Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Velvick, a prisoner at HMP The Mount on 27 April 2016

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.

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

Mr Michael Velvick died in his cell at HMP The Mount on 27 April 2016. A post mortem examination identified his cause of death as sudden adult/arrhythmic death syndrome (SADS). He was 43 years old. I offer my condolences to Mr Velvick's family and friends.

I am concerned that new psychoactive substances (NPS) may have played a role in Mr Velvick's death. The Mount has no clear strategy to manage and monitor prisoners suspected of taking NPS or to reduce NPS availability and demand. The emergency response was inadequate, with an unacceptable delay before anyone called an ambulance. I am also concerned that despite the Governor of The Mount accepting previous recommendations I made about their emergency response, I have to repeat these concerns.

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 **May 2017**

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Summary

Events

1. On 18 January 2016, Mr Michael Velvick was released on licence from HMP Wayland to an approved premises. On 3 February, he was recalled to HMP Norwich because of his inappropriate behaviour after taking Spice, a new psychoactive substance (NPS).

2. On 11 February, Mr Velvick was transferred to HMP The Mount. At an initial health screen, the reception nurse noted that Mr Velvick had depression, asthma, hepatitis C and tested positive for benzodiazepines and opiates. The nurse referred Mr Velvick to the primary mental health team, substance misuse team and the primary healthcare team.

3. On 14 February, Mr Velvick's cellmate pressed the emergency cell bell. He told staff that Mr Velvick was "having a Spice attack" and had collapsed unconscious. Wing staff called an ambulance immediately, but when it arrived Mr Velvick refused to let paramedics examine him. Healthcare staff were not on duty at the time and no one recorded the incident in Mr Velvick's medical record.

4. On 19 February, the Rehabilitation for Addicted Prisoners Trust (RAPt) team saw Mr Velvick, but did not record their intervention in his medical record or share relevant health information about him with other healthcare staff.

5. During the evening roll check on 26 April, an officer found Mr Velvick lying on his cell floor. Mr Velvick was unable to move and was incomprehensible. Staff radioed a medical emergency code blue at 7.03pm and the control room promptly called an ambulance. Before the ambulance arrived, Mr Velvick stood up and started walking around his cell, still muttering. Staff believed that his behaviour was that of someone who had taken Spice. As Mr Velvick was conscious and walking around, staff cancelled the ambulance, without him having been seen by medical staff, and agreed to observe him at half hourly intervals.

6. Around 8.30pm, the night duty officer checked Mr Velvick, who told her he was okay and asked her to stop turning his light on. She did not check Mr Velvick again that night.

7. The next morning at 6.00am on 27 April, the night duty officer found Mr Velvick unresponsive on his cell floor. She radioed a code blue emergency and staff attended Mr Velvick's cell. Mr Velvick was cold and it appeared rigor mortis was present, so no one tried to resuscitate him. Staff called an ambulance, and when the paramedics arrived they confirmed that Mr Velvick was dead. A post mortem examination found that Mr Velvick died from sudden adult/arrhythmic death syndrome (SADS). A toxicology examination found NPS present in Mr Velvick's bloodstream when he died.

Findings

8. Although the post mortem does not attribute Mr Velvick's death directly or indirectly to substance abuse, and the clinical reviewer says there is no clinical evidence to make that link, it is clear that Mr Velvick had a significant history of substance misuse, including NPS.

9. Mr Velvick's management showed no strategic approach to support and monitor prisoners suspected of taking NPS. Staff did not record in Mr Velvick's medical record the therapeutic intervention he received or share health information with the substance misuse team or prison staff. This meant that Mr Velvick's substance misuse was not appropriately addressed.

10. There was no evidence of prison and healthcare staff taking a joined-up approach to reduce the supply of and demand for NPS. There was no strategy to manage NPS and associated risks. Staff failed to complete security information reports or conduct cell searches for suspected drug users to tackle use of NPS.

11. There was confusion among staff on 26 April 2016 about what to do and how to monitor Mr Velvick to reduce his risk and ensure his wellbeing. Staff cancelled an ambulance without appropriate medical advice and failed to monitor him effectively.

