

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Cole a prisoner at HMP Cardiff on 6 December 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Christopher Cole died of bronchopneumonia and methadone use on 6 December 2016 at HMP Cardiff. He was 27 years old. I offer my condolences to his family and friends.

Mr Cole had a history of substance misuse, and received methadone treatment at Cardiff. We are concerned that no one tested Mr Cole for drugs to determine his recent drug use and level of dependency, that the dose of methadone that Mr Cole was initially administered was higher than national guidelines indicate and that there is no record to explain this decision.

Nevertheless, we accept that Mr Cole did not display any symptoms of bronchopneumonia or signs that his physical health had declined, and we are otherwise satisfied that the treatment he received at Cardiff was equivalent to that which he could have expected to receive in the community.

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

January 2018

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Summary

Events

1. On 17 October 2016, Mr Christopher Cole was released on licence from HMP Parc. He was recalled to HMP Cardiff on 29 October 2016 for a public order offence.
2. At his initial health screen, a healthcare assistant noted that Mr Cole had anxiety and depression. He noted that Mr Cole had a history of drug and alcohol misuse, but that he denied taking any drugs before he arrived at prison. A drugs test was not carried out to verify this. The healthcare assistant referred Mr Cole to the mental health team and drug and alcohol support services. At a second health screen, a nurse noted that he appeared psychotic and prescribed 10mg of olanzapine (an antipsychotic medication).
3. A few days later, Mr Cole saw a substance misuse worker and said that he was likely to take opioids (a class of drugs including heroin) when he was released, and he wanted help. The substance misuse worker considered Mr Cole's long history of substance misuse, and that it was linked to his offending behaviour. He referred him to Dyfodol (a community drug and alcohol support service), who agreed to support him with methadone treatment on release.
4. A psychiatrist assessed Mr Cole on 17 November and noted that he was disordered and distracted. Mr Cole told him that he had taken 'spice', a new psychoactive substance (NPS – a range of drugs designed to mimic established illicit drugs). The psychiatrist noted he was probably in a drug-induced psychosis. This intelligence was not passed to prison staff. The psychiatrist increased Mr Cole's olanzapine to 15mg.
5. On 28 November, Mr Cole became disruptive and prison staff took him to the Care and Separation Unit (CSU) for observation. A psychiatric nurse assessed him, and he later admitted he had taken spice. He said he was being bullied and was in debt to other prisoners. The next day, Mr Cole was re-located to the healthcare unit. The psychiatric nurse noted that spice and a lack of sleep had affected his mental health. Generic mental health care plans were created to manage his hygiene, sleep and eating.
6. On 1 December, a prison GP prescribed Mr Cole his first dose of 30ml methadone, which he continued to take daily under supervision. (The investigator was unable to interview the doctor who made this decision as she was on long term sick leave for the duration of the investigation.) In her absence, there is no evidence or documentation explaining this decision. Although Mr Cole's care plan was not updated to reflect his methadone treatment, healthcare staff checked him frequently throughout the day and night in line with his care plans. He did not complain about or display any symptoms of bronchopneumonia, or any other physical health problems.
7. On 5 December, the psychiatrist noted that Mr Cole appeared to be settling and that he was to remain in healthcare, and reviewed a week later.

Events of 6 December

8. A nursing assistant noted that hourly checks had been carried out through the night and there were no issues or concerns. At 4.51am, he recorded that Mr Cole had been settled, and slept. At 8.07am, a nurse called Mr Cole for his medication and asked an officer to unlock his cell. She saw he was unresponsive and immediately alerted another nurse who began cardiopulmonary resuscitation. An officer telephoned the control room for an ambulance, which arrived at 8.15am. The paramedic continued to treat Mr Cole but he was declared dead at 8.26am.

