

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derek Hewson a prisoner at HMP Oakwood on 30 August 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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*



© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

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

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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

Mr Derek Hewson died on 30 August 2016 in his cell at HMP Oakwood, of sepsis caused by pus in his lung cavity. He was 48 years old. I offer my condolences to Mr Hewson's family and friends.

Mr Hewson received good support from substance misuse services and I am satisfied that he received a good standard of healthcare at the prison, equivalent to that he could have expected to receive in the community.

The post mortem does not conclude that drug misuse contributed directly to Mr Hewson's death, although it may have made him more susceptible to infections and made them harder to treat. However, illicit substances were found in his body and this, together with his open acknowledgment of their regular use in prison, indicates that Oakwood needs to do more to reduce supply and demand for illicit substances.

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

Contents

Summary	1
The Investigation Process	2
Background Information	3
Key Events	5
Findings.....	8

Summary

Events

1. On 11 May 2016, Mr Derek Hewson was sentenced to 16 months in prison for producing cannabis, and was initially sent to HMP Hewell. On 4 July, he transferred to HMP Oakwood.
2. Mr Hewson had a history of mental health issues and a long history of substance misuse. He told staff in HMP Hewell he had used illicit drugs, a New Psychoactive Substance (an NPS called Black Mamba, a synthetic cannabis that mimics the effects of illicit drugs) and had had a bad reaction. He said he intended to continue using drugs.
3. On 30 August, Mr Hewson had breathing difficulties. Officers called for healthcare assistance as Mr Hewson collapsed and stopped breathing. Nurses began cardiopulmonary resuscitation (CPR).
4. Paramedics arrived at 8.55am and with the nurses and a GP continued to try to resuscitate Mr Hewson. At 9.12am, a prison GP confirmed that Mr Hewson had died.

Findings

5. The clinical reviewer concluded that the standard of healthcare Mr Hewson received at the prison was equivalent to what he could have expected to receive in the community.
6. The investigation found that he frequently used illicit substances while in the prison. Mr Hewson was given appropriate emotional support for his NPS use and was monitored well by the prison, although there appears to have been insufficient effort made to restrict Mr Hewson's access to substances.

Recommendation

- The Director should ensure there is effective implementation of the prison's substance misuse strategy to help reduce the availability and demand for new psychoactive substances.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Oakwood informing them of the investigation and asking anyone with relevant information to contact her. One person responded.
8. The investigator visited HMP Oakwood on 13 September 2016. She obtained copies of relevant extracts from Mr Hewson's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Hewson's clinical care at the prison.
10. The investigator interviewed four members of staff and one prisoner at HMP Oakwood on 6 October 2016.
11. We informed HM Coroner for South Staffordshire District of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Hewson's parents to explain the investigation. They had a number of concerns for the investigation to consider, including:
 - What advice was given and steps taken to safely manage Mr Hewson's medication?
 - Did anyone monitor him during the night before he died and had he used his cell bell on the night prior to his death?
 - The events on 30 August.
13. Mr Hewson'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 on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Oakwood

15. HMP Oakwood opened in 2012. It is near Wolverhampton and managed privately by G4S. Oakwood is one of the largest prisons in England and Wales, providing places for up to 1,605 Category C male prisoners.
16. Care UK provides the healthcare services, which include a daily GP clinic, some specialist services and out-of-hours GPs. There are no in patient facilities.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Oakwood was in December 2014. Inspectors reported that health services had improved considerably since the last inspection and, overall, were reasonably good. The range of services was appropriate and the management of prisoners with lifelong or complex health needs was very good, although staff shortages had led to a backlog of nurse reviews. Inspectors found that the healthcare rooms were well equipped and staff created appropriate care plans.
18. Inspectors noted that there was a significant threat of drugs, including new psychoactive substances (particularly Black Mamba) and diverted medication in the prison. They reported an overuse of strip searching, and closed visits (a glass pane separates prisoners and their visitors). They said that despite a comprehensive and robust supply reduction strategy, prisoners said that it was easy to get drugs at the prison.

Independent Monitoring Board

19. Each prison has an Independent Monitoring Board made up of unpaid volunteers from the local community who help to help ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to March 2016, the IMB reported that, due to the uncertainty arising from the change of healthcare provider (Worcester Health and Care Trust provided healthcare services before April 2016), there were a high number of vacancies and the use of agency staff had hindered continuity of care. There was no nurse cover during the night.

Previous deaths at HMP Oakwood

20. Mr Hewson was the fifth prisoner to die from natural causes at Oakwood since January 2013. There have been three deaths since. There were no significant similarities with the circumstances of the previous deaths.

