

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Shaun Harvey a prisoner at HMP Holme House on 20 February 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*



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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 Shaun Harvey died from the effects of methadone, bronchopneumonia and bronchitis at HMP Holme House on 20 February 2016. He was 46 years old. I offer my condolences to Mr Harvey's family and friends.

The investigation found that staff managed Mr Harvey's methadone prescription safely and that he received appropriate substance misuse support from the prison's drug and alcohol recovery team. We found no evidence that he was misusing methadone and I do not think that staff could have foreseen or prevented his death. Mr Harvey's existing physical health conditions made him susceptible to chest infections but I am satisfied that the healthcare he received at Holme House was equivalent to what he might have expected to receive in the community.

However, staff did not understand or comply with national and local instructions about when to go into a cell in an emergency. Although I do not think the delay affected the outcome for Mr Harvey, any delay could be critical in a similar situation.

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**

**December 2016**

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# Summary

## Events

1. On 10 April 2015, Mr Shaun Harvey was remanded to HMP Holme House charged with burglary and, on 8 June, he was sentenced to four years imprisonment. He had been in prison before. Mr Harvey had a history of substance misuse, both in prison and in the community. He also suffered with chronic obstructive pulmonary disease (COPD - a term used to describe a range of serious lung conditions).
2. At an initial health assessment, Mr Harvey said that he was prescribed buprenorphine, an opiate substitute, by his community GP. At Holme House, he was prescribed methadone, another opiate substitute. Healthcare staff gradually raised the dose to 30ml a day, on which Mr Harvey felt stable. Healthcare staff referred Mr Harvey to the Drug and Alcohol Recovery Team (DART) who met with him several times. At least twice, the DART worker explained to Mr Harvey the risks of taking illicit drugs on top of his prescribed methadone.
3. In August, Mr Harvey was hospitalised and diagnosed with pneumonia. He spent two further periods in hospital and, when he was discharged, was admitted to the prison inpatient unit and prescribed an opiate pain relief medication. By early December, he was well enough to return to a standard residential wing.
4. On 24 October, an officer saw Mr Harvey swallow a package his visitor had given him. As a precaution, healthcare staff stopped his methadone and opiate pain relief medication. Drug tests showed only that Mr Harvey had used methadone and opiates, both of which he had been prescribed. Three days later, another officer found four tablets in Mr Harvey's cell, which he had not been prescribed. Mr Harvey admitted breaking prison rules. There was no further evidence to suggest that Mr Harvey misused illicit substances at Holme House.
5. At around 5:20am on 20 February 2016, a night patrol officer found Mr Harvey unresponsive on his cell floor and raised the alarm. When other staff arrived shortly after, they went into the cell and tried to resuscitate Mr Harvey. Paramedics arrived at 5.40am and continued to attempt resuscitation, but at 6.20am, pronounced that Mr Harvey had died.
6. The post-mortem examination concluded that Mr Harvey died as a result of the effects of methadone, bronchopneumonia and bronchitis. The levels of methadone in his body were higher than expected with a therapeutic dose and at a level associated with fatal overdose.

## Findings

7. Although we conclude that Mr Harvey probably used additional methadone to that prescribed to him, we do not know how or where he obtained it. We found that healthcare staff and drug workers managed Mr Harvey's methadone maintenance programme appropriately, and discussed with Mr Harvey the risks of taking illicit substances as well as his prescribed methadone. After October 2015, staff had no reason to suspect that Mr Harvey was misusing substances at Holme House, and there was no evidence that the misuse or trading of

methadone was a particular problem at Holme House. We do not think that staff could have foreseen or prevented Mr Harvey's death.

8. Mr Harvey had COPD, which meant he was susceptible to chest infections and other related health problems. We found that he received appropriate clinical treatment for his physical health problems.
9. Contrary to national and local instructions, which direct all staff to consider going into a cell in an emergency after a dynamic risk assessment, staff at Holme House thought that night patrol officers should always wait for other staff to arrive before going into a cell. The night patrol officer did not go into Mr Harvey's cell when he found him unresponsive, but waited for other staff to arrive.