Findings

9. The post-mortem examination concluded that a combination of bronchopneumonia and methadone use caused Mr Cole's death.
10. Mr Cole was located in the healthcare unit and subject to regular observations by healthcare staff. He did not show any signs of bronchopneumonia or a decline in his physical health. We agree with the clinical reviewer who concluded that, overall, the treatment Mr Cole received at Cardiff was equivalent to that which he could have expected to receive in the community.
11. However, a drugs test was not carried out at any point to verify whether Mr Cole had taken any drugs, and determine his level of dependency. While we consider that the decision to administer methadone treatment to Mr Cole was appropriate, the initial dose prescribed to Mr Cole exceeded that advised in national and local guidelines for prescription in the absence of an understanding of his tolerance.
12. Mr Cole's medical record does not explain the GP's decision to prescribe a 30ml dose of methadone, and in the absence of records about the decision making process, we cannot conclude whether Mr Cole's care in this regard was equivalent to that which he could have expected to receive in the community.
13. Intelligence was not shared about his use of NPS or associated debt and bullying at Cardiff as we would have expected.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
 - Carry out drugs tests for new arrivals with a history of substance misuse; and
 - Record sufficient detail about a prisoner's tolerance of methadone to support the dose of methadone prescribed in line with national guidelines.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Cardiff informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
15. The investigator visited Cardiff on 11 April 2017. She obtained copies of relevant extracts from Mr Cole's prison and medical records.
16. Healthcare Inspectorate Wales commissioned a clinical reviewer to review Mr Cole's clinical care at the prison.
17. The investigator and clinical reviewer interviewed three members of staff at Cardiff on 11 April 2017.
18. We informed HM Coroner for Bridgend and Glamorgan Valleys of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers, contacted Mr Cole's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Cole's mother asked for a full chronology of events and asked us to consider why he was in the healthcare unit, what medication he was taking and whether he was seen the night before he died.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.
21. Mr Cole's mother received a copy of the initial report. She did not make any comments.

Background Information

HMP Cardiff

22. HMP Cardiff is a Category B local training prison that holds around 800 men, mostly from South East Wales. Many of the prisoners come from local courts on remand. Cardiff and Vale University Health Board is responsible for delivering primary, physical and mental health services at the prison. There is a 22 bed healthcare centre providing 24 hour nursing care and a full time doctor's service between 8.00am and 5.00pm on weekdays and a 24-hour on call provision 7 days a week.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Cardiff was in July and August 2016. Inspectors were concerned that healthcare staff were not examining clinical reviews about deaths in custody, which meant that learning opportunities were missed. They said that inpatient beds were being used inappropriately for non-clinical reasons. Inspectors found that while service provision for serious physical illness was good, there were gaps in service provision for men with mild to moderate mental health problems. They said that there was an increased availability and use of NPS, which led to an inevitable increase in unpredictable and violent behaviour. Inspectors were concerned that supply reduction work lacked rigour and co-ordination, that there was no supply reduction action plan and that suspicion testing was not usually completed. They made recommendations to address these issues.

Independent Monitoring Board

24. 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 September 2016, the IMB reported that the availability of new psychoactive substances (NPS) had increased and that staff shortages had been a factor in fewer staff being available to carry out searches and multi-disciplinary team procedures.

Previous deaths at HMP Cardiff

25. Mr Cole was the fourth prisoner to die from natural causes at Cardiff since January 2014. There have not been any deaths since. There were no similarities between the circumstances of Mr Cole's death and previous deaths at the prison.

New Psychoactive Substances (NPS)

26. New 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 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.

27. 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.
28. HM Prisons 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

Background

29. On 17 October 2016, Mr Christopher Cole was released on licence from HMP Parc after he served a four month sentence for assault. On 29 October 2016, he was recalled to HMP Cardiff for a public order offence, a breach of his licence conditions.

