Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Shazad Ali a prisoner at HMP Sudbury on 4 September 2015

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Shazad Ali was found dead in his cell, at HMP Sudbury on 4 September 2015. A post-mortem examination identified that the effects of synthetic cannabinoids (new psychoactive substances) was the likely cause of death, with severe atheroma (furring) of a coronary artery a contributory factor. Mr Ali was 34 years old. I offer my condolences to Mr Ali's family and friends.

I am very concerned to report on another death in a prison, attributed to the use of new psychoactive substances. Other prisoners said that they thought that Mr Ali had used a 'bad batch' and had been unwell for a week before his death as a result. He had mentioned some minor symptoms to officers who had advised him to see healthcare staff. I am satisfied that this was appropriate, as there was no evidence of any serious symptoms. I do not consider that staff at Sudbury could have foreseen or prevented Mr Ali's sudden death, but there is a need to eradicate the use of such substances at the prison and staff need to be vigilant for signs of its use.

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

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

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Summary

Events

1. In July 2008, Mr Ali was remanded to prison charged with violent and drug-related offences. On 17 March 2009, he was sentenced to 16 years. He had been at HMP Sudbury since 31 July 2014. He had asthma, but rarely reported any health concerns.

2. On the evening of Thursday 3 September 2015, Mr Ali told an officer that he felt unwell. As he did not appear to have any urgent or concerning symptoms, the officer advised him to see healthcare staff the next day. (Other prisoners later told us that Mr Ali had been unwell for a week. Officers had not noticed this and Mr Ali had not gone to see healthcare staff.)

3. On morning of Friday 4 September, Mr Ali was due to be released on temporary licence for the day to see his family. A friend went to his room to wake him but he could not be roused and his door was locked. Another prisoner got in through the window and opened the door from inside. The prisoners realised Mr Ali was dead and alerted officers who radioed an emergency. Nurses responded quickly and tried to resuscitate Mr Ali, although they recognised there were clear signs of death. At 8.00am, shortly after they arrived, paramedics recorded that Mr Ali had died.

4. Mr Ali's mother and sister were waiting outside the prison to pick him up. Another prisoner, who was being released that morning, saw Mr Ali's family and told them that he had died. Later, prison staff took Mr Ali's family into the prison and, at 8.40am, the Governor told them what had happened.

Findings

5. A pathologist found that Mr Ali had used synthetic cannabinoids, a new psychoactive substance (NPS) before he died and that this was the likely cause of his death. We do not know where he obtained the drugs, but it is apparent that the use of such substances had been a problem at the prison for some time. While the prison has now introduced a new strategy to help tackle the demand and supply for such substances, it is important that all prison staff are vigilant for signs of prisoners using NPS and know how to respond.

6. Prisoners said that Mr Ali had not been well for a week before he died and had been behaving strangely. Mr Ali's family were concerned that he had not received appropriate treatment. Officers said that they did not notice anything unusual about his behaviour. Mr Ali told an officer during the week before he died that he had a headache and, the night before he died, told another officer he was well. Neither officer identified any urgent symptoms needing immediate attention and said that they had advised Mr Ali to see healthcare staff. We consider this was appropriate advice.

7. Although Mr Ali would not have had the opportunity to see healthcare staff the night before he died, he had not reported to healthcare staff at any time during the week, that he was unwell. None of the other prisoners had reported any concerns about Mr Ali to staff, other than one prisoner who went with Mr Ali to

the centre office the night before he died, apparently because they did not want to say anything that might jeopardise his release on temporary licence. The clinical reviewer considered that Mr Ali received an appropriate standard of healthcare during his time at the prison. The emergency response was prompt although we are concerned that staff tried to resuscitate him, when the presence of rigor mortis should have indicated this would be futile.