## **Recommendations**

- The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Holme House's local Instruction and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited Holme House on 29 February 2016, and obtained copies of relevant extracts from Mr Harvey's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Harvey's clinical care at the prison.
13. The investigator interviewed 11 members of staff, five jointly with the clinical reviewer, and two prisoners at Holme House between March and May 2016.
14. We informed HM Coroner for Teesside District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Harvey's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific matters for the investigator to consider.
16. Mr Harvey's sister received a copy of this report. She did not make any comments.
17. The service also received a copy of the initial report.

## Background Information

### HMP Holme House

18. HMP Holme House is a local prison, which holds over 1200 men. Most are on remand, or recently convicted by courts in the local area. G4S provides the health services at the prison.

### HM Inspectorate of Prisons

19. The most recent inspection of HMP Holme House was in August 2013. Inspectors reported that clinical support for prisoners with drug and alcohol issues was generally good, but overnight observation was inadequate. The prison did not offer the full range of opiate substitution treatment options, which the Inspectorate considered could jeopardise prisoners' recovery. More prisoners than at comparator prisons reported developing a problem with diverted medication. The Drug Recovery Wing provided useful support, but there was insufficient activity for prisoners who were not working. Inspectors found that the overall quality of healthcare had improved and was good.

### Independent Monitoring Board

20. 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 December 2015, the IMB reported that the prison had established a peer mentor programme to help prisoners with substance misuse issues. The Board noted that, in 2015, Holme House had received fewer prisoners needing methadone due to a reorganisation of prisons in the North East.

### Previous deaths at HMP Holme House

21. Mr Harvey was the fifth prisoner to die at Holme House since November 2014. In previous cases, we found that the clinical care provided to prisoners was equivalent to what they might have expected to receive in the community.

## Key Events

22. On 10 April 2015, Mr Shaun Harvey was remanded to HMP Holme House charged with burglary, which he was alleged to have committed ten days after being released on licence from Holme House, having served three years six months for a previous offence of burglary. On 8 June, he was sentenced to four years imprisonment. Mr Harvey had a history of substance misuse both in prison and in the community.
23. At an initial health assessment, Mr Harvey told a nurse that he had used crack cocaine, cocaine, benzodiazepines and methadone in the past. He said that his community GP had prescribed a daily dose of 8mg of buprenorphine, a synthetic opioid used to treat heroin addiction. She told the investigator that methadone was the only heroin substitute prescribed at Holme House. Mr Harvey also suffered with Chronic Obstructive Pulmonary Disease (COPD) and was prescribed two inhalers. COPD is a term used to describe a range of serious lung conditions including emphysema and chronic bronchitis, in which the airways become inflamed and the air sacs in the lungs are damaged.
24. Later that day, Mr Harvey told a prison GP that he had been using cannabis, cocaine and heroin daily until a few days earlier, and that he had used unprescribed methadone two weeks earlier. The GP referred him for a further review the next day in the substance misuse clinic. He did not prescribe methadone because Mr Harvey said he had taken buprenorphine before arriving and he displayed no withdrawal symptoms. Mr Harvey was allocated a cell on the first night centre.
25. On 11 April, a substance misuse nurse assessed Mr Harvey's opiate withdrawal symptoms using the Custody Opiate Withdrawal Health Observation Scale (COWS). Mr Harvey scored six, which indicated he was experiencing mild withdrawal symptoms, and she moved him to the Drug Recovery Unit for observation.
26. Later that day, another prison GP reviewed Mr Harvey, who was clammy and pale. The GP instructed that Mr Harvey's prescribed dose of methadone should be adjusted until he had no withdrawal symptoms. Once he was stable on the dose, they could consider gradually reducing the dose. The GP prescribed 15ml of methadone daily, which was equivalent to the 8mg dose of buprenorphine.
27. Two days later, a prison GP increased Mr Harvey's methadone dose to 25ml, and four days later to 35ml, because he displayed withdrawal symptoms. After 13 May, healthcare staff gradually reduced the methadone dose to 30ml daily, with which Mr Harvey was content.
28. At Holme House prisoners prescribed methadone must swallow the medication and then drink a cup of water in front of the dispensing nurses. The nurses also ask the prisoners to talk to them before leaving the medication room to try to ensure that they have swallowed the methadone and to minimise the opportunities for trading methadone with other prisoners.
29. On 13 April, healthcare staff referred Mr Harvey to the Drug and Alcohol Recovery Team (DART). On 20 April, a DART support worker assessed and

