

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Jamie Inglis a prisoner at HMP Elmley on 3 December 2017

A report by the Prisons and Probation Ombudsman

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 Jamie Inglis died in hospital on 3 December 2017 having been found unresponsive in his cell at HMP Elmley two days before. He died of a lack of oxygen to the brain, most likely caused by co-codamol toxicity. Mr Inglis was 42 years old. I offer my condolences to Mr Inglis's family and friends.

Mr Inglis was not prescribed co-codamol and must have obtained it illicitly within the prison. He had a long history of substance misuse. I am concerned that an opportunity was missed to refer Mr Inglis for help with his substance misuse issues when he arrived at Elmley. The investigation also found that when Mr Inglis was found under the influence of illicit substances on two occasions, staff did not refer him to the substance misuse team or report the incidents to the security department as they should have done.

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

October 2018

Contents

Summary.....	1
The Investigation Process.....	3
Background information.....	4
Key Events.....	6
Findings.....	10

Summary

Events

1. On 28 October 2017, Mr Jamie Inglis was sent to HMP Elmley. At an initial reception screen, a nurse recorded that he had recently used illicit drugs but did not consider a substance misuse referral. On 30 October, Mr Inglis made cuts to his face with a razor blade and prison staff started suicide and self-harm prevention procedures (known as ACCT). The next day, Mr Inglis told staff that he was being bullied and they arranged for him to move houseblocks.
2. On 9 November, a mental health nurse saw Mr Inglis for an initial assessment and offered support. Over the next three weeks, prison and healthcare staff saw Mr Inglis under the influence of illicit substances and attempting to conceal his medication on several occasions. Prison staff monitored Mr Inglis frequently and stopped ACCT procedures on 21 November, when he reported feeling more settled after the change of houseblock.
3. On 1 December, Mr Inglis reportedly told one of his cellmates that he had taken several co-codamol tablets. At around 5.30pm, Mr Inglis and his two cellmates returned to their cell for the evening. Later that evening, his cellmates found him crouched unresponsive in front of the toilet.
4. At around 7.20pm, an officer heard prisoners banging and a cell bell. He went to Mr Inglis's cell and one of Mr Inglis's cellmates told him that Mr Inglis had died. The officer saw Mr Inglis in front of the toilet and, at 7.25pm, called an emergency medical code. Officers entered the cell within 30 seconds and started cardiopulmonary resuscitation (CPR). A nurse arrived within six minutes and requested assistance from a prison GP, who arrived four minutes later. Paramedics arrived at 7.51pm and took Mr Inglis to Medway Maritime Hospital at 8.51pm.
5. Hospital staff admitted Mr Inglis to the Intensive Care Unit where his condition continued to deteriorate. On 3 December, at 12.15am, a hospital doctor pronounced that Mr Inglis had died.
6. The post-mortem report concluded that Mr Inglis died from a hypoxic brain injury (lack of oxygen to the brain), which was probably caused by co-codamol toxicity. (Co-codamol is a painkiller containing paracetamol and codeine.) Mr Inglis had never been prescribed co-codamol but a packet was found in his cell just before he was taken to hospital.

Findings

7. Mr Inglis had a long history of substance misuse. We are concerned that he was not referred for help with his substance misuse issues following the initial reception screening. We are also concerned that he was not referred, and minimal action was taken, when staff observed him under the influence of illicit substances and attempting to conceal his prescribed medication.
8. We found that staff did not follow the post-closure procedures after they stopped ACCT monitoring.

9. We also found a deficiency in the emergency response, although the delay would not have affected the outcome for Mr Inglis.