8. Mr Ali's family were very distressed that another prisoner had told them that Mr Ali had died, and that prison managers did not inform them quickly enough about what had happened. It is regrettable that Mr Ali's family learnt of his death in this way, but we do not consider that the prison was responsible for this and, when they learnt that his family were waiting at the gate, a manager brought them into the prison, and the Governor saw them to explain what had happened. Mr Ali's death was sudden and unexpected and we consider this was appropriate.

Recommendations

- The Governor should ensure that prisoners understand that they can seek help for substance misuse and associated health concerns and that this will be treated as medical in confidence.
- The Governor should ensure that all staff are vigilant for signs of prisoners using NPS and are briefed about how to respond when prisoners appear to be under the influence of such substances.
- The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and asking anyone with relevant information to contact her. Seven prisoners replied.

10. The investigator visited Sudbury on 8 September 2015. She obtained copies of relevant extracts from Mr Ali's prison and medical records.

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

12. The investigator interviewed nine members of staff and five prisoners at Sudbury in September, October, and November 2015. The clinical reviewer joined her for interviews in October.

13. We informed HM Coroner for Derby and South Derbyshire of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Ali's brother to explain the investigation and to ask if he had any matters he wanted the investigation to consider. The Ombudsman's family liaison officer and the investigator met Mr Ali's brother and father. They were concerned that Mr Ali had been ill for a few days before he died and that staff had not acted appropriately to ensure his safety. They wanted to know what had happened to Mr Ali, and why it had taken prison staff so long to tell his mother and sister, who were outside the prison at the time, that he had died.

15. Mr Ali's family received a copy of the initial report. The solicitor representing them wrote to us pointing out some factual inaccuracies. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

16. The prison has also submitted an action plan detailing what they have done to address the issues we raised and this as an annex to the report.

Background Information

HMP Sudbury

17. HMP Sudbury is an open prison that houses over 550 adult men. Derbyshire Health United provides healthcare services during the day on weekdays and in the mornings at weekends. There are specialist clinics to treat substance misuse. A number of prisoners are released each day on licence to help with their resettlement.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Sudbury was in November 2013. Inspectors reported that very low staffing levels created feelings of insecurity for the prisoners and the relationship between staff and prisoners was poor. Despite a well-constructed strategic approach to reducing drug supplies, illicit substance use remained a significant problem. Random mandatory drug testing positive rates were low, but undetectable new psychoactive substances were a serious problem. Prisoners who tested positive for prescribed medication were routinely put on hold for release on temporary licence, even when the medication was part of their treatment. Prisoners were unhappy about healthcare provision, which inspectors considered was partly due to more restrictive prescribing practices. Overall, inspectors considered that health services had improved but staffing shortages had had an adverse impact on service delivery.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2015, the IMB was concerned about the rising use of new psychoactive substances (NPS) at the prison.

Previous deaths at HMP Sudbury

20. Mr Ali was the eighth prisoner to die at Sudbury since 2005. There were no similarities to the circumstances of the previous deaths.

New Psychoactive Substances

21. New Psychoactive Substances (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, it is possible that there are 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 23 July 2008, Mr Shazad Ali was remanded to prison charged with violent and drug-related offences. On 17 March 2009, he was sentenced to 16 years in prison. He had been at HMP Sudbury since 31 July 2014. He was due to be released in July 2016.

25. At an initial health screen at Sudbury, a nurse noted that Mr Ali suffered from asthma and used an inhaler. He declined help to stop smoking. The nurse did not record any other significant health concerns.

26. Mr Ali had been convicted for his involvement in supplying drugs but had no history of substance misuse or addiction problems before he arrived at Sudbury. In October 2014, he reported that he was suffering with asthma, but he had little interaction with healthcare services after that.

27. Mr Ali began working as a cleaner in his unit in January 2015. On 20 March, he tested positive for opiates after a mandatory random drug test. On 9 April, at a disciplinary hearing, he said that he had not taken any illicit substances and did not know how they had got into his system. He was found guilty and was not allowed to apply for release on temporary licence for the next three months. There are no other records that Mr Ali misused substances while he was at Sudbury and nothing in the records we have seen to indicate that he had previously used drugs in prison. On 8 August, a test was negative for drugs.