12. The prison did not call an ambulance as soon as the emergency code blue had been used and there were delays once the ambulance had arrived at the prison before paramedics were able to reach Mr Velvick's cell.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a clear pathway for the substance misuse service and that all intervention is recorded in the prisoner's medical record to ensure quick and effective assessment and management of prisoner needs.
- The Governor and Head of Healthcare should ensure that:
    - There is an effective and joined-up strategy to reduce the supply of and demand for new psychoactive substances, including completing security intelligence reports and cell searches.
    - Staff are vigilant for signs of prisoners using illicit substances.
    - Staff are briefed on how to respond when prisoners appear under the influence of substances, including how to monitor them, when to refer prisoners to hospital and how to access clinical support and advice.
- The Governor should ensure that local emergency procedures are in line with PSI 03/2013 and ensure that all prison staff are aware of and understand their responsibilities during medical emergencies, including that:
    - Staff call the appropriate emergency code immediately in an emergency

- Staff enter cells quickly when there are serious concerns about the health of a prisoner.
- The control room calls an ambulance as soon as an emergency code is broadcast and ensure there is no avoidable delay in ambulance staff reaching prisoners.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP The Mount informing them of the investigation and asking anyone with relevant information to contact him. No one came forward.

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

15. The investigator visited The Mount on 6 May 2016. He obtained copies of relevant extracts from Mr Velvick's prison and medical records. He interviewed 12 members of staff and five prisoners at The Mount.

16. In line with the Ombudsman's terms of reference, the investigation was suspended while Hertfordshire Police investigated the circumstances of Mr Velvick's death. The investigator remained in contact with the police during the investigation and shared information with them. The police provided a number of witness statements with staff and prisoners.

17. We informed HM Coroner for Hertfordshire of the investigation and have sent him a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Velvick's ex-partner and brother to explain the investigation. They asked us:

    - Whether Mr Velvick had any health concerns of which the prison was aware;
    - How, why and how long staff monitored Mr Velvick before his death; and
    - Details about who had cancelled the ambulance on 26 April and whether this decision had been appropriately taken.

19. Mr Velvick's ex-partner and brother received a copy of the initial report and chose not to comment or provide feedback.

Background Information

HMP The Mount

20. HMP The Mount is a medium security prison holding more than 1,000 men. Hertfordshire Community NHS Trust provides primary healthcare services and GP services. There are daily GP sessions from Monday to Friday, with out of hours provision at other times. There are no healthcare staff on duty between 6.30pm and 8.00am. Prisoners with mild and moderate mental illness are supported by the GP and the primary care mental health nurse. Prisoners with severe and enduring mental health problems are supported by the in-reach team with staff on duty between 8.00am and 4.00pm, Monday to Friday. There is no weekend or out of hours mental health service.

Her Majesty's Inspectorate of Prisons

21. The most recent inspection of HMP The Mount was in April 2015. Inspectors said that care for men at risk of suicide and self-harm was adequate, though some lessons from our previous investigations into deaths had not been fully embedded. They highlighted that drug treatment for prisoners was good but this was undermined by the high availability of drugs. Inspectors found that new psychoactive substances were a continuing concern.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recently published report for the year to February 2016, the IMB noted that the availability of new psychoactive substances were an ongoing problem. They reported that prisoners were being used to test new batches of Spice to find out their effects.

Previous deaths at HMP The Mount

23. Mr Velvick was the fifth prisoner to have died at The Mount since January 2014. We made recommendations in two of these investigations about the poor emergency response, and we highlight this issue again in this report.

New psychoactive substances

24. New psychoactive substances (NPS), previously known as 'legal highs' (although they are now illegal), are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide and self-harm.

25. In July 2015, we published a Learning Lesson Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the

dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

26. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

27. On 18 January 2013, Mr Michael Velvick was sentenced to six years in prison for robbery. He was released on early licence on 18 January 2016.

28. On 3 February, police arrested Mr Velvick at an approved premises for breaching his licence terms. Mr Velvick admitted taking Spice, a new psychoactive substance (NPS). Mr Velvick was recalled to prison and sent to HMP Norwich. His escort record, which accompanied him to prison, identified that he had a history of suicide and self-harm.

29. At an initial health screen, Mr Velvick told the nurse that he was disappointed that he had been recalled to prison. The nurse noted a history of substance misuse and that Mr Velvick had previously overdosed on heroin and methadone. Mr Velvick admitted using Spice recently, and tested positive for opiates and benzodiazepines. Mr Velvick said he had depression, but no thoughts of suicide or self-harm.

