Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr William Abel a prisoner at HMP Holme House on 18 November 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 William Maxwell Abel died on 18 November 2016 at HMP Holme House after cutting his wrists. I offer my condolences to Mr Abel's family and friends.

Mr Abel received good support from the mental health team and the Drug and Alcohol Recovery Team (DART) at Holme House, and he gave staff little cause to open suicide and self-harm prevention procedures. However, the prison needs to continue to address the availability of NPS (New Psychoactive Substances), not least in the Therapeutic Community Unit, where prisoners undertake drug recovery programmes.

There were also deficiencies in the emergency response. The prison took too long getting paramedics to Mr Abel's cell after they arrived at the prison and earlier assistance might have changed the outcome for him.

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 **August 2017**

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Summary

Events

1. On 15 April 2016, Mr William Abel was remanded to HMP Durham, charged with attempted robbery and, on 29 September, he was sentenced to four and a half years in prison.

2. Mr Abel had a history of drug and alcohol misuse and started a methadone reduction programme. On 23 May, Mr Abel was transferred to HMP Holme House where he successfully completed the methadone reduction programme and engaged well with the Drug and Alcohol Recovery Team (DART).

3. A mental health practitioner reviewed Mr Abel and assessed that he had moderate depression. He was referred to group therapy, in which he engaged well. Often, Mr Abel did not want to take any medication for his depression. He mentioned to mental health and DART staff that he was concerned about his partner. Staff listened to him and offered him support.

4. Mr Abel did not attend the final mental health group session. He later told mental health staff that he did not want further help and support and was discharged from their care. On 4 October, Mr Abel told a nurse that he felt anxious and wanted to see a GP. He saw a GP two days later who prescribed him with medication.

5. On 13 October, Mr Abel moved to the therapeutic community unit which holds prisoners recovering from substance misuse and he received frequent support from the substance misuse team.

6. On 17 November, Mr Abel asked a unit manager for help with an internal application relating to his incentives and earned privileges scheme status. The manager initially dismissed Mr Abel's request, but later told Mr Abel that he would help him. At 6.00pm, officers locked Mr Abel and his cellmate in their cell.

7. On 18 November, Mr Abel's cellmate said that Mr Abel went to the toilet at around 3.00am. He then heard a noise and saw blood on the floor. At 3.27am, Mr Abel's cellmate pressed their emergency cell bell. Seconds later, a night patrol officer went to Mr Abel's cell and, at 3.30am, called a medical emergency code over the radio. Shortly after, officers and a nurse arrived at the cell and started cardiopulmonary resuscitation. At 3.41am, an ambulance crew arrived at the prison and 15 minutes later at Mr Abel's cell. Paramedics continued with resuscitation procedures until 4.18am, when they pronounced that Mr Abel had died.

Findings

8. Mr Abel received good support from the mental health team and the substance misuse team at Holme House. Mr Abel's relationship with his partner was a source for anxiety and stress for him. Staff listened to Mr Abel's concerns about his partner and frequently offered support to him. They had no reason to believe that Mr Abel was at imminent risk of suicide and self-harm. He

appeared to be positive about the future, did not express suicidal thoughts and did not self-harm. We believe that decision not to begin ACCT monitoring for Mr Abel was reasonable.

9. Although Mr Abel successfully completed his drug recovery programme and DART supported him well, although he was able to take New Psychoactive Substances (NPS) while at Holme House, including the day before he died. Holme House does not have a robust strategy to tackle the demand and supply of NPS which appear to be readily available on the therapeutic community unit and prisoners are not tested for NPS under the voluntary drug testing scheme. The prison has not provided clear guidelines to staff on how to deal with NPS cases.

10. There was a significant delay in an ambulance reaching Mr Abel which might have affected the outcome, as Mr Abel was still alive when the night patrol officer found him.

Recommendations

- **The Governor and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of and demand for NPS, that staff are vigilant for signs of their use, are briefed how to respond when prisoners appear to be under the influence of such substances and that NPS is included in Voluntary Drug Testing (VDT).**
- **The Governor should ensure that Holme House meets the requirements of PSI 03/2013, so that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.**

The Investigation Process

11. 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.