28. Mr Ali's three-month suspension from applying for release on temporary licence expired in July 2015. He applied later that month, and the first unaccompanied visit with his family on day release was arranged for 4 September 2015.

29. Some prisoners told the investigator that Mr Ali had said that he had felt unwell for up to ten days leading up to 4 September. They said that he had behaved strangely, such as showering when he was fully dressed and said that he had had hallucinations. They said that for a week, he did not collect his food from the servery and did not eat. He was quiet and withdrawn when he was usually upbeat and joking.

30. After Mr Ali's death, some prisoners said that Mr Ali and other prisoners had taken new psychoactive substances (NPS) about a week before and that Mr Ali and others had reacted badly. Mr Ali had been particularly unwell but they did not report this to staff as they assumed they would have noticed his strange behaviour. Prison officers say they did not see anything unusual.

31. There is a lunchtime and evening roll check at Sudbury when prisoners are expected to stand at their doors and show their ID cards to the officer during the check. Prisoners said that Mr Ali was not standing at his door for one of the 5.00pm evening checks in the week before he died and that Officer, A, had challenged him about this. Mr Ali was in his room but said he felt too unwell. The prisoner said that the officer did not ask him what was wrong and had been rude to him. The officer said she did not remember this and said she had not seen Mr Ali for several weeks before he died.

32. It appears likely that the prisoner misidentified Officer A, as Officer B said that Mr Ali was in bed one evening when she did the roll check. (She could not remember exactly when, but thought it was in the week before he died.) She said she had asked him why he was not standing at his door and he had said he was too unwell with a headache. She said that she had advised him to see healthcare staff.

33. On evening of 3 September, Officer C received a phone call from Mr Ali's sister, who was worried that she had not heard from him. The officer called Mr Ali to the centre office using the tannoy system.

34. A friend of Mr Ali heard the tannoy message and took Mr Ali to the office because he felt too unwell to go alone. The friend said that he and Mr Ali told Officer C that Mr Ali was not well and that the officer had said that he and Mr Ali knew what was wrong with him and that he needed to see healthcare staff. The officer said that he did not say that but had joked that all he could offer Mr Ali was a cuddle and he needed to see healthcare staff if he was unwell. The officer said that he did not think that Mr Ali looked ill and he had laughed at his comment. He said he saw nothing to suggest that Mr Ali had been using drugs.

35. Officer C said that when he saw Mr Ali he seemed to be standing and walking okay. No other prisoners had reported to him that Mr Ali was not well that week. As it was around 6.00pm, healthcare staff would not be in until the next morning but the officer said he saw nothing about Mr Ali that made him think he needed to seek urgent healthcare advice before that. Mr Ali left the office, phoned his sister, and then went back to his cell. The officer said he had checked the landings later that evening and Mr Ali was in bed.

36. Mr Ali's friend said he left Mr Ali in his cell at about 7.30pm and went back to check on him again at 8.10pm. Mr Ali's door was shut and he saw through the observation panel that the window was shut and the lights were off. At about 9.30pm, he said he was in the kitchen on his own landing, and saw that Mr Ali had opened his window.

37. An operational support grade patrolled the landings once an hour during the night to check that all was in order and that no one had absconded. The operational support grade did not notice anything out of the ordinary that night.

Friday 4 September

38. Mr Ali was due to leave the prison at 8.00am on Friday 4 September for his home visit to his family. Another prisoner went to Mr Ali's cell to make sure he was ready. (The prisoner thought this was about 7.45am, but other timings suggest this must have been earlier.) Mr Ali was in bed so the prisoner banged on the door but got no response. Other prisoners joined him and tried to wake Mr Ali but he still did not stir. One prisoner, ran outside, climbed through the window and opened the door from inside to let the others in. They pulled back the quilt and realised that Mr Ali was dead. One prisoner went to the centre office to alert staff.

