Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Hill a prisoner at HMP Hewell on 3 December 2017

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.

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 Lee Hill was found unconscious in his cell at HMP Hewell on 30 November and died in hospital on 3 December. He was 33 years old. I offer my condolences to Mr Hill's family and friends.

Mr Hill died from a lack of oxygen following a heart attack. Mr Hill had a history of substance misuse and prison staff thought that he might have taken illicit substances two days before he died. While drugs were detected in Mr Hill's system, they were not found at levels of acute toxicity that would explain a cardiac arrest.

Mr Hill was strongly suspected of abusing psychoactive substances (PS) at Hewell but we found no direct evidence that PS contributed to Mr Hill's death. We note the efforts which the prison is taking to address the risk of illicit substances

We are satisfied that the prison provided Mr Hill with appropriate support for his drug misuse, however, we identified some weaknesses in ensuring relevant information was available to all staff about Mr Hill's suspected ongoing drug abuse.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **July 2018**

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Summary

Events

1. On 25 August 2017, Mr Lee Hill was sent to HMP Hewell after being sentenced to three months and 20 days imprisonment for theft. This was not his first time in prison. Mr Hill had a history of substance misuse including crack cocaine and heroin. He was prescribed methadone by a prison GP and the substance misuse team monitored his withdrawal from opiates.

2. On 19 October, Mr Hill was released from HMP Hewell but was recalled to prison on 23 November because he had missed appointments with his supervising officer and substance misuse services.

3. On 27 November, Mr Hill was transferred back to HMP Hewell. He was assessed by a nurse in reception who noted that he tested positive for cocaine, opiates and benzodiazepines. A nurse prescriber gave Mr Hill medication to help with the symptoms of withdrawal. Mr Hill did not want methadone and did not want to be located on the substance misuse wing. The substance misuse team noted that Mr Hill had mild withdrawal symptoms and they continued to monitor him.

4. On 28 November, prison staff called an emergency code for Mr Hill's cellmate after they suspected he had taken a psychoactive substance (PS). An officer noted that Mr Hill's speech was slurred and asked him if he had also taken PS but Mr Hill said he had not. The officer did not note any other symptoms of illicit drug use but submitted an intelligence report and asked for Mr Hill and his cell mate to undergo mandatory drug testing.

5. On 29 November, Mr Hill was reviewed by an assistant practitioner in the substance misuse team. The assistant practitioner did not know about the incident with Mr Hill and his cellmate the night before but noted that Mr Hill wanted diazepam for alcohol withdrawal. He told Mr Hill that he could not have this medication because he had no objective symptoms of alcohol withdrawal. Mr Hill went around the wing calling out the names of prisoners and the assistant practitioner said that he thought Mr Hill was trying to get drugs. He did not submit an intelligence report or note this in Mr Hill's prison record.

6. On 30 November, a prisoner who was cleaning the wing heard Mr Hill's cellmate banging on his cell door. He looked through the observation panel and saw Mr Hill lying half off the bed. He called for help and officers called an emergency code, went into the cell and started CPR. They were told by Mr Hills' cellmate that he had taken PS. The control room called an ambulance. Healthcare staff arrived and tried to resuscitate Mr Hill. An ambulance arrived and took Mr Hill to hospital. He was placed on life support.

7. On 3 December, Mr Hill's life support was turned off and he died.

8. The post mortem indicated that Mr Hill died from reduced oxygen supply to the brain during a period of cardiac arrest. The post mortem, which tested for but did not detect PS, showed evidence of prior drug abuse but did not indicate acute toxicity that would explain a cardiac arrest.

Findings

9. Although Mr Hill's post-mortem report indicated that illicit substances did not contribute to his death, he had a history of substance misuse, was suspected to have been under the influence of illicit substances two days before he died and his cellmate indicated he had taken PS before becoming unwell. It is hard not to conclude that PS were involved leading up to his death.

10. Hewell is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them.

11. The prison provided Mr Hill with appropriate support for his drug problems and the clinical reviewer found that Mr Hill received care that was equivalent to that which he could have expected to receive in the community.