HMP Cardiff

30. At his initial health screen, a healthcare assistant noted that Mr Cole had suicidal thoughts in 2015, and depression and anxiety, for which he had been prescribed diazepam. He had a history of mental health problems for which he had been prescribed olanzapine (an antipsychotic medication).
31. He noted that Mr Cole appeared physically fit and well, but that he had used several illicit drugs in the past. Mr Cole told him that he had not used drugs in the last month; no one carried out a drugs test to verify this. Mr Cole said he drank 50 units of alcohol per week. (Men are advised not to drink more than 14 units a week.) The healthcare assistant referred Mr Cole to the mental health team, drug and alcohol support services and for a second health screening.
32. At Mr Cole's second health screening on 30 October, a nurse assessed that he appeared psychotic. She noted he had a history of overdose, self-harm and substance misuse and assessed him as unsuitable to have medication in possession. She prescribed Mr Cole 10mg of olanzapine.
33. On 31 October, a senior offender interventions practitioner saw Mr Cole who told him he was likely to take opioids (a class of drugs, including heroin) on release and wanted to address his substance misuse issues. He considered Mr Cole's long history of substance misuse, which was linked to his offending behaviour, and considered methadone treatment (an opiate replacement program to minimise the risk of an overdose upon release, administering a small dose of methadone, gradually increased until the optimal dose is met). He gave Mr Cole information about the treatment and arranged to see him again on 2 November. During the assessment on 2 November, Mr Cole was incoherent and appeared mentally unwell. He stopped the assessment. A member of healthcare staff confirmed that Mr Cole had been referred for a mental health assessment.
34. On 17 November, a psychiatrist assessed Mr Cole. He noted that he was disordered and distracted. Mr Cole told him that he had taken 'spice', an NPS. The psychiatrist noted that Mr Cole was probably in a drug-induced psychosis but had no thoughts of harming himself or others and increased his olanzapine to 15mg. He did not tell anyone that Mr Cole had taken spice and did not complete an intelligence report about it.
35. On 18 November, an offender interventions worker asked her colleagues at Dyfodol (a community drug and alcohol support service) if they could support Mr Cole's methadone treatment on his release. On 24 November, they agreed to support Mr Cole in the community and agreed that he could start methadone

treatment. On the same day, Mr Cole was downgraded to the basic Incentives and Earned Privileges regime for trying to light cigarettes using his cell kettle and television.

36. On 28 November, Mr Cole became disruptive and refused to return from the workshop to his wing. He said he was in debt to other prisoners and was being bullied. Prison staff restrained him and placed him in a cell with a camera in the CSU, where they could observe him. It was decided that he was to remain on basic regime due to his violent outburst. A psychiatric nurse, assessed Mr Cole and noted he was displaying odd behaviour and rambling to himself.
37. The psychiatric nurse asked prison staff to test Mr Cole for drugs and recommended that he move to the healthcare unit. Later that day, Mr Cole admitted that he had taken spice on the wing and in the workshop. Prison staff did not consider it necessary to test him for drugs or take any further action against Mr Cole for taking spice. He was moved to the healthcare unit that night for his own welfare and so that he could be monitored. In the healthcare unit, he set off the fire alarms and was issued with a written warning.
38. The psychiatric nurse reviewed Mr Cole the next day and noted that he had delusional thoughts and that his mental health problems might be affected by his use of spice and lack of sleep. The same day, a nurse created generic mental health care plans to manage Mr Cole's hygiene, sleep and nutrition.
39. On 1 December, a prison GP prescribed Mr Cole his first dose of 30ml of methadone, which he continued to take daily under supervision.
40. Healthcare staff interacted with Mr Cole frequently while he was in the healthcare unit, and recorded formal checks on him four times a day. They noted no concerns about his physical health, and Mr Cole did not complain about or display any symptoms of bronchopneumonia.
41. On 5 December, a prison GP examined Mr Cole. He noted that Mr Cole appeared to be settling, was to remain in the healthcare unit and was to be reviewed a week later.

Events of 6 December

42. A nursing assistant, noted in Mr Cole's medical record that he had been checked hourly throughout the night in line with his care plan, and that he had no concerns about Mr Cole. At 4.51am, he recorded that Mr Cole had slept and been settled throughout the night.
43. At 8.07am, a nurse called Mr Cole for his medication and asked an officer to unlock his cell. Mr Cole was unresponsive and the nurse immediately called out to a second nurse. The second nurse began cardiopulmonary resuscitation, with the help of a custodial manager. The officer instructed another officer to telephone the control room for an ambulance, which he did immediately at 8.07am. The ambulance arrived at 8.15am. The paramedic continued to treat Mr Cole but pronounced him dead at 8.26am.