39. Officer E and Officer F were in the office and went to Mr Ali's cell. Officer D told the investigator that there were clear signs that Mr Ali was dead. He could not

move Mr Ali's arm when he tried to check for a pulse and chest movement and thought that rigor mortis had started. Officer E radioed a code blue medical emergency (which indicates a prisoner is unconscious or not breathing). The call was logged at 7.40am and staff in the control room called an ambulance immediately.

40. Nurse A and Nurse B arrived within two minutes. Although they said there were clear signs of death, they attempted to resuscitate Mr Ali, with the help of Officer D. An ambulance arrived at the prison at 7.52am. Paramedics were with Mr Ali at 7.56am and assessed him. They noted that Mr Ali's body was cold, there was rigor mortis present and they were unable to open his jaw. At 8.00am, the paramedics recorded that Mr Ali had died.

Contact with Mr Ali's family.

41. Mr Ali's mother and his sister were waiting for him outside the prison. Another prisoner who was being released from prison that day saw them as he left and told them that Mr Ali had died. They were naturally distressed and went to the gate to ask what had happened. The deputy governor then went to see Mr Ali's family, brought them into the prison and confirmed that he had died. At 8.40am, the Governor saw them and offered condolences and support. The prison's imam came to the prison to support Mr Ali's family. Other family members came to the prison later and the governor spoke to them and explained what had happened.

42. Mr Ali's funeral was on 6 September and the prison contributed towards the costs, in line with national instructions. Members of Mr Ali's family visited the prison on 11 September and saw the room where he had died.

Support for prisoners and staff

43. After Mr Ali's death the Head of the Offender Management Unit, debriefed the staff involved in the emergency response and offered his support and that of the staff care team.

44. Officers spoke individually to prisoners who had been on Mr Ali's unit and the chaplaincy and Listeners (prisoners trained by the Samaritans) came to offer support. The prison posted notices informing other prisoners of Mr Ali's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Ali's death.

Post-mortem report

45. The post-mortem examination found that Mr Ali had used synthetic cannabinoids (a type of new psychoactive substance). The pathologist considered that the effect of these synthetic cannabinoids was the most likely cause of death, with severe atheroma (furring) of a coronary artery a contributory factor.

Findings

New Psychoactive Substances

46. The use of new psychoactive substances (NPS) is an increasing problem in prisons. The Advisory Council on the Misuse of Drugs (the Government's independent statutory drug advisers) has reported that the short term harms of NPS can include paranoia, psychosis and seizures and that their long term harms are often unknown. Sudbury has a known problem with illicit substances, particularly NPS and in November 2013, HM Inspectorate of Prisons noted that the use of NPS was a serious problem at the prison.

47. After Mr Ali died, the prison sent leaflets to all prisoners to raise awareness of the dangers of NPS. The prison also circulated a warning that there was a very strong batch of NPS in the Derbyshire area. The warning advised prisoners to seek advice from the substance misuse team and, if they felt unwell, to tell a member of staff.

48. In July 2015, shortly before Mr Ali died, Sudbury had developed a new drug supply and reduction strategy. The strategy sets out plans to interrupt the various ways drugs come in to the prison and plans to reduce demand for drugs. A "summary of needs" section makes it clear that NPS is the illicit substance of choice at Sudbury.

49. The policy also contains a short section about staff training, including a commitment to substance misuse training for all relevant staff in the prison. As Sudbury has recently introduced this policy, we do not make a recommendation about reducing supply or demand. However, it is important that the prison does all it can to eradicate the use of new psychoactive substances.

50. Most prisoners in open prisons are nearing the end of their sentences and can be reluctant to seek help for drug problems for fear of jeopardising resettlement opportunities, such as release on temporary licence, or their prospects of parole. No member of staff was aware that Mr Ali had been using NPS and he had little history of drug use. It is important that prisoners understand that if they seek therapeutic help for drug problems or associated health issues, substance misuse that healthcare staff will treat this as medical in confidence, as they would in the community. Information will not be disclosed, unless there is a risk of death or serious harm. It is also particularly important in an open prison, where there are relatively few staff and opportunities for staff interaction with prisoners can be limited, that all staff are vigilant for signs of its use. We make the following recommendations:

    The Governor should ensure that prisoners understand that they can seek help for substance misuse and associated health concerns and that this will be treated as medical in confidence.

