Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ricardo Holgate a prisoner at HMP Birmingham on 26 March 2018

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*

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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 Ricardo Holgate was found dead in his cell at HMP Birmingham on 26 March 2018. He died of coronary artery thrombosis (a blood clot in the heart). The combined effects of psychoactive substances (PS) and codeine were contributory factors. Mr Holgate was 35 years old. I offer my condolences to Mr Holgate's family and friends.

The post-mortem examination showed that Mr Holgate had undiagnosed heart disease. My investigation found that Mr Holgate's blood pressure was never checked at HMP Hewell, his previous prison, and a high blood pressure reading when he arrived at Birmingham was never followed up. I consider the standard of care provided to Mr Holgate was not equivalent to that which he could have expected to receive in the community.

Mr Holgate was suspected of being under the influence of PS on the day before he was found dead. The prison's response to this was inadequate. Staff failed to report their suspicions to healthcare staff until two hours later and then, as Mr Holgate seemed to have recovered by then, healthcare staff did not examine him. At the time of Mr Holgate's death, there was no official prison or healthcare guidance on the management of prisoners suspected to be under the influence of PS.

I am pleased to note that since Mr Holgate's death, Birmingham has introduced new procedures for monitoring prisoners suspected of being under the influence of PS. The prison will need to ensure that the new procedures are followed by all staff so that prisoners suspected of being under the influence are cared for appropriately.

I am concerned, along with HM Inspectorate of Prisons and the Independent Monitoring Board, that PS use among prisoners at Birmingham is rife. While the prison has taken measures to tackle the issue, more needs to be done. I am increasingly concerned by the number of deaths my office investigates in which PS has played at least some part. In the same month that Mr Holgate died, there were two other deaths at Birmingham linked to PS.

I am concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. The Acting Ombudsman also wrote to the Prisons Minister recently setting out concerns at the number of drug-related deaths in custody.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2019**

Contents

Summary 1

The Investigation Process 3

Background Information 4

Key Events 6

Findings 9

Summary

Events

1. On 15 December 2017, Mr Holgate was charged with attempted rape and civil contempt and remanded into custody at HMP Hewell. He did not have an initial health screening as he refused to engage with healthcare staff. On 18 December, Mr Holgate refused to complete his basic custody screening "due to bad detox". Mr Holgate was not referred to the prison's Integrated Substance Misuse Service (ISMS).

2. On 15 January 2018, Mr Holgate was sentenced to six months for civil contempt. He remained on remand for the charge of attempted rape. He was moved to HMP Birmingham on 7 March.

3. When he arrived at Birmingham, Mr Holgate was told about the dangers of psychoactive substances (PS). During an initial health screen, a nurse recorded that Mr Holgate had high blood pressure but this was not followed up.

4. At 3pm on 25 March, an officer suspected Mr Holgate was under the influence of PS. He let him return to his cell to "sleep it off". At 5pm, the officer told two nurses who were on the wing that Mr Holgate had been under the influence earlier that day but appeared fine now. The nurses did not examine Mr Holgate.

5. At approximately 7.49am, an officer went to unlock Mr Holgate's cell. He found him unresponsive lying face down on his bed. The officer immediately called a medical emergency code blue (which indicates that a prisoner is unconscious or is having breathing difficulties) and entered the cell. Control room staff called an ambulance at 7.50am.

6. Two nurses responded to the code blue and arrived at the cell within minutes. Mr Holgate was cold to the touch and there was evidence of rigor mortis. Staff did not attempt cardiopulmonary resuscitation as it appeared he had been dead for some time. At 8.04am, West Midlands Ambulance Service declared Mr Holgate was dead.

7. A post-mortem examination found that Mr Holgate died from coronary artery thrombosis (blood clot in the heart) caused by coronary artery atherosclerosis (hardening and narrowing of the arteries that supply the heart). Toxicology tests showed that Mr Holgate had PS and codeine in his blood which contributed to his death.