Transfer to HMP The Mount

30. On 11 February 2016, Mr Velvick was transferred to HMP The Mount. At his first reception screen, a nurse noted that Mr Velvick was taking medication for depression and pain relief for a historic wrist injury. He had asthma and hepatitis C. The nurse referred Mr Velvick to the primary mental healthcare team, substance misuse team and the primary healthcare team. Mr Velvick was placed in a shared cell in the induction and resettlement unit.

31. On the evening of 14 February, Mr Velvick's cellmate rang the cell bell. He told the night duty officer that Mr Velvick had had a Spice attack and had collapsed unconscious. Wing staff radioed a medical emergency code and an ambulance was called. (No healthcare staff were on duty as it was after 6.30pm.) When the paramedics arrived at the prison, Mr Velvick was conscious but refused to be examined. Staff agreed that Mr Velvick should be monitored throughout the night. There was no record of the incident in Mr Velvick's medical record. Healthcare staff interviewed told the investigator that they would have expected prison staff to include the incident in a security report (discussed at the security briefing meeting every morning) and the healthcare representative would have relayed this to the healthcare team and updated Mr Velvick's medical record. We have seen no evidence that this happened.

32. On 18 February, staff moved Mr Velvick to a single cell at the request of the healthcare team. No one recorded the reason for the move. On the same day a mental health nurse from the in-reach team assessed Mr Velvick. She noted his history of self-harm and that he had been recalled to prison.

33. On 19 February, the Rehabilitation for Addicted Prisoners Trust (RAPt), a charitable organisation that delivers drug and alcohol services in prisons and in the community to help people move away from addiction and crime, assessed Mr Velvick. There was no record of this assessment in Mr Velvick's medical record. The RAPt record noted that Mr Velvick had tried to take his life three times in the past. Mr Velvick said he had used intravenous heroin on a daily basis but was

recalled to prison for using Spice. He said he had nowhere to live and no family contact.

34. The RAPt record noted that Mr Velvick had completed management of substance misuse courses during an earlier sentence at Norwich. Mr Velvick told the RAPt worker that he did not need to repeat the course because he had the tools to avoid heroin, but struggled with Spice in prison. Mr Velvick described his mood as low because he had been recalled so quickly after being released from prison. The RAPt worker referred Mr Velvick to the Alcohol and Drug Treatment Programme (ADTP) and the Peer Led User Group (PLUG, where RAPt peer supporters hold meetings and workshops on the wings to discuss abstinence-based treatment). The RAPt worker agreed to see Mr Velvick within a fortnight to discuss how he could access their service.

35. On 24 February, the mental health nurse discussed Mr Velvick at the weekly multi-disciplinary meeting (which members of the substance misuse team and other health services attended). She referred Mr Velvick to the primary mental health team because of his high score for depression and anxiety at Norwich and that he had tested positive at The Mount for benzodiazepines and opiates.

36. That day, an ADTP worker assessed Mr Velvick, who said he did not want to take part in the ADTP group as he preferred one-to-one work or to work on his own.

Events from 7 March

37. On 7 March, a worker from The Mount's probation office, talked to Mr Velvick. He admitted using Spice at The Mount and said he had had a "Spice attack" and collapsed unconscious. She advised Mr Velvick about the potentially serious impact of Spice, including mental health issues, aggression and sometimes death. She reminded Mr Velvick that he had to engage with RAPt.

38. On 21 March, Mr Velvick started work in The Mount's farms and gardens.

39. On 31 March, a nurse reviewed Mr Velvick's asthma. She noted that he had been diagnosed with chronic obstructive pulmonary disease (COPD) in 2014, and created a care plan for him. Mr Velvick was a smoker so she referred him to the smoking cessation service.

40. On 1 April, Mr Velvick attended his first one-to-one session with RAPt. He declined to attend the ADTP due to anxiety and medication issues. The RAPt worker noted that Mr Velvick was attending PLUG. There was no evidence about how Mr Velvick participated in these sessions.

41. On 4 April, a nurse from the primary mental health team assessed Mr Velvick six weeks after the in-reach team had referred him on 24 February 2016. She noted that Mr Velvick had had a Spice attack in the community and another at The Mount. He said that he would not use Spice again as it had scared him. She recorded that Mr Velvick's mood was okay and that he declined to have counselling. Mr Velvick said he did not need mental health support but would ask for it if necessary. She discharged Mr Velvick from the primary mental health team's caseload, but agreed the team would review his antidepressants regularly.