referred Mr Harvey to the drug recovery programme, a 12-week programme focusing on topics including relationships, money management and living skills. She discussed with Mr Harvey the risks associated with using illicit drugs. On 15 May, another DART support worker recorded in his case notes that Mr Harvey had engaged in group therapy. The following four months were uneventful and no one recorded any concerns about Mr Harvey's substance misuse or health.

30. On 18 August, Mr Harvey complained of a cough and was prescribed antibiotics and steroids. On 21 August, he complained of breathlessness and was admitted to hospital, where he was diagnosed with pneumonia. He returned to Holme House on 25 August, and was admitted to the prison inpatient unit. Healthcare staff continued to prescribe 30ml of methadone to Mr Harvey during this period. On 4 September, Mr Harvey moved back to the Drug Recovery Unit, where he also worked as a cleaner.
31. On 18 September, a healthcare assistant discussed with Mr Harvey his methadone care plan. Mr Harvey said he knew he could reduce his methadone dose if he wanted to, and said that he understood the risks associated with using illicit drugs. Mr Harvey said that he had engaged in one to one therapy with DART and had done some work to become a peer mentor.
32. On 21 September, a prison GP examined Mr Harvey and noted that he had not fully recovered from the pneumonia. Mr Harvey was admitted to hospital again and diagnosed with an abscess on his lung, a complication of pneumonia. He remained in hospital until 2 October, where he continued to be prescribed 30ml of methadone. Hospital staff also prescribed Mr Harvey codeine, an opiate pain relief medication. On his return to the prison, he returned to the Drug Recovery Unit.
33. On 16 October, Mr Harvey had a blood test, which showed that he still had a lung abscess. On 19 October, he returned to hospital and had an operation to treat the abscess. Three days later, Mr Harvey returned to Holme House and was admitted to the prison's inpatient unit, still prescribed 30ml of methadone daily.
34. On 24 October, the staff supervising prisoner visits saw Mr Harvey swallow a small package given to him by his visitor. An officer submitted a security report, and the visitor was banned from the prison and Mr Harvey's future visits were subject to strict controls. A prison GP stopped Mr Harvey's methadone and codeine prescriptions, in case he had swallowed drugs and was at risk of overdose. Healthcare staff frequently checked Mr Harvey during the night and the next day.
35. On 26 October, Mr Harvey's urine tested positive for methadone and opiates only. Mr Harvey had last received his prescribed doses of methadone and codeine on 24 October, so the test did not reveal whether Mr Harvey had swallowed drugs during his visit.
36. On 27 October, an officer cleared Mr Harvey's cell on the Drug Recovery Unit and found four tablets in a small bag. A nurse said they might be antipsychotic medication, which Mr Harvey had never been prescribed. The officer submitted a security report and staff charged Mr Harvey with a disciplinary offence. Mr Harvey pleaded guilty and received seven days' loss of privileges as the

punishment. No one submitted any further security reports about Mr Harvey after this incident.