12. An assistant practitioner from the substance misuse team who reviewed Mr Hill did not know about the incident where Mr Hill and his cellmate were suspected of taking drugs the day before or that prison staff had referred Mr Hill for mandatory drug testing. The assistant practitioner noted in Mr Hill's medical record that he saw Mr Hill shouting out to other prisoners and thought he was trying to buy drugs during a review, but did not note this in his prison record or submit an intelligence report. This meant that prison staff were not aware of this incident.

13. The prison could not tell us how Mr Hill's mother was informed that he was seriously ill in hospital.

Recommendations

- The Head of Healthcare should ensure that healthcare staff are aware of the importance of recording incidents on NOMIS and reviewing prison records when assessing and monitoring prisoners.

- The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. One prisoner contacted the investigator with general concerns about safety in the prison.

15. The investigator visited HMP Hewell on 6 December 2017. She obtained copies of relevant extracts from Mr Hill's prison and medical records.

16. The investigator interviewed seven members of staff at HMP Hewell on 31 January and 1 February. She interviewed a further four members of staff on 15 and 16 February and 19 March, and two prisoners on 13 February and 26 February.

17. NHS England commissioned a clinical reviewer to review Mr Hill's clinical care at the prison. She participated in interviews at the prison on 31 January.

18. We informed HM Coroner for Worcestershire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. We contacted Mr Hill's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr Hill's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Hewell

21. HMP Hewell is an amalgamation of two prisons: the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local category B prison. Mr Hill was housed at the former Blakenhurst site, which comprises six houseblocks, holding around 1,100 men. Care UK provides health services at Hewell.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported the security was well-managed and generally proportionate, but the availability of drugs remained very high. Mandatory drug testing had exceeded the target for the previous 12 months and 60% of prisoners said that it was easy to obtain illegal drugs. Despite the prevalence of drugs, inspectors found that supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee.

Independent Monitoring Board

23. 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 their latest annual report, for the year to September 2017, the IMB reported that staff and prisoners felt the prison was not safe. Incidents involving psychoactive substances (PS) were regularly reported in the daily briefings but the ready availability of these illicit substances continued to put staff and prisoners at risk.

Previous deaths at HMP Hewell

24. Mr Hill's is the sixth of eight deaths at HMP Hewell since 2017. There were no significant similarities with the circumstances of the previous deaths.

Psychoactive substances (PS)

25. 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 PS 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.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS 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 PS; the need for more effective drug supply reduction strategies;

better monitoring by drug treatment services; and effective violence reduction strategies.

27. 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 PS are included in the testing process.

Key Events

28. On 25 August 2017, Mr Lee Hill was sentenced to three months and 20 days imprisonment for theft and was sent to HMP Hewell. This was not his first time in prison.

29. Mr Hill told a nurse in reception that he had used drugs in the past month and had a history of crack cocaine and heroin misuse. He tested positive for heroin and opiates. The nurse noted that Mr Hill was agitated because he was withdrawing from opiates and referred him to the GP and the substance misuse team. A GP prescribed methadone (used as a substitute drug in the treatment of morphine and heroin addiction).

30. Mr Hill started methadone reduction and was monitored by the substance misuse team for five days. On 14 September, Mr Hill told a member of the substance misuse team he had been taking 600mg of pregabalin in the community to cope with pain from a hand injury. She explained the risks of mixing pregabalin and methadone with other substances and booked Mr Hill an appointment with the GP to discuss his hand injury, but there is no evidence that Mr Hill saw the GP about this. On 20 September, Mr Hill told the substance misuse worker that he was aware of the risks of taking illicit substances and that he was 'not interested in that shit'.

31. On 19 October, Mr Hill was released from prison, but on 23 November, he was recalled to prison because he had not attended appointments with his supervising officer and had not engaged with substance misuse services.

HMP Hewell

32. On 27 November, Mr Hill was sent to Hewell. A nurse assessed Mr Hill in reception and noted no physical health problems. Mr Hill told the nurse that he had used crack cocaine and heroin in the past month. A drug test showed that Mr Hill tested positive for cocaine, opiates and benzodiazepines. The nurse referred Mr Hill to the GP and to the substance misuse team.