Events on 26 April

42. At around 8.30am on 26 April, Mr Velvick went to work. He did not return to work after lunch because he had an appointment with a smoking cessation advisor. Mr Velvick said he wanted to quit smoking for health reasons and was prescribed nicotine replacement lozenges.

43. At around 5.15pm, a prisoner had a brief conversation with Mr Velvick. Another prisoner said that Mr Velvick visited him in his cell between 5.45pm and 6.00pm. Mr Velvick stopped at a prisoner's cell on the way to his own cell. The prisoner said he gave Mr Velvick some Rizla rolling papers. None of these prisoners was concerned about Mr Velvick.

44. From 6.15pm, prison staff began the process of locking prisoners in their cells for the night.

45. At 7.00pm, two officers began the roll check of the wing. Officer A opened Mr Velvick's door observation panel to check him. He said he saw Mr Velvick lying on the floor, his head partly obscured under the bed. He shouted to Officer B for help.

46. Officer B arrived within 30 seconds and went with Officer A into the cell. Officer A bent down and asked Mr Velvick to get back on his bed. He said that although Mr Velvick was conscious, he was mumbling and unable to speak. Mr Velvick's legs were trembling and he appeared unable to get up from the floor. At 7.03pm, he radioed an emergency code blue (life threatening situation).

47. Mr Velvick eventually got up from the floor, and sat on his bed before standing up, walking around his cell and sitting down again. Mr Velvick was unsteady on his feet and his speech was slurred. Officer A said Mr Velvick appeared "high" as if he had taken an illicit substance. Mr Velvick denied this.

48. Two more officers responded to the emergency alarm. Officer C saw Mr Velvick sitting on his bed, shaking and swaying. He believed Mr Velvick was displaying signs of someone who had smoked Spice. There was no strategy or guidance available at The Mount to instruct officers about how to respond to NPS incidents. In the absence of instructions or guidance, Officer C and another officer told Mr Velvick to rest in bed, but Mr Velvick replied that he did not want to lie down. When asked if he had smoked anything that he should not have, Mr Velvick said that another prisoner had given him something. Officer C looked in Mr Velvick's cell for suspicious substances but found nothing.

49. A prisoner who lived in the cell next to Mr Velvick said that he heard officers going into Mr Velvick's cell. He said Mr Velvick sounded agitated, asked staff for help and said he was going to die. He said he heard staff reassuring Mr Velvick, telling him he would be okay and to lie down.

50. The Mount does not a have a 24-hour healthcare service, and healthcare staff had completed their daily shift at 6.30pm. The control room officer radioed that an ambulance was on its way and that the ambulance control operator was asking for an update about it from the wing office telephone.

51. A supervising officer (SO) asked Officer A to go to the wing office to speak to the ambulance control operator. Healthcare staff reported that NPS use was a regular occurrence at The Mount and ambulances were usually called, but stood down if the prisoner recovered quickly. If suspected NPS use occurred when healthcare staff were not on duty, they said prison staff would either contact the ambulance service or the GP Out of Hours service.

52. Officer A told the investigator that the SO told him to cancel the ambulance. He said he was not surprised by this instruction as Mr Velvick was conscious and walking around his cell. The SO was unavailable for interview and his police statement did not say whether or not he cancelled the ambulance.

53. As staff continued to talk to Mr Velvick, he became less compliant. The SO told staff to leave the cell to avoid unnecessary confrontation. As staff left the cell, Mr Velvick was sitting on his bed. He asked staff why he was being locked in his cell and was told that it was the time that cells are locked. CCTV footage showed staff leaving Mr Velvick's cell at around 7.11pm.

54. In the wing office, Office A told the ambulance control operator about Mr Velvick's circumstances and that staff suspected he had taken Spice. He explained that Mr Velvick was now conscious, walking and talking. As Mr Velvick appeared okay, he said an ambulance was no longer needed.

55. The ambulance control operator did not provide any medical advice to Officer A and we have seen no evidence that staff sought or received medical advice before they cancelled the ambulance for Mr Velvick.