12. The investigator visited HMP Holme House on 12 January and obtained copies of relevant extracts from Mr Abel's prison and medical records.

13. The investigator interviewed 12 members of staff and five prisoners between January and March 2017.

14. NHS England commissioned a clinical reviewer to review Mr Abel's clinical care at the prison. She carried out three interviews jointly with the investigator.

15. 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.

16. One of the Ombudsman's family liaison officers contacted Mr Abel's mother and son. Mr Abel's son asked for information about the circumstances of Mr Abel's death.

17. Mr Abel's family received a copy of the initial report. They did not make any comments on the factual accuracy of this report.

18. The prison service also received a copy of the initial report. Their response to our recommendations.

Background Information

HMP Holme House

19. 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

20. The last inspection at 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 substance misuse provision at the prison was good. The drug recovery wing provided useful support but there was insufficient activity there for prisoners who were not working. The therapeutic community provided valuable structured support. Inspectors found that the overall quality of healthcare had improved and was good.

Independent Monitoring Board

21. 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. In 2015, the IMB noted that Holme House had received fewer prisoners needing methadone due to a reorganisation of prisons in the North East.

Previous deaths at HMP Holme House

22. Mr Abel was the seventh prisoner to die at Holme House since January 2015 and the second self-inflicted death. 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 and that healthcare staff adequately implemented methadone maintenance programmes but in the death of man in 2015, we found that the prison did not have a clear joint healthcare and prison protocol about how to respond to and monitor prisoners suspected of taking NPS.

New Psychoactive Substances (NPS)

23. NPS, described in the Psychoactive Substances Act 2016, 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.

24. 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.

25. Her Majesty's Prison and Probation Service (HMPPS) 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 HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

26. On 15 April 2016, Mr William Abel was remanded to HMP Durham charged with attempted robbery, four months after being released on licence from a previous sentence. On 29 September, he was sentenced to four and a half years in prison.

27. Mr Abel had a history of drug and alcohol misuse in the community. He told a resettlement caseworker on 20 April that he was using amphetamines heavily and had drunk alcohol and smoked heroin before his arrest. When Mr Abel arrived at Durham, a nurse began ACCT monitoring because he told a police officer that he had thoughts of killing himself if sent back to prison, was low in mood because of his recall and had alcohol and substance misuse issues. During the ACCT assessment interview, Mr Abel told an officer that he 'unknowingly' took NPS before committing the offence. During a multidisciplinary ACCT review the next day, officers stopped the ACCT because Mr Abel no longer had suicidal thoughts and engaged well with the Drug and Alcohol Recovery Team (DART provides treatment options for prisoners with substance misuse issues).

28. On 18 April, Mr Abel started a methadone maintenance programme and a prison GP prescribed methadone, and increased his dose on 26 April.

29. On 23 May, Mr Abel was transferred to HMP Holme House. At an initial health screening, he told a nurse that he used methadone, heroin and amphetamines in the community. She tested Mr Abel's urine for drugs and the results were negative for buprenorphine, amphetamine, cocaine, benzodiazepine and opiates. Mr Abel told the nurse that he had cut his arms in 1996 but said that he did not have any current thoughts of suicide or self-harm, and that he was taking citalopram (an antidepressant) in the community. She referred Mr Abel for a mental health assessment. Another nurse frequently monitored his health. Neither she nor Mr Abel raised any concerns about his treatment.

30. On 24 May, Mr Abel met a DART team support worker and agreed to continue engaging with the DART team. (Mr Abel's DART file shows a comprehensive record of his attendance and engagement in the group sessions). The same day a prison GP reviewed Mr Abel who kept his methadone maintenance programme and prescribed him methadone daily.

31. On 27 May, a mental health practitioner reviewed Mr Abel, who appeared low in mood and tearful. She assessed Mr Abel and concluded that he had moderate depression. She referred Mr Abel for to group therapy with the mental health team, and Mr Abel engaged consistently. She told the investigator that Mr Abel said he did not want to take medication.