Findings

8. Mr Holgate did not receive an initial health screen at Hewell and staff there failed to refer him for support with his substance misuse issues when he told them that he was suffering drug withdrawal symptoms.

9. Mr Holgate's blood pressure was never checked at Hewell and his high blood pressure reading at Birmingham was not followed up in line with national guidance. His care was not equivalent to that which he could have expected to receive in the community.

10. The officer who suspected Mr Holgate was under the influence of PS on 25 March should have reported it to healthcare staff, who should have examined him. At the time of our investigation there was no official prison guidance on the management of prisoners suspected to be under the influence of PS.

11. On 10 September, Birmingham introduced a new joint management plan and incident log (healthcare and operational prison staff) for prisoners who are discovered or suspected to be under the influence of PS.

12. We are concerned at the availability of PS at Birmingham. Despite a comprehensive local drugs strategy, it is clear that more needs to be done to limit supply and demand. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis. We have made a recommendation to this effect to the Chief Executive of HMPPS in a previous investigation and raised our concerns with the prisons minister.

Recommendations

- The Governor at HMP Hewell should ensure that all prisoners suspected of drug misuse are referred to the prison's ISMS for support.
- The Head of Healthcare at HMP Birmingham should implement a blood pressure pathway in line with national health guidance.
- The Governor at HMP Birmingham should ensure that all prison staff are aware of their responsibilities when a prisoner is suspected of being under the influence in line with the new joint management plan introduced in September 2018.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact her. One prisoner contacted her.

14. The investigator obtained copies of relevant extracts from Mr Holgate's prison and medical records.

15. The investigator interviewed seven members of staff and one prisoner at Birmingham on 16 May and 13 June 2018. On 13 June, the investigator also met with the Director and other senior managers to provide initial feedback.

16. NHS England commissioned a clinical reviewer to review Mr Holgate's clinical care at the prison. The clinical reviewer attended all interviews.

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

18. A letter was sent to Mr Holgate's girlfriend and his mother to explain the investigation and to ask if they had any matters they wanted us to consider. Mr Holgate's girlfriend contacted one of the Ombudsman's family liaison officers to say she did not wish to be involved in the investigation. The family liaison officer later spoke to Mr Holgate's mother who raised the following concerns:

    - She believed her son may have taken illicit substances on 24 and 25 March, and that he may have had a medical assessment the evening before he died.
    - When she visited her son in the mortuary it looked like he had a dent in his head. This was approximately two to three inches long, by the right side of his temple. She asked for details of how this happened. She also questioned why he was "blood red" in colour. She explained that his face and head which was clean shaven, was such a pronounced red and asked why.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly. The action plan has been annexed to this report.

20. Mr Holgate's mother and her solicitor received a copy of the initial report. They did not make any comments.

Background Information

HMP Birmingham

21. HMP Birmingham is a local prison which holds up to 1,450 prisoners. It was managed by G4S Care and Justice Services at the time of Mr Holgate's death but is now managed by HM Prison and Probation Service. Birmingham and Solihull Mental Health Foundation Trust continue to provide 24-hour healthcare services at the prison and subcontract Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

22. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham during the week of 30 July 2018, which found the prison to be fundamentally unsafe. On 16 August 2018, HMIP invoked the Urgent Notification (UN) process which committed the Secretary of State to respond publicly to the concerns raised within 28 days. Key findings from the inspection included:

- Levels of violence had increased and when measured over the last 12 months, were the highest for any local prison in the country.
- 71% of prisoners said that they felt unsafe at some time in Birmingham. 37% felt unsafe at the time of the inspection and many reported being bullied or victimised.
- Prisoners were isolating themselves in their cells, refusing to emerge because of their fear of violence. Virtually nothing was being done to support them.
- There was a tenuous lack of control. Accounting for prisoners was poor, with wing staff often not knowing where their prisoners were at any given time.
- Many prisoners were under the influence of drugs and the smell of cannabis and other burning substances pervaded many parts of the prison. Over half the population thought that drugs were easy to obtain. One in seven said that they had developed a problem with illicit drugs since they had been in Birmingham. The trafficking of illegal substances was blatant. It was shocking that many staff did not seem prepared to tackle the drugs misuse.
- Many staff lacked both confidence and competence in key prison skills. Wings were poorly supervised and prisoners routinely disregarded rules even to the extent of open drug use. Living conditions were as poor as seen anywhere in recent years and staff and managers had come to accept the decay in standards.

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 its latest annual report, for the year to 30 June 2017, the IMB reported that healthcare managers had reviewed practices and liaised with prison managers to resolve some of the problems caused by a shortage of staff. Waiting times to see a GP were comparable to those in the community.

Previous deaths at HMP Birmingham

24. Mr Holgate was the 21st prisoner to die at Birmingham since March 2015. Of the previous deaths, four were self-inflicted, 15 were from natural causes and one was drugs related. There have been five deaths since, one self-inflicted, one from natural causes, two drugs related and one awaiting classification. The type of PS (type 5F-ADB) found in Mr Holgate's blood was found in two other prisoners who died in the same month as him. One of those deaths is still being investigated.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious 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 (still at that time 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 PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. HM 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.

Key Events

28. On 15 December 2017, Mr Holgate was charged with attempted rape and civil contempt and remanded into custody at HMP Hewell.

29. When he arrived at Hewell, Mr Holgate refused to leave the prison van. He was placed on report for refusing an order and sent to the care and separation unit (CSU - segregation unit). Mr Holgate did not have an initial health screening as he refused to engage with healthcare staff. A healthcare algorithm completed the following day, 16 December, assessed that Mr Holgate was fit to be held in segregation. A medical examination was not completed.

30. On 18 December, Mr Holgate's prison record shows that he declined to complete his basic custody screening "due to bad detox". Mr Holgate was not seen by or referred to the prison's Integrated Substance Misuse Service (ISMS).

31. On 31 December, Mr Holgate refused to leave the CSU to move to the wing. He wanted a transfer to another prison and said he was happy to stay in the CSU until then.

32. On 15 January 2018, Mr Holgate was sentenced to six months for civil contempt. He remained on remand for the charge of attempted rape and was told he would return to court at a later date.

33. On 31 January, Mr Holgate was seen by a prison physiotherapist after complaining of back pain. He was later prescribed codeine for pain relief.

34. On 7 March, a detective constable submitted an intelligence report to say that one of Mr Holgate's visitors was suspected of bringing drugs in. Prison staff working in the visits hall were briefed but Mr Holgate was moved to HMP Birmingham the same day. This information was not shared with prison staff at Birmingham.

35. Mr Holgate was given a single cell at Birmingham and was seen by the prison's Drug and Alcohol Rehabilitation Team (DART) as part of the normal reception process. They told him about the dangers of using psychoactive substances (PS). Mr Holgate stated that he did not take drugs. During an initial health screen a nurse recorded Mr Holgate's blood pressure as 158/96 (high). Mr Holgate was given a repeat prescription of codeine for back pain.

36. At 3pm on 25 March, an officer saw Mr Holgate walking around the wing looking "a bit stoned". He nodded to Mr Holgate as he walked past but did not speak to him. Two hours later at roughly 5pm, two nurses attended the wing as a number of other prisoners needed medical attention as they were suspected of being under the influence of PS. As the nurses were leaving the wing, the officer mentioned his earlier encounter with Mr Holgate. He said that Mr Holgate appeared fine now and the nurses left the wing without examining Mr Holgate.

37. An officer arrived for duty at roughly 9.15pm that evening. She was unaware that Mr Holgate had been suspected of being under the influence of drugs earlier that day. She completed a roll check of the prisoners on the wing at 9.15pm and then again at 6am the following morning, 26 March. She raised no concerns.