New Psychoactive Substances (NPS)

21. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of 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 or self-harm.

22. In July 2015, we published a Learning Lessons 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.
23. 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

24. On 11 May 2016, Mr Derek Hewson was sentenced to 16 months in prison for producing cannabis, and was initially sent to HMP Hewell. He had a history of back pain and paranoia, which were well controlled with medication. He also had a history of mental health issues (including schizophrenia and personality disorder) which had been diagnosed while in the community. Mr Hewson was known to have a substantial history of drug misuse. On 1 June, Mr Hewson used NPS and had a bad reaction. A nurse examined him and he was left to sleep off the effects as his breathing and pulse rate were within the normal range.
25. On 4 July, he was transferred to HMP Oakwood. A prison GP issued a prescription to continue with prescribed pain relief (tramadol and naproxen) for chronic pain, an antipsychotic (quetiapine), and medication to control tremors (procyclidine) and reduce stomach acid (lansoprazole).
26. The next day Mr Hewson told a worker from the substance misuse team that he had used heroin and crack cocaine for ten years. He said he had used NPS "Black Mamba". He said he would continue to use drugs but wanted help with alcohol consumption. He said he was not currently using any illicit drugs. She explained how the substance misuse service worked at Oakwood.
27. From 19 July, a nurse prescribed 34mls daily of methadone as an opiate replacement therapy and noted that the GPs would review and discuss pain management. Healthcare staff saw Mr Hewson daily as part of his methadone programme.
28. On 21 July, Mr Hewson had an Electrocardiogram (ECG – to test the electrical rhythm of the heart). A healthcare assistant organised ECGs as part of the substance misuse clinic. There is no record of the result of the ECG.
29. During a substance misuse session on 26 July with the substance misuse worker, Mr Hewson said he was still smoking NPS and had a "few drags of a spliff of an evening" which did not cause him any problems. He said that his NPS use had decreased and his methadone use was stable. She offered harm reduction advice.
30. When Mr Hewson attended his substance misuse appointment on 9 August, he admitted he was under the influence of NPS. The substance misuse worker ended the session and asked him not to use any more substances and said they would be discussing this at the next session.
31. At the next session on 15 August, Mr Hewson told the substance misuse worker that he was under the influence of NPS for the last session. He said he had only had "a few drags" and felt intoxicated, as it was stronger than usual.
32. On 28 August, when Mr Hewson went to the medical hatch to collect his methadone, he complained to healthcare assistant that he had a sore throat and felt feverish. She checked his throat and noted it was red and swollen with white spots on his tonsils. She asked a prison GP to examine him. The GP

examined Mr Hewson at 11.37am and diagnosed tonsillitis. He prescribed antibiotics.

33. Later that night, just after 11.00pm, wing staff asked a prison GP to see Mr Hewson, as he looked unwell. The GP saw Mr Hewson and arranged for him to go to hospital. Mr Hewson left the prison at 11.45pm. Two officers escorted him and he was restrained using an escort chain (an escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer). Mr Hewson arrived at the accident and emergency department at hospital just after midnight. A hospital doctor diagnosed tonsillitis and discharged Mr Hewson with paracetamol. Mr Hewson arrived back at Oakwood at 1.38am on 29 August.
34. Later that day, wing staff called healthcare staff to Mr Hewson's cell. At 14.50pm, healthcare staff saw Mr Hewson. He was sitting on a chair smoking. They told him that he needed to complete his course of antibiotics and increase his fluid intake in order to feel better.

Events on 30 August 2016

35. A Prison Custody Officer (PCO) A unlocked Mr Hewson's cell at approximately 7.40am and saw him lying on the bed. At 8.30am, he began locking up prisoners who remained on the wing. When he reached Mr Hewson's cell, he saw him sitting on his bed, breathing heavily. He asked him if he was "ok" as he appeared to be short of breath. At the same time, PCO B asked PCO A what was wrong. He told her Mr Hewson was unwell.
36. PCO B went to the cell door and opened the observation flap. Mr Hewson was sitting on a chair sorting through things on his desk. She knocked on the cell door, entered the cell and asked Mr Hewson to collect his medication. She said that Mr Hewson responded but she could not hear what he was saying as he was mumbling and slurring his words. His breathing was uneasy. She said he stood up and was putting his clothes on. She told him she would get a nurse to bring his medication to him (as the medication hatch is opposite the wing). However, the nurse told her she could not leave the medication hatch so she returned to Mr Hewson's cell. She said his breathing had not changed and Mr Hewson was sitting on the chair. She used her radio to call an emergency code blue (this indicates circumstances such as when a prisoner is unconscious, not breathing or is having breathing difficulties).
37. Staff in the control room immediately called for an ambulance at 8.44am. The first nurse to reach the cell noted that Mr Hewson was in respiratory distress and he could not communicate. He asked a senior nurse to collect the oxygen and emergency bag and call for a prison GP. At 8.52am, Mr Hewson collapsed and the nurses immediately began cardiopulmonary resuscitation (CPR).
38. The first nurse said that another nurse and a healthcare assistant arrived with the defibrillator. He said that the reading from the defibrillator indicated Mr Hewson was dead.
39. A prison GP said at approximately 8.50am he was in his office when he received a computer message and a telephone call that he should go to Mr