32. On 16 June, Mr Abel told a drug recovery worker during a DART session that he felt stressed, he had not been able to contact his partner and that she was using drugs. She listened to Mr Abel and discussed his concerns. She referred him to a DART family worker. Mr Abel told the drug recovery worker that he wanted to reduce his dose of methadone and become methadone free. On 17 June, he moved to the drug recovery wing (a dedicated wing for prisoners who are taking methadone and receive substance misuse treatment)

and from 21 June, healthcare staff started to decrease Mr Abel's methadone dose gradually.

33. On 5 July, Mr Abel told the DART family worker that he was concerned about his partner because she was homeless and using heroin. She told Mr Abel that she would contact his partner to offer her help. She contacted Mr Abel's partner and left a message. On 28 July, Mr Abel spoke to a drug recovery worker and repeated his concerns about his partner. She recorded that Mr Abel appeared low in mood. She referred him to the mental health team.

34. On 16 August, a trainee mental health practitioner who co-facilitated the group sessions with the mental health practitioner, assessed Mr Abel and concluded that he was anxious. Mr Abel also completed a patient health questionnaire which indicated that he had moderate depression. Mr Abel said that he felt down, depressed or hopeless nearly every day but he said that he did not have thoughts of suicide or self-harm.

35. The mental health practitioner told the investigator that given Mr Abel's high scores, she planned to continue monitoring him in the group sessions using the assessment tools. On 30 August, she re-assessed Mr Abel. He was less anxious and less depressed. She said that she knew Mr Abel well and noted that he was positive, interacted well with other prisoners during the group sessions and raised no concerns about his safety. She assessed that he was not at risk of suicide or self-harm.

36. On 24 August, Mr Abel told the mental health practitioner during a drop-in session (a session that takes place at the prisoner's unit and where he can voluntarily approach a DART worker) that he was upset because his relationship with his partner had ended. Mr Abel reassured her that he wanted to focus on his welfare and continue with his drug recovery. She listened to Mr Abel and offered him support. She told the investigator that she believed that Mr Abel did not require ACCT monitoring because he presented well, did not express any suicidal thoughts and appeared to cope.

37. On 13 September, Mr Abel did not attend his final group session with the mental health team. The mental health practitioner told the investigator that the trainee mental health practitioner spoke to Mr Abel days later to find out why he did not attend but Mr Abel told him that he did not want any further assistance from the mental health team. He said that he was fine and was engaging well with DART.

38. The mental health practitioner said that on 30 September, the mental health team decided to discharge Mr Abel from their care because at the last group session Mr Abel was less anxious and had raised no concerns. She said that Mr Abel had always presented as positive and insightful about himself. She recorded that she sent a discharge letter to Mr Abel which gave him information about how to deal with a crisis and what to do if he wanted further support from the mental health team. She told the investigator she assessed Mr Abel as having mild depressive symptoms but not at risk of suicide or self-harm.

39. On 3 October, Mr Abel successfully completed the methadone reduction programme. The next day, he told a nurse that he felt anxious as he had

issues with his partner, who had sold his possessions. He said that she was chaotic and was using drugs. Mr Abel felt stressed about being in prison because he could not keep an eye on her. He wanted to see the GP so that he could start taking medication. She referred Mr Abel to a prison GP who, on 6 October, carried out a comprehensive assessment of Mr Abel and prescribed him citalopram for his depression.

40. On 11 October, Mr Abel moved to the therapeutic community unit which holds prisoners who are recovering from substance misuse and undertaking drug treatment. (Staff are employed by Lifeline, a charity that specialises in management of drug and alcohol services.)

41. On 3 November, the GP reviewed Mr Abel again. Mr Abel said that the medication had not helped him and he had problems sleeping. The GP noted that Mr Abel was engaging, maintained good eye contact and presented well. Mr Abel said that he did not have any thoughts of suicide or self-harm and agreed for his dose of citalopram to be increased. The GP also prescribed promethazine, a medication for sleeping difficulties.