38. An officer arrived for duty at 7.15am that morning. At approximately 7.49am, he went to unlock Mr Holgate's cell. He found Mr Holgate lying on the bottom bunk, face down with his head slightly moved to the side of the edge of the bed. There was a pool of clear liquid on the floor with a small pool of blood in it. The officer immediately called a medical emergency code blue and entered the cell to check his neck for a pulse, which he could not find. Control room staff called an ambulance at 7.50am.

39. Two nurses responded to the emergency call and arrived at the cell within minutes. Mr Holgate was cold to the touch with cyanosis to his face (a bluish colour to the skin due to a lack of oxygen in the blood). A nurse was unable to place an oxygen saturation probe on Mr Holgate's finger due to stiffening of his fingers. As they were unable to find any signs of life and there was evidence of rigor mortis, cardiopulmonary resuscitation was not attempted. At 8.04am, West Midlands Ambulance Service confirmed the presence of rigor mortis and certified Mr Holgate's death.

Contact with Mr Holgate's family

40. Mr Holgate's next of kin was his girlfriend. At 8.30am, the prison family liaison officer (FLO) and the Head of Safer Custody left the prison to travel to Mr Holgate's girlfriend's house in Bristol. When they arrived, Mr Holgate's girlfriend asked if they could contact his mother and brother.

41. The prison FLO was initially unable to contact Mr Holgate's mother as she had moved from her last known address, and her phone number went to an answerphone. They attempted to speak to Mr Holgate's brother but after arriving at his address they had to leave due to safety concerns. Mr Holgate's mother contacted the prison later that day after receiving a call from her son.

42. Mr Holgate's girlfriend later asked that all contact be made through his mother. The prison FLO kept in regular contact with Mr Holgate's mother. Mr Holgate's funeral was held on 25 April 2018. The prison contributed to the cost of the funeral in line with national prison policy.

Support for prisoners and staff

43. After Mr Holgate's death, a custodial 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 Holgate'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 Holgate's death.

Post-mortem report

45. A post-mortem examination found that Mr Holgate died from coronary artery thrombosis (blood clot in the heart) which was caused by coronary artery atherosclerosis (hardening and narrowing of the arteries that supply the heart). Toxicology tests showed that Mr Holgate had PS and codeine in his blood. The pathologist noted that the degree of underlying heart disease might have been

capable of explaining the death in its own right, but he considered that on the balance of probabilities, the PS and codeine could have contributed to his death.

46. The pathologist said that there was no injury to Mr Holgate's head. He said that the pattern of hypostasis (the accumulation of fluid or blood in the body under the influence of gravity after death) indicated that he had been found in a face-down position which could have caused both the red colour of his face and a post-mortem pressure indentation to his head seen by Mr Holgate's mother. He also said the indentation could have been the result of the replaced skull cap having slipped after the post-mortem examination.

Findings

Health care at HMP Hewell

47. Mr Holgate was remanded into custody at HMP Hewell on 15 December 2017. While at Hewell, he did not have an initial or secondary health screening. The clinical reviewer concluded that Mr Holgate did not receive the expected level of health screen assessments at Hewell and we agree.

48. On 18 December, an officer noted in Mr Holgate's prison record that he "declined to complete BCS [basic custody screening] due to bad detox." Mr Holgate was not referred to the prison's Integrated Substance Misuse Service (ISMS) and there is no record of healthcare being informed. On 30 April 2018, the Residential Safety Hub Manager told the investigator by email that all prisoners should have a BCS interview the day after arrival, which details any issues they might have in custody and any support needed. She added that if Mr Holgate had been unable to complete the BCS interview, this should have been flagged to ISMS. If Mr Holgate had been referred, he could have received education and support for suspected drugs misuse. We make the following recommendation:

    The Governor at HMP Hewell should ensure that all prisoners suspected of drugs misuse are referred to the prison's ISMS for support.