56. Officer C told the investigator that the SO, another officer and he discussed what to do about Mr Velvick. They agreed that Mr Velvick should be observed at half hourly intervals as a precautionary measure. He said that although the decision was not part of a specific local policy, it was routine practice at The Mount to monitor prisoners suspected of taking an illicit substance in this way. The three officers returned to the wing office as Officer A was updating the wing observation book. They told Officer A that Mr Velvick had become rude towards them and so they had locked his cell door. The SO told Officer A that Mr Velvick should be observed every 30 minutes throughout the night, and should be checked by healthcare the next morning.

57. Officer A recorded in the wing observation book that Mr Velvick was found lying on his cell floor at 7.00pm, "fitting or something similar. He came around and appeared under the influence of substance. Became rude and aggressive to staff, 30 mins obs @ night".

58. At 7.15pm, Officer A responded to Mr Velvick's cell bell. Mr Velvick was walking around his cell and told him to "fuck off". He finished his shift at 7.30pm.

59. A custodial manager (CM) and the officer in charge telephoned Mr Velvick's wing for an update. Officer C said that as wing staff and the Ambulance Service agreed that as Mr Velvick appeared okay, there was no need for an ambulance to attend the prison. Mr Velvick was to be monitored every 30 minutes. The CM told Officer C to ensure he recorded this in the wing observation book and passed the information to night staff. He told the investigator that staff discussed

Mr Velvick and decided to monitor him every 30 minutes until he felt better, not throughout the night.

60. Officer D said he heard the SO say that Mr Velvick should be observed every 30 minutes, but he did not know for how long the observations were to continue. He wrote at the top of an ongoing observation log sheet, "Velvick A1-35 30 min obs". He recorded in the document that when he checked Mr Velvick at 7.15pm, he was talking but was unsteady on his feet. Officer C checked him at 7.30pm, recorded that Mr Velvick was "up and down" in his cell, and Mr Velvick had complained that his elbow was hurting.

61. At around 7.30pm, the CM finished her duty and gave a verbal handover to another custodial manager who no longer works for the Prison Service but was in charge of the prison that night. In his police statement, he said he was told that Mr Velvick had had a Spice attack earlier that day. Wing staff had called an ambulance, but because Mr Velvick had regained consciousness he did not need to go to hospital.

62. At 8.00pm, Officer D noted in the ongoing observation log that Mr Velvick was watching television and appeared okay.

63. At about 8.10pm, Officer C handed over to Officer E, who started her night duty shift on Mr Velvick's wing. The record of his handover in the wing observation book did not refer to Mr Velvick. He told her that Mr Velvick had had a "Spice attack" earlier and was on 30 minute observations until he felt better. He gave her the 30 minute ongoing observation log sheet.

64. Officer E and an operational support grade officer (OSG) then started the roll check of the wing. At 8.23pm, Officer E checked Mr Velvick. She told the investigator that Mr Velvick appeared asleep in bed and did not respond when called. She continued the roll check but returned to Mr Velvick's cell with the OSG about ten minutes later to check him. She looked through the door observation panel and shouted to Mr Velvick, asking him if he was okay. Mr Velvick still appeared to be sleeping. She flicked Mr Velvick's cell light on and off to get a response from him. After around a minute, Mr Velvick responded in an abrupt and rude tone. He said, "I'm fine now, turn my fucking light off". She said she believed that as Mr Velvick appeared okay he did not need to be checked until the roll check the next morning.

Events of 27 April

65. At 5.58am, Officer E and the OSG started the roll check on Mr Velvick's wing. When the officer checked Mr Velvick by looking through the door observation panel, she saw him lying face down on the floor. He was clothed and his bed was made. She shouted to him and banged his cell door. Mr Velvick did not respond. She said she did not know whether Mr Velvick was feigning an injury so did not go into Mr Velvick's cell for security reasons. She went to the wing office, where she telephoned the prison communication room. She told them there was a code blue emergency and that Mr Velvick was unresponsive.

66. The communications room officer told the investigator that Officer E had said she thought it was a code blue and asked to speak the night manager in charge of

the prison. She immediately passed the phone to him. She did not broadcast the emergency over the radio network, but recorded in the control room log that Officer E had called a code blue at 6.00am.

67. The night manager spoke to Officer E. In his police statement, he said the officer told him that Mr Velvick was on the floor unresponsive. He told her that he and other staff would attend the wing to help her. He told her to return to Mr Velvick's cell and to continue trying to get a response from him. The communications room officer telephoned Officer F and asked him to go to the wing.