42. On 7 November, Mr Abel undertook a voluntary drug test, which was negative for opiates, cannabis, methadone, benzodiazepine and cocaine. (Voluntary drug testing at Holme House does not include testing for NPS.) Officers did not witness Mr Abel dealing or taking drugs in the prison and there were no intelligence reports that indicated that Mr Abel was involved in the prison drug culture. Mr Abel's cellmate said that Mr Abel occasionally took NPS in the TCU and used NPS the day before he died.

43. On 12 November, Mr Abel called his stepdaughter. It was his fourth call to her since 31 October. The investigator listened to the calls and noted that Mr Abel was calm and positive, and did not mention or raise any concerns. The conversations were about planned prison visits and the activities of his stepdaughter in the community.

17 November

44. At around 10.00am on 17 November, Mr Abel attended a guitar lesson with another prisoner. He told the investigator that Mr Abel was fine and did not raise any concerns during the lesson.

45. At around 10.40am, Mr Abel went out to the landing for a break and asked a unit manager if he could speak to him. A member of staff submitted an intelligence report following Mr Abel's death stating that a prisoner overheard the manager say that he did not want to speak to Mr Abel 'because he did not like him' and then walked away. The prisoner who overheard the conversation said that Mr Abel looked visibly upset. He said that Mr Abel was quiet and looked upset for the rest of association time.

46. Three prisoners who socialised with Mr Abel during the day said that Mr Abel was playing his guitar, socialising well with them and he appeared fine. An IMB member who was in Mr Abel's unit at the time said she did not hear or note anything concerning.

47. CCTV footage at 11.37am showed the unit manager speaking to Mr Abel again. He told the investigator that Mr Abel asked him to help him to expedite an application for enhanced status on the Incentives and Earned Privileges (IEP) scheme and he said that he would help him with it. CCTV showed that Mr Abel walked back towards his cell. He told the investigator that it was possible that he had initially spoken to Mr Abel, as reported, in a spirit of banter. He pointed out that in the later conversation he dealt with Mr Abel's request.

48. At around 6.00pm, officers locked Mr Abel and his cellmate in their cell. The cellmate told the investigator he started to watch television, while Mr Abel read his newspaper. He said that at around 11.00pm Mr Abel turned off the television and the lights in the cell, and they both went to sleep.

18 November

49. On 18 November, at around 3.00am, the cellmate noted that Mr Abel went to the toilet. He heard a noise, which he described as if Mr Abel had left the tap on. He said that he was half-asleep but looked at the floor and saw blood everywhere. He panicked and rang the emergency cell bell. The prison did not record the time when he rang the bell, nor when it was answered, due to a technical fault in the unit, but CCTV footage showed that at 3.27am the lights in the corridors started to flash.

50. The night patrol officer attended seconds later. He said that the cellmate was in front of the observation panel banging at the door and he could not see inside the cell. He said that the cellmate appeared to be agitated and told him that Mr Abel had cut his wrists. At 3.30am he called a code red over the radio (code red indicates that a prisoner is bleeding). The Ambulance Service records show that it received the first call from the prison at 3.33am. He told the investigator that he thought about entering the cell but decided not to because he thought it was not safe to do so.

51. The night patrol officer looked through the observation panel again and saw that Mr Abel appeared to be on his bed but he could not see his arms, wrists, blood or fluid. He said that he thought that it was not safe to enter the cell at this point either because he could not see blood or confirm Mr Abel's condition. He then noted that Mr Abel suddenly moved and rolled out of his bed.

52. At 3.33am, an operational manager arrived with two officers and a nurse and entered the cell. An officer took the cellmate out of the cell and into a room in the unit. The nurse said that she saw Mr Abel lying on the floor on his left hand side with his head against the far wall. She saw that Mr Abel had cut each of his arms. She said that it was clear that Mr Abel was still alive as he was moving his arms and making noises. She and the other officer then attached a defibrillator, which indicated the need to start cardiopulmonary resuscitation (CPR). She carried out resuscitation procedures with the other officers until paramedics arrived who continued with CPR. The Ambulance Service records show that at 3.41am an ambulance crew arrived at the prison, but did not reach Mr Abel's cell until 3.56am. (The prison recorded that the ambulance arrived at the prison entrance at 3.44am.) At 4.18am, paramedics pronounced that Mr Abel had died.

