cells on the wing. At 8.56am, Mr Rose-Fowler pressed his cell bell and an officer responded a few minutes later. Mr Rose-Fowler was watching television and said his canteen had still not arrived. The officer had already checked for any left over bags and told Mr Rose-Fowler that no canteen had been delivered for him and his name was not on the canteen list. The officer said he would check to see if any money had left his Mr Rose-Fowler's prison account, if he came to the office later. Mr Rose-Fowler also mentioned his neck pain.

57. The officer went back to the wing officer and checked Mr Rose-Fowler's account. He said there were only a few pounds in it and it did not look as if Mr Rose-Fowler had made a canteen order that week. (Records show that Mr Rose-Fowler last paid £10.15 for a canteen order on 27 May. On 3 June, he had £2.94

in his account and had not ordered any canteen. It appears that he wanted other prisoners to believe that his order had not arrived.)

58. About 15 minutes before they were due to be unlocked, Mr Rowland, in the next cell, said he heard a regular tapping sound coming from Mr Rose-Fowler's cell. He said it was not a loud or violent bang, more like something knocking into the sink unit. He thought the noise lasted for a minute to a minute and a half.

59. The officer began unlocking the landing just after 10.00am, starting with the cell opposite Mr Rose-Fowler. She got to Mr Rose-Fowler's cell, number 63, last. A prisoner had just been unlocked. She noticed that Mr Rose-Fowler had covered the door observation panel with tissue paper. She unlocked the door and saw that Mr Rose-Fowler was at the back of the cell with a dressing gown cord tied around his neck attached to the window lock. He was kneeling, with his head slumped forward.

60. At 10.04am, the officer radioed a code blue emergency. She and the prisoner went into the cell, held Mr Rose-Fowler up, loosened the cord around his neck and took it off. She could not get a response. Two more officers arrived around 30 seconds later. Mr Rose-Fowler was unresponsive and an officer began chest compressions, helped by another officer, and asked someone to bring a defibrillator. The officer said that Mr Rose-Fowler's face was purple and black. Records show that the control room rang for an ambulance at 10:06am.

61. The emergency response nurse reached the cell two minutes and 30 seconds after the code blue. Another nurse collected emergency equipment (an oxygen cylinder, defibrillator and ambu-bag) and got to the cell half a minute later. The emergency response nurse attached the defibrillator to Mr Rose-Fowler but it did not detect a shockable heart rhythm. The nurses inserted an airway and gave Mr Rose-Fowler oxygen. She said his face was blue and mottled, but his body was still warm. They continued to attempt resuscitation.

62. An ambulance arrived at 10.15am, and a second at 10.20am. Paramedics took over emergency treatment. They administered emergency medication and established a pulse at 10.30am. Mr Rose-Fowler could not breathe on his own and still needed the airway and oxygen. Just before 11.00am, paramedics took him to hospital. Hospital staff were unable to stabilise Mr Rose-Fowler and he did not recover. The hospital recorded his death at 1.09pm.

63. Mr Rose-Fowler did not leave any letters or notes in his cell, explaining his actions.

Contact with Mr Rose-Fowler's family.

64. At 10.30am, the deputy governor contacted Mr Rose-Fowler's mother to tell her what had happened and that her son was in a critical condition. His mother was unable to reach the hospital before Mr Rose-Fowler died. The prison's family liaison officer, the deputy governor and a prison chaplain met Mr Rose-Fowler's mother at the hospital later. They offered their condolences and explained what had happened. In line with national Prison Service instructions, the prison contributed towards the cost of Mr Rose-Fowler's funeral.

Support for prisoners and staff

65. The deputy governor debriefed the staff involved in the emergency response and offered her support and that of the staff care team. Two officers said that they did not feel well supported by senior managers afterwards. Although the care team had spoken to them initially, they said that there had been no follow up offers of help.

Information from prisoners after Mr Rose-Fowler's death

66. After Mr Rose-Fowler's death, a prisoner told an officer that Mr Rose-Fowler had large debts because he used black mamba and subutex, but could not pay for them. The prisoner said he had heard other prisoners shouting abuse to Mr Rose-Fowler the night before his death because he was unable to repay his debts. Mr Rose-Fowler told them that his canteen had not arrived but the other prisoners did not believe him. The prisoner, who did not want to be interviewed by us, said that Mr Rose-Fowler had pressed his cell bell and asked an officer why his canteen had not arrived.

67. The prisoners we interviewed said that Mr Rose-Fowler might have had small debts, but they did not think that he was very concerned. A wing cleaner said he had heard that other prisoners had been shouting at Mr Rose-Fowler the night before his death, but when he spoke to him the next morning he seemed his normal self. Another prisoner did not think that anyone was threatening Mr Rose-Fowler or bullying him. Another prisoner said he did not think Mr Rose-Fowler was the kind of person to feel very stressed, even if he was in debt. On the morning of 5 June, Mr Rose-Fowler had asked for a cigarette, as his canteen order had not arrived. He said that he gave no indication that he was intending to harm himself.