33. A nurse prescriber assessed Mr Hill as part of his first night assessment. She said that Mr Hill was 'rude and dismissive' during the assessment, would not give straight answers to her questions and kept smirking and laughing. Mr Hill told the nurse that he smoked five to six bags of heroin a day and five to six stones of crack cocaine and that he last used drugs four days ago. Mr Hill said he last drank alcohol four days ago but could not remember how much he had drunk. The nurse noted that Mr Hill did not show any signs of alcohol withdrawal but that staff would reassess him in the morning.

34. The nurse noted that Mr Hill agreed to be prescribed methadone but later in reception he told another nurse that he wanted lofexadine instead (lofexadine is used to treat the physical symptoms of opiate withdrawal). The nurse said that she did not know why Mr Hill changed his mind about methadone. She noted that another reception nurse told Mr Hill that it was his decision to take lofexadine, but if he started this medication he could not have methadone later.

35. The nurse noted that she told Mr Hill in 'strong terms' not to take any medication that was not prescribed to him or any illicit drugs and that he should not smoke PS because it could be potentially fatal. She told the investigator that she gives these warnings to all prisoners and did not say this to Mr Hill because of anything he had told her specifically. The nurse prescribed mebeverine (used to treat stomach cramps) and naproxen (used to treat pain and inflammation). Mr Hill did not go to the substance misuse wing but was located on a normal wing, Houseblock 6.

36. On 28 November, Mr Hill told an assistant practitioner in the substance misuse team that he did not want to be located on the substance misuse wing because he wanted to be with his cousin. The assistant practitioner noted that Mr Hill's withdrawal symptoms were mild. Nursing staff continued to monitor Mr Hill's withdrawal and medication.

37. At 8.42pm that evening, prison staff found Mr Hill's cellmate lying on the floor of their cell covered in vomit and called a code blue (an emergency code indicating a prisoner is unconscious, not breathing or is having breathing difficulties). A supervising officer (SO) went to Mr Hill's cell and took Mr Hill's cellmate to the shower and Mr Hill offered to clean the cell, which was covered in vomit. The SO noted that Mr Hill's speech was slurred and he 'didn't look to (sic) clever himself'. Mr Hill told the SO that he had just woken up.

38. After Mr Hill had been cleaning the cell for 20 minutes, the SO spoke to him again and noted that his speech had become more slurred. He asked Mr Hill if he had smoked Mamba (a form of PS) but Mr Hill said, 'I don't smoke that shit.' The SO told Mr Hill that his speech was still slurred and Mr Hill again said that he had just woken up. The SO said that Mr Hill had been cleaning the cell for some time and should have woken up by now. The SO said that he had 'some words' with Mr Hill about whether he was under the influence of drugs and Mr Hill said, 'fucking prove it then'. The SO said that was easy enough to do and told Mr Hill to carry on cleaning or he would put him away. Mr Hill said that he would keep cleaning and the SO went to the showers to get Me Hill's cellmate and returned him to his cell.

39. The SO submitted an intelligence report asking for Mr Hill and his cellmate to be put on the list for mandatory drug testing. He said that although Mr Hill was slurring his speech, he was not showing any other signs of having taken an illicit substance and did not need healthcare staff to assess him. He said that Mr Hill was not sweating, was walking around, was steady on his feet and did not fall over at any point, and had cleaned up his cellmate's vomit in the cell. He said he did not know if Mr Hill's speech could have been due to a medical condition, but he submitted an intelligence report to be on the safe side.

40. On 29 November, the assistant practitioner in the substance misuse team reviewed Mr Hill and noted that he was not happy that he was not having alcohol detoxification and asked for diazepam. The assistant practitioner explained that he could not have this because he was not showing any objective signs of withdrawal. Mr Hill said that there was no point in arguing with him and then started walking around the wing shouting out the names of different prisoners. The assistant practitioner said that he thought Mr Hill was doing this to try and

get drugs from other prisoners and noted this in his medical records, but he did not submit an intelligence report or make an entry in Mr Hill's prison record. He told the investigator that when he reviewed Mr Hill, he did not know that a code blue had been called for Mr Hill's cellmate the night before or that the SO suspected Mr Hill might also have been under the influence of drugs.