37. On 28 October, Mr Harvey complained of withdrawal symptoms and pain. A prison GP recorded in the medical record that Mr Harvey had scored 12 on the COWS, indicating mild withdrawal symptoms. He prescribed Mr Harvey 10ml of methadone, increasing to 20ml on 29 October and 30ml on 30 October. On 31 October, his COWS withdrawal score had dropped to three and Mr Harvey said he felt stable with the dose. After 24 October, Mr Harvey was not prescribed codeine.
38. Mr Harvey remained in the prison inpatient unit in November and healthcare staff recorded no concerns about him. On 2 December, a prison GP noted that Mr Harvey was well and could be discharged from the inpatient unit. Staff did not consider that Mr Harvey was suitable for the Drug Recovery Unit any longer, so on 3 December they moved him to a single cell on Houseblock 7, a standard prison unit. Healthcare staff continued to dispense him 30ml of methadone daily.
39. On 16 December, Mr Harvey saw a prison GP, complaining of breathlessness and coughing up dark coloured phlegm. The doctor diagnosed Mr Harvey with an exacerbation of his COPD and prescribed antibiotics. The GP reviewed Mr Harvey again over the following weeks and prescribed antibiotics again in January and on 10 February.
40. On 22 December, a DART case worker reviewed Mr Harvey's progress and recorded that his drug recovery work had been affected by his ill health. She recorded that Mr Harvey was prescribed 30ml of methadone daily and that he had not used illicit drugs since arriving at the prison (her notes make no mention of the incident during visits, or the tablets found in his cell). She created a new recovery plan for Mr Harvey focused on avoiding relapse on release. She recorded that she had discussed with him his methadone plan and that he did not want to reduce his current dose until his health had improved. She no longer works at Holme House and was not available for interview.
41. On 28 December, Mr Harvey was selected for a random drug test and tested positive for methadone only, in line with his prescription.
42. A nurse told the investigator that she had dispensed Mr Harvey methadone a number of times. She said that she had never had any concerns that he was using other substances as well as his prescribed methadone and had never thought that he appeared to be under the influence of drugs. Officers and prisoners who knew Mr Harvey told the investigator that they did not know whether he was using any illicit substances as well as his prescribed methadone.
43. On 18 January 2016, a nurse discussed with Mr Harvey his methadone maintenance programme. Mr Harvey repeated that he understood the risks associated with using illicit drugs while being prescribed methadone. Over the next month, Mr Harvey did not raise any concerns and appeared to be well. Mr Harvey's nephew, who was also at Holme House, told the investigator that around this time Mr Harvey commented that he was feeling very well and strong, and that he had recovered well from the pneumonia.

44. According to Closed Circuit Television (CCTV) footage, on the evening of 19 February, Mr Harvey was out of his cell during the houseblock association period (when prisoners are unlocked and free to socialise with each other) talking to prisoners. Just after 6.00pm, an officer locked Mr Harvey in his cell. At 7.30pm, the night patrol officer started working on Mr Harvey's houseblock and checked all of the prisoners. He told the investigator that he checked Mr Harvey and did not notice anything unusual. During the night, Mr Harvey did not press his cell bell and he said that he did not hear or notice anything concerning when he patrolled the houseblock.

### **Saturday 20 February**

45. At around 5.00am, the night patrol officer started another routine check and count of the prisoners on the houseblock and, according to CCTV, arrived at Mr Harvey's cell at 5.16am. He shone his torch through the observation panel in Mr Harvey's cell door but could not see Mr Harvey in his bed, which looked as if no one had slept in it. He thought that the cell was empty and decided to go back after he had finished checking the other cells on the houseblock. At 5.19am, having finished the check, and realising that he was one prisoner short in his count, he returned to Mr Harvey's cell and looked again through the observation panel.
46. The night patrol officer saw Mr Harvey's feet on the floor and kicked the door and shouted to try and rouse Mr Harvey. When Mr Harvey did not respond, he radioed a code blue emergency (indicating that a prisoner is unconscious, not breathing or is having breathing difficulties). He told the investigator that he did not unlock and go into Mr Harvey's cell because he had been told, during training at another prison, that he should never enter a cell alone and should always wait for other staff to arrive. The night manager, three officers and a nurse responded and arrived at the cell at 5:22am. Local ambulance service records show that staff in the Holme House control room requested an ambulance at 5:24am.
47. The night manager unlocked the door and the nurse Headley went in, checked Mr Harvey for signs of life and found none. The nurse said that he saw a small amount of fluid (which he thought was probably bile) on the floor near Mr Harvey's body. The nurse asked the night patrol officer to get the defibrillator from the central office on houseblock 7, and he returned with it seconds later. The nurse, the officers and another nurse, who had also arrived, attempted to resuscitate Mr Harvey.
48. At 5.37am, the ambulance arrived at the prison and three minutes later, the paramedics reached Mr Harvey's cell and took over the resuscitation attempt. At 6.20am, the paramedics pronounced that Mr Harvey had died.