    The Governor should ensure that all staff are vigilant for signs of prisoners using NPS and are briefed about how to respond when prisoners appear to be under the influence of such substances.

Clinical care

51. The clinical reviewer considered that Mr Ali's clinical care at the prison was equivalent to that he would have received in the community. Mr Ali was generally healthy and there is no record that Mr Ali saw anyone from the healthcare team between February 2015 and his death

52. Mr Ali's family was concerned that Mr Ali had been ill in the week before his death, but that staff did not take appropriate action. Several prisoners told the investigator that Mr Ali was unwell in the days before he died and had not completed his cleaning duty or collected his meals. Some prisoners said that an officer had seen Mr Ali vomit during the night sometime in the week before he died. But the officer denied this.

53. There is no system at Sudbury to record when prisoners collect their meals so officers would not have been able to identify if Mr Ali had not been taking his meals and we have been unable to check this. There is a tick by Mr Ali's name on the cleaning records for 1 and 2 September, but not for 3 September. Officers would not necessarily have been aware of this at the time, as not all units are checked every day. Prisoners in open prisons are expected to have a degree of autonomy and self-responsibility and we consider this was reasonable.

54. In the week before Mr Ali's death, it seems that two officers were aware that Mr Ali might be ill. On one occasion, Mr Ali was in bed and not at his door for a 5.00pm roll check. He said this was because he had a headache and Officer B said that she had told him to see the healthcare team. On Thursday 3 September, a friend of the prisoner went with Mr Ali to the centre office and told Officer C that Mr Ali was unwell. Officer C told us that as Mr Ali was walking and talking and did not seem that unwell, he did not consider contacting an out of hours health service. We consider that these were appropriate responses. We do not consider the symptoms he reported were sufficiently serious for officers to have alerted healthcare staff, although further questioning might have led to suspicions about drug use. Mr Ali did not report any concerns to healthcare staff and we do not consider that the staff could have anticipated or prevented his sudden death.

Resuscitation

55. The European Resuscitation Council Guidelines for Resuscitation 2010 say that '*Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile*'. The guidelines define examples of futility as including the presence of rigor mortis and post-mortem staining. In October 2014, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual's situation. Decisions should never be dictated by 'blanket' policies.

56. Signs of death include rigor mortis. Nurse A and Nurse B both said that they had great difficulty moving Mr Ali's arm before the started resuscitation, and they

thought he had been dead for some time. The ambulance log states that Mr Ali was in a state of full rigor mortis, and that the paramedics were unable to open Mr Ali's jaw. The pathologist considered that Mr Ali had been dead for a number of hours before he was discovered unresponsive.

57. We understand that the natural inclination of healthcare staff is to begin emergency first aid by giving life support but attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. As Sudbury does not have 24 hour nursing cover, all staff should be given clear guidance on when resuscitation is inappropriate. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is inappropriate.

Family contact

58. Mr Ali's family were very distressed about the how they learnt of his death from a prisoner who was being discharged from the prison that day. They said that they went straight to the gate but it was some time before a manager came to see them to explain what happened and to confirm that Mr Ali had died.

59. According to the family liaison log, Mr Ali's family saw the Governor inside the prison at around 8.40am. Paramedics had pronounced Mr Ali's death at 8.00am. The prison was not aware that Mr Ali's family were outside until they approached the officer at the gate for information and a manager then went to see them. We do not consider that there was an unreasonable delay in managers speaking to his family. It is unfortunate that another prisoner told them that Mr Ali had died, but we do not consider that the prison could have anticipated this or prevented it.

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