Health care at HMP Birmingham

49. At his initial reception screening, Mr Holgate's blood pressure was taken and was noted as being high. There was no follow up. According to national guidance, follow up readings should have been taken.

50. The Head of Healthcare agreed that this was not good practice and told the clinical reviewer that she was currently designing a pathway for blood pressure follow up. This will be based on the Birmingham Community Healthcare Trust Policy to ensure that there are at least three follow up readings after a high reading. We make the following recommendation:

    The Head of Healthcare at HMP Birmingham should implement a blood pressure pathway in line with national health guidance.

51. Mr Holgate did not receive a secondary health screen at Birmingham (a follow up health screen that is expected to be completed within the first two weeks after arrival in prison). Staff thought this was unnecessary as Mr Holgate had been transferred from Hewell and therefore was not a 'new' prisoner. However, Mr Holgate had not received any health screening while at Hewell.

52. The post-mortem examination found that Mr Holgate had undiagnosed heart disease, which was noted as being unusual for a man of his age. His blood pressure was not checked at Hewell and not monitored while at Birmingham.

53. The clinical reviewer concluded that the standard of care provided to Mr Holgate was not equivalent to that which he could have expected to receive in the community.

Staff response to suspicions of being under the influence of PS

54. An officer saw Mr Holgate walking around the wing "looking stoned" at around 3pm on 25 March. He did not report this to healthcare staff until two hours later. The nurses both remember the officer telling them that Mr Holgate had been 'off his face' earlier that day. One of the nurses said that the officer seemed unconcerned during the conversation saying that Mr Holgate was now walking around and had recovered. The nurses left the wing without visiting Mr Holgate.

55. The officer told the investigator at interview that there was no official prison guidance on the management of prisoners suspected to be under the influence of PS. He said, if the prisoner was very unwell healthcare would be called immediately. However, if "someone's not causing any harm to themselves or any others, some just sort of sleep it off". He confirmed that if healthcare staff were not informed an entry would be made in the wing observation book, he would then notify wing staff and "they're put in their cell, in a position that they couldn't throw up in". He said that a prisoner under the influence would never be allowed to return to a single cell on their own.

56. On 25 March, the officer did not make an entry in the wing observation book, did not notify wing staff that Mr Holgate was under the influence and allowed him to return to his single cell by himself 'to sleep it off'.

57. At the time of Mr Holgate's death the officer had been employed by G4S for only ten months, this being his first role within the prison system. He had basic first aid knowledge and no specific drug related training. As an inexperienced officer he made the judgement not to inform healthcare staff at the time of the incident. Healthcare staff should be told about all prisoners suspected of being under the influence at the time. An entry should also be made in the wing history book for all officers to see.

58. One of the nurses told the investigator at interview that on 25 March she saw Mr Holgate from a distance when he was walking back to his cell with a baguette in his hand. She could see his face and at the time did not think he needed further assessment. The other nurse said that she did not have sight of Mr Holgate at that time.

59. Healthcare staff expressed differing opinions on whether medical observations should be taken on a prisoner who was reported to have taken an illicit substance but appeared to be physically well. A nurse who attended the emergency response said that he thought observations should always be taken, whereas other nurses felt that if the prisoner looked well, observations were not required and that sometimes speaking to the prisoner would be enough. As Mr Holgate was walking around and appeared to have recovered the nurses decided not to talk to Mr Holgate directly or take any observations. The clinical reviewer said that this situation was difficult to compare to community care standards but was a prison procedure that required improvement.

60. Healthcare staff told the investigator that they were not always told when a prisoner was suspected of being under the influence. We found no evidence of a healthcare policy or guidance to support the clinical decision-making process. The Head of Healthcare said that healthcare staff were now in talks with G4S

designing a shared standard operating procedure (SOP) for all operational and healthcare staff to follow when someone is suspected of being under the influence.