Hewson's cell. He saw the nurses conducting CPR and the first nurse updated him on the situation. He said that, with the agreement of the other nurses, they moved Mr Hewson to the floor outside of the cell for more space and continued with CPR.

40. Paramedics arrived at 8.55am and with the nurses and GP continued to try to resuscitate Mr Hewson. At 9.12am, the GP confirmed that Mr Hewson had died.

Contact with Mr Hewson's family

41. On 30 August, the prison appointed the Head of Safer Custody as the family liaison officer. At 10.40am, she and a colleague left the prison to break the news to Mr Hewson's parents. They arrived at 12.00pm and broke the news. They offered their condolences and ongoing advice and support.
42. Mr Hewson's funeral was held on 7 October 2016 and the prison contributed towards the costs of the funeral in line with national policy.

Support for prisoners and staff

43. After Mr Hewson's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
44. The prison posted notices informing other prisoners of Mr Hewson's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Hewson's death.

Post-mortem report

45. The post-mortem examination found that Mr Hewson had died from sepsis caused by pus in his lung cavity. High blood pressure was a contributory factor.
46. A pathologist noted that there were therapeutic levels of buprenorphine, naproxen, quetiapine and methadone in Mr Hewson's blood. However, he did not consider these contributed to his death.
47. The pathologist also noted that there were traces of a synthetic cannabinoid. He said there was little knowledge of the toxicity and metabolism of this drug but the low levels found were not a contributing factor to death. However, it showed that Mr Hewson had access to illicit drugs. He said that such drug use meant that any infections were easily acquired and more difficult to treat.

Findings

Clinical care

48. The clinical reviewer found that, overall, the clinical care Mr Hewson received was the equivalent to what he could have expected to receive in the community. The sudden events on 30 August could not have been anticipated. We agree with the clinical reviewer's conclusion.
49. However, the clinical reviewer said that there should be a record of any ECG tests. It was unlikely to have changed the outcome for Mr Hewson so we do not make a recommendation here. The Head of Healthcare will need to address the points raised in the clinical review.

Illicit drugs

50. Although not a direct contributory factor in Mr Hewson's death, the post mortem makes clear that he was using a NPS called Black Mamba, synthetic cannabis. NPS can cause a wide range of complications including accelerated heartbeat, high blood pressure, blurred vision, epileptic fits, hallucinations, acute psychosis and loss of bowel control. Such drug use can also lead to infections being more easily acquired and more difficult to treat.
51. The prison's safer custody manager outlined a number of initiatives to disrupt drugs being smuggled into the prison and to support and deter prisoners from taking them. These initiatives, in theory at least, appear appropriate, involving a mix of therapeutic support and discipline procedures to discourage NPS use.
52. In the case of Mr Hewson, there was at least one intelligence report on his substance use, and was frequently recorded in his records that, by his own admission, he was under the influence of a substance. However, it does not appear that sufficient steps were taken to restrict his opportunities to access illicit drugs.
53. Healthcare and substance misuse staff gave Mr Hewson regular and appropriate support and medication to help him deal with his substance misuse problems. Mr Hewson did not, though, seem inclined to abstain from using illicit substances. He appeared to have a good relationship with his support worker, and would admit to using NPS. His support worker gave harm reduction advice to Mr Hewson, so he was aware of the dangers of using illicit substances.
54. Given that prison and healthcare staff were aware of Mr Hewson's drug misuse, we would have expected more evidence of measures to address his opportunities to continue using. This could have included, for example, use of disciplinary procedures, review of Mr Hewson's incentives and earned privileges status (he was on the standard level), targeted searching or closed visits. We therefore make the following recommendation:

The Director should ensure there is an effective implementation of the prison's substance misuse strategy to help reduce the availability and demand for new psychoactive substances.

**Prisons &
Probation**

Ombudsman
Independent Investigations