Recommendations

- The Governor and Head of Healthcare should ensure that:
 - prisoners who use illicit substances are referred to drug treatment services and warned about the dangers and risks to health; and
 - The drug and alcohol strategy is reviewed to ensure staff are fully aware of their responsibilities for reporting and acting on instances of concealing medication and illicit drug misuse.
- The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, ensuring post-closure reviews take place at the proper time and take into consideration events following the closure of the ACCT.
- The Head of Healthcare should ensure that all healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including responding to emergency medical codes without delay.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator visited HMP Elmley 14 December 2017. He obtained copies of relevant extracts from Mr Inglis's prison and medical records and interviewed two prisoners.
12. The investigator interviewed six members of staff and one prisoner at Elmley on 12 January 2018.
13. NHS England commissioned a clinical reviewer to review Mr Inglis's clinical care at the prison.
14. We informed HM Coroner for Mid Kent and Medway of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Inglis's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Inglis's mother wanted to know:
 - how Mr Inglis's risk of substance misuse was managed;
 - whether the prison's mental health team assessed him; and
 - what happened when Mr Inglis was taken to hospital on 1 December.
16. Mr Inglis'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.
17. 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 Elmley

18. HMP Elmley serves the courts in Kent and holds up to 1,252 men, remanded and sentenced, in six houseblocks, with a mixture of single, double and triple cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Forward Trust provides substance misuse services.

HM Inspectorate of Prisons

19. The most recent inspection of HMP Elmley was in November 2015. Inspectors reported that a greater number of prisoners than would be expected in similar prisons said it was easy to obtain illegal drugs, and slightly more prisoners than expected provided positive samples at mandatory drugs tests. Inspectors reported that drug and alcohol dependent prisoners could access prompt and flexible treatment, and there was a good range of substance misuse support programmes.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 October 2017, the IMB reported that illicit substances entering the prison were a growing problem that resulted in violence, self-harm and assaults. They highlighted ongoing work by the security team to gather intelligence and conduct targeted searches. They reported that the mental health team provided an excellent service, but were challenged by the amount of mental health issues throughout the prison.

Previous deaths at HMP Elmley

21. Mr Inglis was the 21st prisoner to die at Elmley since December 2014. Of the previous deaths, 16 were due to natural causes, three prisoners took their own lives and one died as the result of a drugs overdose in November 2017. In our report into that death, we found that it was too easy for prisoners to obtain illicit substances and that more needed to be done to prevent the diversion of prescribed medication.

Assessment, Care in Custody and Teamwork

22. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service

Instruction (PSI) 64/2011, Management of prisoners at risk of harm, to self, to others and from others (Safer Custody).

Key Events

23. On 13 May 2017, Mr Jamie Inglis was convicted of possession of a bladed article and sent to HMP Wandsworth. On 9 June, he was sentenced to eight months in prison and was transferred to HMP Thameside. Mr Inglis had substance misuse problems and mental health issues and was frequently subject to self-harm and suicide prevention measures, known as ACCT. Records show that he reported a history of drug overdoses to staff at Thameside and that he received support from the prison's mental health team. Mr Inglis was released on 12 September, but was recalled to HMP Elmley for nine days on 20 September for breaching the conditions of his licence.
24. At an initial reception screen, a nurse recorded that Mr Inglis suffered from epilepsy and appeared intoxicated. He assessed him as not suitable for in-possession medication and made a substance misuse and mental health referral. A prison GP prescribed olanzapine (an antipsychotic medication), pregabalin (a medication used to treat epilepsy and nerve pain) and clonazepam (a medication used to prevent seizures). On 29 September, a nurse reviewed Mr Inglis prior to his release and recorded that he appeared calm and relaxed. He did not report any health concerns, but he did mention his substance misuse history. The nurse gave Mr Inglis harm reduction advice and confirmed he had a community GP.
25. On 28 October, Mr Inglis was remanded to custody for possession of a bladed article and sent to Elmley. At an initial reception screen, a nurse assessed Mr Inglis as suitable for in-possession medication despite noting that he had used illicit substances within the last month. She made a referral to the prison's mental health in-reach team, but there is no record that she considered a substance misuse referral. Healthcare staff offered Mr Inglis a secondary health screen the next day, but he refused to engage.
26. On 30 October, Mr Inglis declined a triage assessment with a mental health nurse and failed to attend a GP appointment. Later that day, prison staff found Mr Inglis with superficial cuts to his face and he said he had self-harmed using a razor blade. A prison paramedic examined him and arranged for his admission to the prison's inpatient department for monitoring. A nurse completed a care plan and identified Mr Inglis's history of drug overdoses as a risk factor, although there is no record he considered a substance misuse referral. Prison staff started ACCT procedures and noted that Mr Inglis reported feeling depressed due to concerns about his family.
27. On 31 October, a nurse noted Mr Inglis was subject to ACCT procedures and assessed him as not suitable for in-possession medication. Another nurse saw Mr Inglis for a review, recorded that he presented as anxious and stressed and referred him for a mental health triage assessment following discharge from the inpatient department. Later that day, after a nurse had discharged him, Mr Inglis asked prison staff if he could move to a different houseblock as prisoners were bullying him. Staff held an ACCT case review and arranged for Mr Inglis to move houseblocks.