Contact with Mr Cole's family

44. On 6 December at 9.50am, an officer, a custodial manager, and a chaplain visited Mr Cole's mother. When no one answered the door, they went to Mr Cole's grandmother's home, where they obtained his mother's mobile telephone number. The officer telephoned Mr Cole's mother and offered to return to her house but she said she would come to them. She arrived ten minutes later. The officer told her of Mr Cole's death and offered his condolences and support. The prison service contributed to the cost of Mr Cole's funeral in line with national instructions.

Support for prisoners and staff

45. After Mr Cole'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.
46. The prison posted notices informing other prisoners of Mr Cole'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 Cole's death.

Post-mortem report

47. The post-mortem examination concluded that Mr Cole died of bronchopneumonia and methadone use. Toxicology results detected methadone and olanzapine in Mr Cole's system. No illicit drugs, including NPS, were detected.

Findings

Clinical care

48. Mr Cole's post-mortem examination established that the combination of bronchopneumonia and methadone use led to his respiratory failure. It concluded that although the levels of methadone in Mr Cole's system were high, it could not be established whether methadone contributed significantly to his death.
49. Nurses checked Mr Cole regularly, day and night, while he was in the healthcare unit and he did not present with any physical health problems, including symptoms of bronchopneumonia. The clinical reviewer concluded that staff could not have predicted or prevented Mr Cole's death and, overall, his care was equivalent to that which he could have expected in the community.
50. Cardiff's opiate substitution guidance recommends an initial dose of 20ml of methadone daily, increased by 10ml every week up to 40ml daily. The Drug and Misuse Dependence Guidelines 2007 recommend that in general, the initial dose should be in the range of 10-30mg but that if tolerance is low or uncertain, it should be 10-20mg (Milligrams (mg) measure weight and Millilitres (ml) measure volume of liquid – methadone is normally prescribed as 1mg in 1ml solution). It says that if users are heavily dependent, and where the clinician is experienced or competent, a first dose can be up to 40mg.
51. When starting a patient on methadone treatment, NICE guidelines recommend considering several factors including the severity of dependence, and poly-drug use. A drugs test to identify whether Mr Cole had taken opiates would have helped determine his level of dependency when considering the appropriate starting dose. The Head of Healthcare confirmed that a drugs test was not carried out because Mr Cole told healthcare staff that he had not recently taken any drugs. Given his extensive history of substance misuse, we would have expected staff to test him for drugs.
52. We agree with the clinical reviewer that the decision to administer methadone treatment to Mr Cole was appropriate. Although the clinical reviewer concluded that Cardiff's clinical care was equivalent to that which he could have expected to receive in the community, they had a number of concerns which we share.
53. The initial dose prescribed to Mr Cole – whose tolerance was uncertain as far as records can now demonstrate – exceeded that advised in national and local guidelines for prescription. Mr Cole's medical record does not explain the GP's decision to prescribe a 30ml dose of methadone, and we were unable to interview her as part of the investigation. In the absence of records about the decision making process, we cannot conclude whether Mr Cole's care in this regard was equivalent to what he could have expected to receive in the community. The clinical review made several recommendations which the Head of Healthcare should address, and we make the following recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **Carry out drugs tests for new arrivals with a history of substance misuse; and**
- **Record sufficient detail about a prisoner's tolerance of methadone to support the dose of methadone prescribed in line with national guidelines.**

NPS

54. We are concerned about the prevalence of NPS in prisons and their effect on the behaviours and health of those taking it. Inspectors noted an increased availability and use of NPS at Cardiff. Our learning lessons bulletin on NPS, published in July 2015, highlights the associated risk of bullying and debt, the need for better awareness of the dangers of NPS, the need for an effective drug supply reduction strategy and better monitoring by drug treatment services.
55. HMPPS introduced NPS testing across the prison estate from September 2016 but Cardiff had not yet implemented it before Mr Cole died. While NPS were not detected in Mr Cole's bloodstream when he died, we are concerned that intelligence about him taking spice was not shared with prison staff and there was no action taken about his allegations that he was being bullied and was in debt to other prisoners. However, as we do not find that NPS contributed to Mr Cole's death, we make no recommendations.

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