Post-mortem report

68. A post-mortem examination found that Mr Rose-Fowler died from a cardiac arrest after being found hanged. Toxicology tests found no drugs or alcohol, apart from a therapeutic amount of paracetamol. They did not test for the presence of new psychoactive substances.

Findings

Mr Rose-Fowler's transfer to Stoke Heath in January 2015

69. Mr Rose-Fowler returned to Stoke Heath in January 2015, as part of a reconfiguration of the prison population to improve resettlement provision. Stoke Heath told us that the National Offender Management Service (NOMS) population management unit contacted Risley to tell them that 20 prisoners in the resettlement area for Stoke Heath, needed to transfer to Stoke Heath on 29 January 2015. Risley chose 20 of their prisoners who met the criteria for Stoke Heath. Stoke Heath told us sometimes the prison receives the names of prisoners in advance but not always. The prison did not know whether or not they had been informed of Mr Rose-Fowler's transfer in advance, but no one considered whether the reasons why he had been moved from the prison some months before might still exist.

70. When Mr Rose-Fowler moved from Featherstone in October 2014, the prison put a security alert on Mr Rose-Fowler's record that he should not return to Featherstone. The reasons for this were not recorded, but Stoke Heath did not put a similar alert on his record. This meant that Risley was not aware that there were any reasons why he should not go back to Stoke Heath. We consider that there should have been a security alert on his record to indicate that Mr Rose-Fowler had moved from Stoke Heath because of threats from other prisoners. This would have prompted staff responsible for his transfer from Risley and reception staff at Stoke Heath to consider whether Mr Rose-Fowler might still be at risk before he moved or when he arrived at the prison. We make the following recommendation:

    The Governor should ensure that appropriate security alerts are entered on prisoners' records when they are moved from Stoke Heath for safety or security reasons so that other prisons can take this into account and reassess the situation when a return to Stoke Heath is proposed.

Mr Rose-Fowler's safety at Stoke Heath

71. Almost as soon as he returned to Stoke Heath, Mr Rose-Fowler told staff that he had been transferred out the previous year because he was under threat from other prisoners because of drug debts. He said that he was scared to leave his wing because he believed he was still at risk from other prisoners at Stoke Heath. There was little information recorded about the original incident and no action was taken when he reported feeling under threat again, other than to record this in the safer custody team's database.

72. When interviewed, an officer said he did not remember Mr Rose-Fowler saying that he did not want to leave the wing because he felt threatened. However, he made an entry about this in the wing observation book on 20 April, when Mr Rose-Fowler had handed him a note about his previous and current problems. (When we interviewed the officer we had not seen his entry in the observation book about Mr Rose-Fowler's vulnerability. He answered further questions by email and said that he did not recall making the entry in the observation book.)

73. The officer sought advice from two custodial managers who said that Mr Rose-Fowler should write a statement naming those he was concerned about. No one submitted a security information report or made a formal referral to the safer custody team (although one of the custodial managers was the head of that team) as we consider should have happened. There is no evidence that the prison investigated Mr Rose-Fowler's concerns and no one considered whether this might raise his risk of suicide and self-harm.

74. Another officer said that Mr Rose-Fowler had not told her about the reasons he had been moved from Stoke Heath originally or that he felt under threat from other prisoners. She said that he appeared quite a strong character who would not be bullied. However, on 22 April, she told the mental health nurse that the reason why Mr Rose-Fowler had missed medical appointments was because he did not feel safe when he left the wing.

75. Another officer thought bullying was rife because prisoners got into debt with other prisoners who demanded repayment with interest. Prisoners frequently asked for a wing move because they were being threatened for these debts.

76. On 2 June, Mr Rose-Fowler told the mental health nurse that he had been using black mamba to self-medicate. She did not refer him to the substance misuse team when he reported this and there is no record that she warned him of the dangers of NPS. Officers told us that drugs were readily available in the prison, particularly new psychoactive substances (NPS), such as black mamba. One prisoner told us that he thought nearly half the prisoners on A Wing used NPS frequently.

77. The use of NPS in prisons is an increasing concern. In July 2015, we issued a Learning Lessons Bulletin about the use of NPS, including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS. We are concerned that no one appears to have taken any action when Mr Rose-Fowler admitted to using NPS.

78. The mental health nurse said that when she last saw Mr Rose-Fowler on 2 June, he did not seem to be under pressure, and he had laughed and joked with her. He said he was concerned about his medication, plans for his release and a prisoner who might come on to the wing. He did not mention being in debt, although he told her that he was using mamba. Evidence from prisoners is that Mr Rose-Fowler might have been in debt for drugs but most did not consider that this caused him much concern. Although being bullied and threatened, and using NPS, increases the risk of suicide and self-harm, we recognise that there was little to indicate that Mr Rose-Fowler was at high risk of suicide immediately before his death. We consider it would have been difficult for staff to have predicted and prevented his actions on 5 June.