28. On 7 November, at an ACCT case review, Mr Inglis told staff that he had tried to self-harm the previous day but his cellmate had stopped him. He said that he felt his psychiatric medication was not working and a nurse referred him for a medication review. On 9 November, a mental health nurse saw Mr Inglis for a triage assessment and recorded that he thought quetiapine (an antipsychotic medication) would be better than olanzapine. Mr Inglis denied ongoing substance misuse problems, but admitted to using illicit drugs prior to his arrival at Elmley. The nurse added Mr Inglis to her caseload and on 13 November, requested further information from his local community mental health service to assist her in formulating a care plan.
29. On 15 November, a nurse saw Mr Inglis attempting to conceal pregabalin at the medication hatch. She noted that she would write to Mr Inglis, but there is no record that she did. The Head of Healthcare told the investigator that such letters usually warn prisoners that a GP will review their prescription if they continue to conceal medication.
30. Later that day, a mental health nurse spoke to Mr Inglis through his cell door as officers were dealing with another matter and were unable to unlock him. She told Mr Inglis that she had requested his community mental health history and had arranged for him to see a psychiatrist for a medication review.
31. On 21 November, the mental health nurse reviewed Mr Inglis's electronic medical record to complete a risk assessment and recorded that he had ongoing support from the prison's substance misuse team. She told us that despite recognising this was different to what Mr Inglis had initially told her, she did not feel the need to check the information was correct, as she did not have any concerns about his substance misuse.
32. Later that day, prison staff held an ACCT case review and decided to close the ACCT as Mr Inglis no longer reported any issues and had settled since moving houseblock.
33. Also on 21 November, a nurse noticed that Mr Inglis appeared under the influence of illicit substances and she refused to issue his medication. On 23 November, an officer recorded that Mr Inglis was observed under the influence of illicit substances and concealing medication. There is no record that staff considered taking any disciplinary action or making a substance misuse referral.
34. On 27 November, a prison psychiatrist noted that Mr Inglis had failed to attend an assessment meeting. Two days later, a mental health nurse saw Mr Inglis for a review. Mr Inglis said that he had attempted to attend his psychiatric appointment, but that staff in the healthcare department had turned him away. The nurse booked him another appointment and recorded that his presentation had improved since she last saw him. Mr Inglis said that he needed his clonazepam reviewing and she advised him to discuss this during an upcoming GP appointment, on 5 December.

Events from Friday 1 to Saturday 3 December

35. On 1 December, during afternoon association, Mr Inglis told one of his cellmates that he had taken several co-codamol tablets (a pain relief medication containing

paracetamol and codeine, an opiate). At around 5.30pm, Mr Inglis and his two cellmates returned to their cell for the night. At interview, his cellmates told the investigator that they started talking, playing cards and watching television as normal. During this time Mr Inglis went to the toilet, and after about 25 minutes, his cellmates decided to check on him. One of them opened the door and they immediately noticed Mr Inglis unresponsive, crouched in front of the toilet. They alerted staff.