68. The OSG attended the wing and saw Officer E who was crying. He said Officer E said, "It's Mr Velvick". The officers went to Mr Velvick's cell and stood outside. The OSG looked through the observation panel and saw Mr Velvick lying on the floor. He said it was difficult to see whether Mr Velvick was breathing. Officer E told him that senior officers were on their way to the wing. While she waited, she asked him to check on another prisoner who was being monitored under suicide and self-harm prevention procedures.

69. At 6.05am, Officer F arrived at Mr Velvick's cell at the same time that the OSG returned. The officer unlocked and went into Mr Velvick's cell, followed by Officer E. The OSG remained at the cell entrance. Mr Velvick was still on the floor unresponsive. Both officers rolled Mr Velvick onto his side and saw that his skin was blue, and he was cold and stiff. Officer E ran to the office and at 6.06am telephoned the communications room to ask for an ambulance.

70. At 6.09am, the night manager arrived at Mr Velvick's cell. Officer F told him that he believed Mr Velvick was dead. He checked Mr Velvick for signs of life but found none. Officer F retrieved the defibrillator from the wing officer. The night manager attached it to Mr Velvick, but it was evident that Mr Velvick had died and no one tried to resuscitate him. The OSG had already returned to the office, and updated the ambulance control operator about the situation.

71. The ambulance report recorded the first ambulance arrived at The Mount at 6.18am. However, the paramedics did not arrive at Mr Velvick's cell until 6.34am. The paramedics did not try to resuscitate Mr Velvick as rigor mortis was present. They pronounced him dead at 6.35am. A second ambulance had arrived at the prison at 6.33am. Both ambulances had delays because of the lack of staff available to escort them through the prison.

Contact with Mr Velvick's family

72. A chaplain from the chaplaincy team and an officer were the prison's family liaison officers. Mr Velvick had listed his ex-partner as his next of kin, but The Mount did not have her current address. At around 10.30am, the officer broke the news of Mr Velvick's death to his ex-partner by telephone and obtained her address. The chaplain and officer visited her to explain what would happen next and to offer support. In line with national instructions, the prison contributed to the cost of Mr Velvick's funeral.

Support for prisoners and staff

73. The duty governor debriefed the staff involved in the emergency response and offered his support and that of the staff care team. Staff reviewed prisoners

assessed as at risk of suicide and self-harm in case they had been affected by Mr Velvick's death.

Post-mortem report

74. A post-mortem examination concluded that the cause of Mr Velvick's death was SADS (Sudden adult/arrhythmic death syndrome). A toxicology examination found the presence of NPS in Mr Velvick's bloodstream when he died, but tests confirmed that this did not cause his death.

Findings

Managing substance misuse

75. Mr Velvick had a history of substance misuse and the reception nurse appropriately referred him to the substance misuse team. Despite this, the substance misuse nurse said that she had had no contact with Mr Velvick. She said it was routine practice for the RAPt team to see all prisoners with substance misuse issues first and only refer prisoners to the substance misuse team if they needed support other than psychosocial intervention.

76. We are concerned that when Mr Velvick had a Spice attack on 14 February, staff did not record the incident in Mr Velvick's medical record or refer him to the substance misuse team. Similarly, when the RAPt team assessed Mr Velvick on 19 February, they failed to record their intervention in Mr Velvick's medical record which meant that the substance misuse team and other healthcare staff could not access the extent to which Mr Velvick's use of NPS affected him and how they should treat him. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that there is a clear pathway for the substance misuse service and that all intervention is recorded in the prisoner's medical record to ensure quick and effective assessment and management of prisoner needs.

NPS

77. We are concerned about the prevalence of NPS in prisons and its effect on the behaviours and health of those taking it, including an association with suicide and self-harm. Our learning lessons on NPS highlights the need for better awareness among staff and prisoners of the dangers of NPS, information to help them staff when prisoners were using NPS, the need for an effective drug supply reduction strategy and better monitoring by drug treatment services.

78. The Mount knew that Mr Velvick was a drug user. Yet, there was no evidence that staff submitted any security reports or conducted a cell search to address Mr Velvick's suspected use of Spice as part of measures to tackle the supply and availability of drugs at The Mount.

79. HMP The Mount did not have a protocol or guidance on managing prisoners who had taken NPS, which is particularly relevant when the healthcare team is not on duty. Staff were not consistent in their approach to dealing with the two occasions that Mr Velvick allegedly reacted badly to NPS. On 14 February, an ambulance attended The Mount. When Mr Velvick refused treatment from paramedics, prison staff observed Mr Velvick throughout the night. On 26 April, staff cancelled the ambulance before it arrived as Mr Velvick was conscious, and did not monitor him throughout the night.