79. We do not know for certain the extent to which Mr Rose-Fowler was under threat from other prisoners in his second period at Stoke Heath after January 2015. However, he told staff that this was the case and his behaviour would indicate that he felt at risk when he left the wing. We do not consider that the prison appropriately investigated his concerns to determine whether he needed additional support or a transfer to another prison. We are also concerned that

there was no appropriate response to his use of NPS. We make the following recommendations:

The Governor should ensure that all information indicating violence, bullying and intimidation is fully coordinated and investigated and that apparent victims are effectively supported and protected.

The Governor should ensure that prisoners who admit to using new psychoactive substances are referred to drug treatment services and warned about the dangers and risks to health.

Clinical care

80. The clinical reviewer considered that Mr Rose-Fowler's care was equivalent to that he would have received in the community. He made no recommendations about healthcare services.

81. A GP reduced and eventually stopped Mr Rose-Fowler's prescription of pregabalin shortly after he arrived at Stoke Heath. When interviewed, the GP said that he followed national guidelines about safe prescribing in secure settings and that all prisons are aiming to reduce the number of prisoners prescribed pregabalin or gabapentin. The guidance is set out in a Public Health England document issued in July 2013, "Managing persistent pain in secure settings". This said that neuropathic pain is difficult to treat and fewer than a third of patients respond to any given drug. Evidence pointed to tricyclic antidepressants as the most effective for first line treatment and, although gabapentin and pregabalin are effective in some cases, they should not be used in the first instance because of the risk of misuse in secure settings. The guidance says doctors can continue to prescribe pregabalin if a patient arrives with a documented history of neuropathic pain, is taking pregabalin and has a known poor response to other painkillers.

82. The GP prescribed nortriptyline (a tricyclic antidepressant) instead of pregabalin, in line with the guidance. He told us that it takes a few months to feel the full effects of tricyclic antidepressants and that Mr Rose-Fowler would not have noticed an immediate benefit. The clinical reviewer was satisfied that the prescription decisions were appropriate and in line with the national guidelines. He had examined Mr Rose-Fowler and explained why he was changing his medication. Mr Rose-Fowler's complaints about the change of medication were not well managed but we understand that the healthcare complaint system at the prison has now changed.

Emergency response

83. Prison Service Instruction (PSI) 03/2013 requires governors to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. The protocol should give guidance on efficiently communicating the nature of a medical emergency, ensuring that staff take the correct equipment to the incident and that there are no delays in calling an ambulance.

84. In line with the PSI, Stoke Heath uses code blue for circumstances such as when a prisoner is unconscious or not breathing. An officer used a code blue appropriately, when Mr Rose-Fowler was found hanged. The control room called an ambulance emergency very shortly afterwards. We are satisfied that there was a swift and appropriate emergency response.

85. However, the prison's instruction about the use of medical emergency codes, issued in June 2014, does not include a specific requirement that the control room should call an ambulance automatically and immediately as soon as a medical emergency code is received, as PSI 03/2013 requires. While this did not affect the response in Mr Rose-Fowler's case, Stoke Heath's current policy is not fully in line with the national instruction. We make the following recommendation:

The Governor should ensure that the local emergency protocol meets the requirements of PSI 03/2013 and that the control room calls an ambulance as soon as an emergency medical code is called.

Family liaison

86. Mr Rose-Fowler's mother was unhappy about Stoke Heath's contact with her. She said she had had initially met the deputy governor and a chaplain at the hospital and considered that said they could not answer basic questions about what had happened. She said contact with the family liaison officer had been poor and he had not called when he said he would.

87. The prison's family liaison log records conversations with Mr Rose-Fowler's family. The log shows the prison organised a memorial service and offered Mr Rose-Fowler's mother the opportunity to visit. According to the log, the family liaison officer tried to telephone Mr Rose-Fowler's family whenever there was new information to pass on. This was not always at pre-arranged times and sometimes Mr Rose-Fowler's mother was not available. Although it is apparent that the relationship between Mr Rose-Fowler's mother and Stoke Heath became strained, we are satisfied that the family liaison officer made reasonable efforts to keep in contact when necessary.

88. Mr Rose-Fowler's mother did not receive Mr Rose-Fowler's property until 7 July and his clothes had been laundered. Mr Rose-Fowler's mother told us she had asked the prison not to wash his clothes and she believed that some items were missing. No-one at the prison remembered this request and there is no record of this in the family liaison log, which had detailed records of contact. It is unfortunate that Mr Rose-Fowler's mother did not have his property returned in line with her preferences. PSI 64/2011 has a mandatory action that family liaison officers must consult a prisoner's family about how they would like their relative's property returned. As there is no record in the family liaison log that anyone asked Mr Rose-Fowler's mother about this, we make the following recommendation:

The Governor should ensure that families are asked how they want a deceased prisoner's property to be returned.

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