Suicide letters and correspondence

53. After Mr Abel's death, the police found four letters that Mr Abel had addressed to his partner, stepdaughter and family. He wrote that he could not continue living away from them. In the letter to his partner, Mr Abel said that his life was over because she had left him for someone else.

Contact with Mr Abel's family

54. Mr Abel had named a number of family members as next of kin, including his father and partner. The prison also had contact details for Mr Abel's sister. At 7.00am on 18 November, a governor appointed an officer as family liaison officer and, at 8.15am, he left the prison with a chaplain to deliver the news of Mr Abel's death to his father and partner. They tried to visit Mr Abel's father, partner, brother and son, but they did not have the correct addresses.

55. At 1.12pm, the officer broke the news of Mr Abel's death to his son by phone. Mr Abel's son provided the officer with the contact details for Mr Abel's father and shortly afterwards they told him and other family members in person that that Mr Abel had died. He kept in touch with Mr Abel's family and offered support. Mr Abel's partner did not want any further involvement. Mr Abel's funeral was held on 1 December 2016. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

56. After Mr Abel's death, an operational 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.

57. The prison posted notices informing other prisoners of Mr Abel'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 Abel's death.

Post-mortem report

58. A post-mortem examination concluded that Mr Abel died of a haemorrhage (escape of blood) due to incised wounds to the wrist. The toxicology examination found therapeutic levels of citalopram (an antidepressant medication) and NPS in Mr Abel's blood sample. The toxicologist said that he was unable to determine the quantity of NPS that Mr Abel took, or whether he had adverse effects from NPS at the time of his death, (which he said was possible).

Findings

Identifying Mr Abel's risk of suicide

59. Prison Service Instruction (PSI) 64/2011 on safer custody requires all staff contact with prisoners to be aware of the triggers and risk factors that might increase prisoner's risk of suicide and self-harm, and to take appropriate action, including starting ACCT procedures. Mr Abel's risk factors included being recalled to prison, a history of self-harm and suicidal thoughts, substance misuse issues including NPS, depression and relationship problems with his partner.

60. As part of his reception, mental health reviews and screenings, staff asked Mr Abel on a number of occasions if he had any thoughts of suicide and self-harm, he said that he did not. A nurse referred Mr Abel to mental health services because of his history of self-harm. Mr Abel had frequent interactions with staff and prisoners who knew him well and were not concerned about his presentation or behaviour. Staff described Mr Abel as someone with a good sense of humour who never caused concern. He appeared to be positive about the future, was presenting well and appeared focused on succeeding in his drug recovery programme.

61. Mr Abel's suicide notes and interactions with healthcare and DART staff suggested that his relationship with his partner was the main source of anxiety. Not every member of staff was aware of his relationship issues with his partner, but those that did recognised his relationship instability as a risk factor. Staff listened and helped him cope with the situation. Mr Abel never expressed suicidal thoughts and did not self-harm while in Holme House. He was positive, engaged well with DART and interacted well with peers. We believe that the staff's decision not to begin ACCT monitoring for Mr Abel was reasonable.

Clinical care

62. Mr Abel was appropriately referred to the mental health team because of his history of self-harm and because he said that he had taken medication for his depression in the community. Suitable mental health screening and monitoring tools were used to assess Mr Abel which identified that he had mild anxiety and depression. He was also referred to group therapy and was re-referred to the mental health team for another assessment on 28 July when he felt low in mood. The mental health team frequently reviewed Mr Abel and offered him support. We consider that Mr Abel's mental health care and medication were appropriately managed.

63. Mr Abel had a known history of substance misuse in the community and was prescribed methadone when he arrived at Holme House, in line with the prison's drug and alcohol strategy. Healthcare staff started Mr Abel on a methadone reduction programme which he successfully completed on 3 October. Mr Abel met members of the Drug and Alcohol Recovery Team (DART) several times to review his substance misuse plan and he was consistently engaged. They offered him psychosocial interventions and support, and comprehensively recorded their interactions with him. The clinical reviewer concluded that Mr Abel's substance misuse treatment at Holme House was very good and commended the DART team for the care they gave Mr Abel.