80. Healthcare staff said that ambulances were routinely cancelled if the prisoner recovered quickly. The cancellation of the ambulance for Mr Velvick reflects this practice and was taken without formal medical advice.

81. The decision on how to monitor Mr Velvick on 26 April was confused and poorly communicated. Although staff originally agreed to monitor at regular intervals throughout the night, they stopped monitoring him after about 90 minutes. Mr Velvick was found unresponsive the next morning with rigor mortis present, which suggested that he had been dead for sometime. We cannot know whether it would have changed the outcome for Mr Velvick if staff had continued to monitor him but it is likely that staff would have found him far sooner.

82. Healthcare staff told the investigator that the way staff managed NPS was still evolving. The RAPt team have held education sessions for some prison staff. There is no clear and joint protocol between the healthcare team and prison staff about managing and monitoring prisoners suspected of taking NPS or other substances. We share HMIP's and the IMB's concerns about the prevalence of and demand for NPS at The Mount. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **There is an effective and joined-up strategy to reduce the supply of and demand for new psychoactive substances, including completing security intelligence reports and cell searches.**
- **Staff are vigilant for signs of prisoners using substances.**
- **Staff are briefed on how to respond when prisoners appear to be under the influence of substances, including when to refer prisoners to hospital and how to access clinical support and advice.**

Emergency response

83. Prison officers have a duty of care to prisoners, to themselves and to other staff. The Mount's night patrol procedures say that cells can be opened at night with only one member of staff present if there is an immediate danger to life, the alarm has been raised and the control room has been informed. The officer who found Mr Velvick did not consider it safe to open his cell because he might have been feigning an injury. We consider that it was reasonable and appropriate that she contacted the control room and spoke to the officer in charge of the prison.

84. Prison Service Instruction (PSI) 03/2013 on Medical Emergency Response Codes specifies that all Governors must have a medical emergency response code protocol. The PSI says that staff should use a code blue to indicate an emergency when a prisoner is unconscious. The control room should automatically call an ambulance on receiving an emergency code blue.

85. The Mount's most recent staff information notice 41/13 about calling an ambulance in an emergency says that staff should call a code blue for prisoners who are unconscious or experiencing breathing difficulties. The notice does not explicitly say that the control room should call an ambulance immediately a medical emergency code is received, in line with the national instruction. The control room did not call an ambulance until six minutes after staff had raised the emergency code blue. Although it is likely Mr Velvick had already died, in other circumstances this delay could have been critical.

86. Despite staff calling a medical emergency code, the control room operator did not broadcast it by radio to alert staff on duty, as they should have done. While it is unlikely to have changed the outcome for Mr Velvick, alerting all staff to emergencies ensures maximum resources are deployed in the preservation of life. We do not therefore consider that The Mount's local instruction accurately reflects the intended purpose of PSI 03/2013.

87. According to ambulance service records, the ambulance arrived at The Mount at 6.18am. However, it took another sixteen minutes for paramedics to reach Mr Velvick's cell. We consider this too long.

88. In another investigation in 2014, we recommended that ambulances should be able to leave The Mount quickly. It is equally important that paramedics reach prisoners quickly in emergencies. The emergency response to Mr Velvick was poor. While it did not affect the outcome for Mr Velvick, as he had been dead for some time, in other emergencies, it might save someone's life. We make the following recommendation:

The Governor should ensure that local emergency procedures are in line with PSI 03/2013 and ensure that all prison staff are aware of and understand their responsibilities during medical emergencies, including that:

- **Staff call the appropriate emergency code immediately in an emergency.**
- **Staff enter cells quickly when there are serious concerns about the health of a prisoner.**
- **The control room calls an ambulance as soon as an emergency code is broadcast and ensure there is no avoidable delay in ambulance staff reaching prisoners.**

Clinical care

89. The clinical reviewer concluded that the standard of care that Mr Velvick received was generally equivalent to the care he would have received in the community. She was concerned about The Mount's process for assessing and managing the use of NPS, their capability to deliver effective primary mental healthcare and substance misuse care pathways and has made a number of recommendations in her report, which the Governor and Head of Healthcare will need to address.

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