30 November

41. At 8.30am, Officer A unlocked Mr Hill for the morning. At around 8.45am, Mr Hill spoke to her about adding some phone numbers to his PIN phone account (once prisoners get phone numbers approved, they add money to their account which provides credit to make calls through their PIN phone account). Officer A said that she planned to do this for Mr Hill once the prisoners were locked up again around 9.30am.

42. Mr Hill's cellmate told the investigator that Mr Hill went to the exercise yard that morning and got some PS from a friend. He said that around 9.15am, he smoked the PS with Mr Hill in their cell. At 9.30am, the prisoners on Houseblock 6 were locked in their cells. Officer A locked Mr Hill's cell and she said that he was sitting in his cell with his cellmate.

43. At 10.14am, CCTV footage showed a prisoner cleaning the landing outside Mr Hill's cell. The prisoner said that he had heard noises coming from their cell so looked through the observation panel and saw Mr Hill's cellmate kicking the cell door. He said that he was 'off his face' and Mr Hill was lying half on and half off the bed and he was not moving. The prisoner said he thought Mr Hill looked dead so he called out to prison staff that someone was having a 'Mamba attack'.

44. Officer A heard the prisoner calling out and went to Mr Hill's cell followed by Officer B. They opened the cell door and saw Mr Hill's cellmate near the toilet and Officer A noted that he looked confused. Mr Hill had his chin resting on the mattress on the bottom bunk, his legs were out behind him, and his arms were on the floor. Officer A said that it looked as though Mr Hill had just dropped on the bed and that his position did not look normal.

45. Officer A asked Mr Hill's cellmate what had happened and he said that it was 'Mamba paper'. Officer B checked Mr Hill to try and find a pulse. He found a faint pulse and the two officers moved Mr Hill and placed him in the recovery position. At 10.15am, Officer B called a code blue and the control room called an ambulance.

46. Officer A put her hand in front of Mr Hill's nose and mouth but could not feel him breathing so she started CPR. Officer C arrived and took turns doing chest compressions with Officer A. Officer A said that she noticed Mr Hill's ears and lips had started to go blue and there was no breath coming from his nose or mouth.

47. A prison paramedic heard the code blue and went to Houseblock 6. When she arrived, she saw some officers standing outside and Mr Hill on the floor of the cell with two officers doing chest compressions. She went into the cell and asked for the defibrillator machine. Officer B went to get the this and when he returned, Officer A left the cell and he took over chest compressions with Officer C. The

prison paramedic managed Mr Hill's airway and set up the defibrillator machine. She tried to give Mr Hill fluids but this was not successful. An officer told her that they thought Mr Hill had taken drugs so she gave him some naloxone (a drug which blocks the effects of opioids).

48. At 10.26am, the prison paramedic told one of the officers to ask over the radio for more healthcare staff to attend. She also asked the officers to help her set up some equipment so it would be ready when the other healthcare staff arrived and asked them to check with the control room that an ambulance was on its way.

49. A nurse responded and went to Houseblock 6. When he arrived, he took over management of Mr Hill's airways while the prison paramedic continued managing the resuscitation.

50. At 10.40am, ambulance paramedics arrived and continued trying to resuscitate Mr Hill. At 11.20am, paramedics took Mr Hill to hospital where he was placed on life support.

51. On 3 December, Mr Hill's life support was turned off and he died.

Contact with Mr Hill's family

52. The prison could not say when they told Mr Hill's mother that he had been taken to hospital but she visited him the next day. Mr Hill's uncle and cousin were with him when he died. The prison contributed to the costs of Mr Hill's funeral, in line with national guidance.

Support for prisoners and staff

53. After Mr Hill's death, the Governor 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. The prison posted notices informing other prisoners of Mr Hill's death, and offering support.