NPS

64. Although there is no evidence that staff were aware that Mr Abel was using illicit substances at Holme House, we are concerned by the evident availability of and demand for drugs, in particular in the TCU, whose purpose is to support prisoners who are being treated for, or are recovering from, substance misuse problems.

65. The cellmate told us that he knew that Mr Abel took NPS the day before he died and occasionally in the TCU, where NPS was readily available. The toxicology examination found NPS in Mr Abel's blood sample at the time of his death. Another prisoner told the investigator that prisoners from other units bring drugs to the TCU. An officer told the investigator that there was evidence of drug trafficking (in particular NPS) at Holme House.

66. The prison issued a notice to staff on 24 February 2016 and 31 May 2016, about how to deal with prisoners who have taken NPS. It provided staff with information about the Psychoactive Substances Act 2016. NPS testing was introduced at Holme House in October 2016 as part of the prison's mandatory drug testing but prisoners are not tested for NPS when they undertake voluntary drug testing which is intended to support them when they want to remain drug-free. On 7 November, Mr Abel undertook a voluntary drug test. The presence of NPS was not checked and this was a missed opportunity for staff to identify that Mr Abel was taking NPS, and to offer him support.

67. We are concerned about the prevalence of NPS in prisons and their effect on the behaviours and health of those taking them. In July 2015, we published a Learning Lesson Bulletin about the deaths associated with the use of NPS. We identified dangers to physical and mental health, as well as risks of bullying and debt and possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff of the dangers of NPS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. It is important that prisons do all they can to eradicate the use of NPS and other illegal drugs. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that there is an effective strategy to reduce the supply of and demand for NPS, that staff are vigilant for signs of its use and are briefed how to respond when prisoners appear to be under the influence of such substances and that NPS is included in Voluntary Drug Testing

Emergency response

68. PSI/03/2013, on Medical Emergency Response Codes, says that there should be no unnecessary delay in escorting ambulances and paramedics to the prisoner in an emergency. The paramedics who attended on 18 November noted in the ambulance service records that there was a delay in reaching Mr Abel due to the 'logistics of entering the prison'. It took paramedics 15 minutes to reach Mr Abel's cell, after they arrived at the prison.

69. Mr Abel was alive when staff found him bleeding in his cell on 18 November. The pathologist said that Mr Abel might have been conscious for minutes or even

tens of minutes before losing consciousness. Earlier assistance might have improved the outcome for Mr Abel. We make the following recommendation:

The Governor should ensure that Holme House meets the requirements of PSI 03/2013, that there is no unnecessary delay in paramedics reaching a prisoner in a medical emergency.

The unit manager's interaction with Mr Abel on 17 November

70. It is not disputed that a unit manager told Mr Abel that he did not want to speak to him 'because he did not like him'. However, the impact of this comment is unclear. After Mr Abel's death, a prisoner who was present at the time and heard the conversation told a member of staff what he had heard. He said that Mr Abel looked visibly upset and was staring at the officer as he walked away, until he could not see him anymore. He said that Mr Abel was quiet and looked upset for the rest of association time. As a result of this information, the member of staff submitted an intelligence report.

71. Later, in the morning of 17 November, Mr Abel spoke to the unit manager again. He said that Mr Abel asked him for help with an application for enhanced status for the IEP scheme, and he said that he would help him.

72. The unit manager told the investigator that he may well have said to Mr Abel that he did not like him, but that it was banter. He said that he believed that Mr Abel did not take it seriously because they used to communicate in that way and he had a good relationship with him. He told the investigator that it was not unusual for him to engage with prisoners in this way.

73. The investigator spoke to four prisoners who interacted with Mr Abel on 17 November. They told him that Mr Abel was fine during the whole day. An IMB representative who was at the TCU during the morning also spoke to him, but noted nothing concerning. The investigator reviewed CCTV footage of the unit. It showed nothing concerning in the unit manager's interactions with Mr Abel. We are unable to draw any firm conclusion on the impact of the comment on Mr Abel and therefore make no recommendation but remind the Governor of the need for staff to be aware of the potential impact of their language and actions.

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