### **Contact with Mr Harvey's family**

49. Shortly after 8.30am, an officer and the Head of Safer Custody arrived at Mr Harvey's cousin's house and broke the news of his death. They then went to Mr Harvey's sister's house and told her. The prison contributed to the cost of Mr Harvey's funeral in line with national instructions.

### **Support for prisoners and staff**

50. After Mr Harvey's death, the night 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.
51. The prison posted notices informing other prisoners of Mr Harvey's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Harvey's death.

### **Post-mortem report**

52. A post-mortem examination established the cause of Mr Harvey's death as the effects of methadone, bronchopneumonia and bronchitis. Toxicology analysis revealed that the level of methadone in Mr Harvey's body was around twice that expected from therapeutic use in opiate replacement therapy and was in the range associated with fatality. The toxicologist concluded that the level of methadone in Mr Harvey's body was sufficient to have caused his death, without the added complications of bronchopneumonia and bronchitis.

# Findings

## Substance Misuse

53. Mr Harvey had a known history of substance misuse in the community and in prison, and had been prescribed buprenorphine (an opiate substitute) by his community GP. At Holme House, Mr Harvey was prescribed methadone in line with the prison's drug and alcohol strategy. Healthcare staff stabilised Mr Harvey on a dose of 30ml a day, which Mr Harvey was content with. In December, Mr Harvey said that he did not want to reduce his dose until his physical health had improved. The clinical reviewer concluded that Mr Harvey's methadone maintenance programme was appropriate.
54. Mr Harvey met members of the Drug and Alcohol Recovery Team several times to review his substance misuse plan. They offered him psychosocial interventions and explained, on at least two occasions, the dangers of taking illicit drugs on top of his prescribed methadone.
55. In October 2015, there were indications that Mr Harvey was misusing substances and he was challenged and disciplined. However, staff had not suspected any further illicit substance misuse after 27 October.
56. The post-mortem toxicology examination found that Mr Harvey had fatal levels of methadone in his body, much higher than would be expected from therapeutic use. We conclude, therefore, that he had used additional methadone to that prescribed to him but we do not know how or where he obtained it. None of the nurses who dispensed methadone to Mr Harvey at Holme House or officers who knew him ever recorded any concerns or suspicions about his misuse of methadone. While HM Inspectorate of Prisons have expressed concern about medication being diverted at Holme House, senior staff said that they had not had any concerns about the misuse or trading of methadone at the prison before Mr Harvey's death. We do not think that staff could have foreseen or prevented Mr Harvey's death.

## Clinical Care

57. Mr Harvey suffered with Chronic Obstructive Pulmonary Disease, which meant he was susceptible to chest infections, bronchopneumonia and bronchitis. From August to early December 2015, Mr Harvey was quite unwell and was admitted to hospital several times. In mid-December, Mr Harvey had an exacerbation of his COPD and complained of further symptoms and was prescribed antibiotics. He was prescribed antibiotics again in January and February 2016. The clinical reviewer, concluded that Mr Harvey's physical health concerns were appropriately managed at Holme House and that the standard of healthcare he received in prison was equivalent to what he could have expected to receive in the community.

## Emergency Response

58. The night patrol officer first checked Mr Harvey's cell at about 5.16am on 20 February, but could not see Mr Harvey. He decided to continue checking the other cells on the unit, before returning about three minutes later, when he

realised his count of prisoners was incorrect. This time, he saw Mr Harvey lying on the cell floor, unresponsive. He radioed a code blue emergency, but did not go into Mr Harvey's cell. He told the investigator that he did not think night patrol officers were allowed to go into a cell without other staff present.

59. At night, officers have a cell key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.
60. Holme House's local instruction says that, at night, staff should consider entering a cell on their own if they suspect the prisoner has died, or where a prisoner's life is in danger, but must balance the preservation of life against the security of the prison.
61. The night manager said that managers instruct night patrol officers not to go into a cell on their own, but to raise the alarm and wait for other staff to arrive. We are concerned that staff at Holme House do not understand or comply with national instructions and the prison's own local policy and we make the following recommendation:

**The Governor should ensure that all prison staff are made aware of PSI 24/2011 and Holme House's local instruction and that they understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life.**

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