61. The Head of Safer Custody provided a copy of the draft policy. In July 2018, two wings trialled (for one month) a new management plan and incident log for prisoners who were discovered or suspected of being under the influence of PS. The plan instructed that, if a prisoner was suspected of being under the influence of an illicit substance, operational staff would call for healthcare to attend. A first-line manager (FLM) would also attend. If the prisoner was unconscious/unresponsive an emergency response code would be called. The following actions should also happen:

- It is not for wing staff to "diagnose" the condition of the prisoner or assume what is causing it. They should not automatically assume they have taken an illicit substance.
- Healthcare will check the prisoner's observations and will later cross reference this with the person's medical records. They will then advise if it is their medical opinion that the prisoner is under the influence of an illicit substance or something he is not prescribed to take.
- The FLM will start a welfare log to record the prisoner's behaviour. Healthcare will also complete a section of the log to record observations and any outcomes.
- The prisoner will be placed on report, have an immediate IEP review and will be seen by a member of the DART within 72 hours.
- An intelligence report will be completed and an appropriate NOMIS entry and record made in the wing observation book.
- The completed welfare log will be filed in the prisoner's prison record and the FLM will send an electronic copy to the DART.

62. On 10 October, the investigator spoke to the Community Engagement Manager for an update on the new management plan. He said that the new management plan was rolled out throughout the whole prison on 10 September.

63. He said that while it was working well, they were experiencing some difficulty with getting the wing FLMs to submit the electronic version to the DART admin team who would then manage the database. He said this was down to educating the FLMs about the new procedures. He said that there was lots of work being done to resolve this to ensure they capture every incident and by doing so ensure they give the best immediate and post care treatment to the prisoners in their care.

64. Birmingham are making positive steps trying to tackle the issues around PS use. However, while there are teething problems with this new management plan we make the following recommendation:

The Governor at HMP Birmingham should ensure that all prison staff are aware of their responsibilities when a prisoner is suspected of being under the influence in line with the new joint management plan introduced in September 2018.

Illicit substances

65. While Mr Holgate was at Hewell, intelligence suggested that a known person was bringing drugs into Mr Holgate during visits. Mr Holgate was moved to Birmingham and this intelligence was not pursued. When he arrived at Birmingham, staff told Mr Holgate about the dangers of using PS and he said he did not use drugs.

66. We note that the type of PS found in Mr Holgate's blood (type 5F-ADB) was also found in two other prisoners who died at Birmingham in the same month as him. The police opened an investigation into how the drug had been trafficked into the prison, but no charges were brought and the case has been closed.

67. A prisoner asked to meet with the Ombudsman's investigator during her visit because he was concerned about the rising numbers of drug related incidents in the prison. He said the prison was now unsafe for both officers and prisoners. PS attacks were a daily occurrence and he believed that prisoners were being left unmonitored in their cells without healthcare being aware.

68. The prisoner said that prisoners knew that the prison did not have CCTV and were openly using drugs on the wings. Those addicted would often sell belongings to buy drugs. He said that unless the issue was tackled now there would be more deaths from PS.

69. This investigation found that Birmingham is undertaking a number of measures to tackle the problem of PS, including the use of search dogs, cell searches, processing mail and using fabric checks to look for illicit items in cells or suspicious behaviour of prisoners.

70. We accept that Birmingham has a drug strategy in place and staff are working hard to implement it. Nevertheless, the HMIP report indicated that drugs are easily accessible to prisoners, the trafficking of illegal substances was blatant and many staff did not seem prepared to tackle substance misuse. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.

71. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Birmingham and it is obviously a cause for concern that Mr Holgate was apparently able to obtain and use illicit drugs so readily.

72. Birmingham is not alone in facing this problem – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

73. In a recent investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive has told us that HMPPS plans to issue a national drug strategy in the autumn of 2018. We therefore make no further recommendation.

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