36. At around 7.20pm, while conducting his evening checks, an officer heard banging and a cell bell. He identified the cell and made his way to the ground floor. When he arrived, he looked through the cell observation hatch. One of Mr Inglis's cellmates told him that Mr Inglis had died and moved out of the way so that he could see into the cell. At 7.25pm, the officer used his radio to call an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems). Control room staff called an ambulance at 7.26pm. CCTV shows that the officer opened the door within 30 seconds and that officers arrived with a defibrillator as he entered the cell. The officer asked Mr Inglis if he was okay and noticed that he was unresponsive. He moved him onto the floor, checked for a pulse and started cardiopulmonary resuscitation (CPR).
37. In the meantime, a nurse put the controlled medication away and made her way to Mr Inglis's cell with an emergency medical bag. She arrived within six minutes and saw that officers had attached a defibrillator to Mr Inglis. The nurse used a suction device to clear Mr Inglis's airway and requested assistance from a prison GP. The GP arrived around four minutes later and assisted staff with the resuscitation attempt.
38. Paramedics arrived at 7.51pm and moved Mr Inglis onto the wing landing for greater accessibility. At around the same time, staff noticed a box of 30 co-codamol 30/500 tablets (30/500 – 30mg codeine to 500mg paracetamol, the highest strength) in Mr Inglis's cell. Emergency life support continued and paramedics transferred Mr Inglis to Medway Maritime Hospital at 8.51pm. Two officers escorted him, without restraints.
39. Mr Inglis was admitted to the Intensive Care Unit where he was placed on life support. Healthcare staff maintained regular contact with the hospital for updates on Mr Inglis's condition, which continued to deteriorate. On 3 December, at 12.15am, a hospital doctor pronounced that Mr Inglis had died.

Contact with Mr Inglis's family

40. On 1 December, at 8pm, the prison appointed a prison chaplain as family liaison officer. At 8.45pm, the chaplain arrived at the prison and noted that Mr Inglis had nominated his mother as his next of kin. At 11pm, the chaplain and a prison manager arrived at Mr Inglis's mother's address in south London. They told her that Mr Inglis was in a critical condition at Medway Maritime Hospital and offered her a taxi. Mr Inglis's mother declined, preferring to wait until the next day. She told them that Mr Inglis had a wife, who she thought lived in Sittingbourne, Kent.
41. At around 7.15am on 2 December, the chaplain phoned Mr Inglis's mother and arranged for a taxi to take her to Medway Maritime Hospital. He met Mr Inglis's family just after 12pm, and one of Mr Inglis's sisters contacted his wife, who

arrived shortly afterwards. On 3 December, at 2am, a prison manager informed the chaplain that Mr Inglis had died. The chaplain made several attempts to phone Mr Inglis's mother, but he could not get through to her. At 11.20am, he contacted the hospital and staff confirmed that they had broken the news to Mr Inglis's mother.

42. On 4 December, the chaplain and a colleague visited Mr Inglis's wife at her home address to offer their condolences and support. Afterwards, they travelled to Mr Inglis's mother's address to discuss the next steps and to offer support. The chaplain provided ongoing support until Mr Inglis's funeral, which he conducted, on 22 December. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

43. After Mr Inglis's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
44. The prison posted notices informing other prisoners of Mr Inglis'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 Inglis's death.

Post-mortem report

45. A post-mortem examination found that the most likely cause of death was cardiac arrest following a period of respiratory depression caused by co-codamol toxicity. The report noted that it was not possible to confirm this, as no toxicology samples were retained in the interval between Mr Inglis's hospital admission and his death.

Findings

Clinical care

46. Mr Inglis had a history of self-harm and mental health issues. Prison GPs at Elmley prescribed appropriate medication and mental health staff completed an appropriate assessment and care plan. The clinical reviewer considered that Mr Inglis was offered appropriate support for his health needs. We are satisfied that Mr Inglis received a good standard of clinical care at Elmley, equivalent to that which he could have expected to receive in the community.