Post-mortem report

54. The post-mortem report indicated that Mr Hill died from reduced oxygen supply to the brain that occurred during a period of cardiac arrest. Toxicological analysis showed evidence of prior drug misuse but did not indicate acute toxicity that would explain a cardiac arrest. Synthetic cannabinoids (PS) were not detected.

55. The report indicated that Mr Hill's death may have been caused by sudden arrhythmic death syndrome (SADS) but noted that it is unusual in these cases that the person survives a period of time after cardiac arrest. The report concluded that there was no evidence that Mr Hill's death was due to unnatural causes.

Findings

Illicit substances

56. Although Mr Hill's toxicology report did not indicate the presence of illicit substances at toxic levels that would have contributed to his death, or the presence of PS, he had a history of substance misuse, was suspected to have been under the influence of illicit substances two days before he died and, according to his cellmate, had taken PS before becoming unwell. At interview, two officers said that there were drugs on Houseblock 6 at the time Mr Hill was located there, and one officer said that drugs were a big issue on the wing.

57. It is hard not to conclude that Mr Hill's abuse of illicit substances, including PS, may have played a significant role in his death.

58. At the last HMIP inspection in August 2016, inspectors found that although drugs were widely available, supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee. Hewell holds a weekly PS meeting and a monthly drug strategy meeting and has implemented a number of strategies to reduce the availability of illicit substances in the prison. These strategies include mandatory drug testing, working with the National Drone Team to do random testing and the use of drug detection dogs. The prison is also trialling a swab machine to check mail, an X-ray machine to scan parcels and a body scanner for all visitors.

59. It is clear that the prison is aware of the very serious issues it faces with illicit drugs and, while it has much still to do, it is being proactive in trying to tackle them. We therefore make no recommendation.

Clinical care

60. The clinical reviewer concluded that the care Mr Hill received was equivalent to that which he could have expected to receive in the community.

61. We are satisfied that the prison provided Mr Hill with appropriate support for his drug problems. The clinical reviewer noted that the paramedic in the prison did not have all the equipment available to carry out advanced life support and recommended that the Head of Healthcare discuss the extent of the role of paramedics employed by the prison in emergency responses.

62. When the SO responded to the code blue call for Mr Hill's cellmate on 28 November, he noted that Mr Hill was slurring his speech. The SO said that Mr Hill did not need healthcare assistance as he was not showing any other signs of being under the influence of drugs. Mr Hill told the SO that he had not taken anything, and he told the investigator that he did not know if Mr Hill may have had a medical condition that made him slur his speech. We are satisfied that the SO took appropriate action in noting this incident in Mr Hill's prison record and submitting an intelligence report requesting that he undergo a mandatory drug test.

63. Mr Hill was under the care of the substance misuse team for opiate withdrawal when he died. However, when the assistant practitioner in the substance misuse team reviewed Mr Hill on 29 November, he did not know about the incident the night before (when Mr Hill was suspected of being under the influence of an illicit substance) or that the SO had referred Mr Hill for mandatory drug testing. When Mr Hill went around the wing shouting out to other prisoners during his review, the assistant practitioner noted this in his medical record but did not submit an intelligence report or make an entry in Mr Hill's prison record. This means that prison staff would not have known about this incident.

64. Prison staff did not have access to all available information about Mr Hill's suspected illicit drug use, and healthcare staff did not review Mr Hill's prison record. It is important that staff review and record incidents so that all available information can be considered when reviewing prisoners. Although Mr Hill's post-mortem and toxicology report did not detect the presence of PS, the assistant practitioner's review on 29 November was a missed opportunity to engage with Mr Hill about his drug use. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are aware of the importance of recording incidents on NOMIS and reviewing prison records when assessing and monitoring prisoners.

65. The prison's family liaison officer (FLO) did not know when Mr Hill's mother was told that he was in hospital. The FLO noted that at 9.15am on 2 December, nurses in the hospital said that Mr Hill's mother wanted to visit him. The investigator asked the prison when Mr Hill's mother was told he was in hospital but the prison was unable to find this information. We make the following recommendation:

The Governor should ensure that staff notify a prisoner's next of kin as soon as possible when a prisoner becomes seriously ill.

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