Substance misuse

47. Mr Inglis had a significant history of dangerous drug taking and had previously received substance misuse support in prison. We are concerned that although Mr Inglis reported recent illicit drug use at his initial reception screen on 23 October, there is no record that a referral to the substance misuse team was considered. The Head of Healthcare told the investigator that the nurse did not make a referral as Mr Inglis did not raise any concerns about his substance misuse. Despite this, we consider that staff missed an early opportunity to try to address Mr Inglis's substance misuse and to limit any impact that it may have had on his health and wellbeing.
48. The post-mortem gave the most likely cause of Mr Inglis's death as co-codamol toxicity. Mr Inglis was not prescribed co-codamol and so he must have obtained it illicitly. Prisoners who knew Mr Inglis said that he frequently used illicit substances in prison and that he would stockpile his prescribed medication so that he could take a large amount in one go, for what he called a "day out". A prisoner also told us that he remembered seeing Mr Inglis under the influence of illicit substances. We are concerned that Mr Inglis was seemingly able to conceal his own medication and to obtain other illicit drugs so easily.
49. Mr Inglis presented to staff as under the influence of illicit drugs on at least two occasions. However, there is little evidence that prison or healthcare staff took any action following these events and no record that they submitted intelligence reports. At interview, the Head of Security told us that there is an expectation on staff to submit intelligence reports if they suspect a prisoner has taken illicit drugs. He said that this helps to identify the need for suspicion based drug testing and cell searches. Although Elmley's drug and alcohol strategy (2017-2019) states that all prisoners who test positive for drugs should be referred for a substance misuse assessment, it does not reflect the expectation that staff should submit intelligence reports. The prison needs to do more to address the findings of this investigation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that:

- **prisoners who use illicit substances are referred to drug treatment services and warned about the dangers and risks to health; and**
- **the substance misuse strategy is reviewed to ensure that staff are fully aware of their responsibilities for reporting and acting on instances of concealing medication and illicit drug misuse.**

50. In a recent investigation into another death at Elmley, we found that the prisoner in that case had also taken medication that had not been prescribed to him. As a result of our recommendation made in that case, aimed at reducing diverted medication, the prison has told us that substance misuse staff now discuss any suspicions that prisoners are diverting medication at a daily multidisciplinary meeting and ensure that medication reviews are scheduled. We therefore make no recommendation.

ACCT procedures

51. Prison staff managed Mr Inglis under ACCT procedures from 30 October until 21 November. Multidisciplinary reviews were held with mental health staff, clinical staff, chaplaincy staff and officers, together with Mr Inglis, attending. A caremap was completed and proposed that staff support Mr Inglis by making a referral to the prison's mental health team. When Mr Inglis reported bullying on 31 October, staff promptly held an ACCT case review and moved him to another houseblock. Prison staff monitored Mr Inglis's reported conflict with prisoners during his ACCT case reviews and records show that he did not report any concerns following his move. We are satisfied that this action was appropriate.
52. Prison Service instruction (PSI) 64/2011 'Safer Custody' sets out the processes that all staff should follow when monitoring prisoners under ACCT procedures. It states that a post-closure interview should be held within seven days of an ACCT being closed. We are concerned that staff did not hold a post-closure interview with Mr Inglis, having closed the ACCT on 21 November. This meant that there was little consideration of how Mr Inglis had progressed since the ACCT had been closed. We make the following recommendation:

The Governor should ensure that staff manage prisoners identified as at risk of suicide or self-harm in line with national guidelines, ensuring post-closure reviews take place at the proper time and take into consideration events following the closure of the ACCT.

Emergency response

53. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Elmley's local policy instructs staff to use a medical code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for a member of healthcare staff to attend.
54. The officer responded quickly when he heard a cell bell and Mr Inglis's cell mates banging on the cell door. He used an appropriate emergency medical code and control room staff called an ambulance immediately, in line with prison service instructions. Additional officers attended with a defibrillator and the officer appropriately started CPR.
55. When the nurse heard the code blue, she continued to put the controlled medication away before making her way to Mr Inglis's cell. She told us that she wanted to make sure prisoners could not access the medication before leaving. The Head of Healthcare told us that a nurse could just lock the door and leave

the medication secure. Although the security of controlled medication is important, we consider that the nurse should have locked the door and should have responded to the code blue immediately. We do not consider that the delay responding to the code blue changed the outcome for Mr Inglis but, in other circumstances, it could be crucial. We therefore make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including responding to emergency medical codes without delay.

56. The clinical reviewer concluded that, overall, the resuscitation was carried out swiftly and professionally.

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