

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neil Black a prisoner at HMP Birmingham on 31 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 Neil Black died of multiple organ failure on 31 March 2018 at HMP Birmingham. This was caused by sepsis, arising from an infected intravenous drug injection site. He was 34 years old. I offer my condolences to his family and friends.

The care that Mr Black received during the five days he spent at Birmingham was not equivalent to that which he could have expected to receive in the community. I am concerned that when his observations were found to be outside the normal range, healthcare staff did not monitor him more closely as the National Early Warning Score system was not used at the prison at the time.

I am also concerned that prison staff did not tell Mr Black's mother when he was seriously ill or even when he had died. It is unsatisfactory that the family liaison officer did not know that only some of the telephones in the prison could connect international calls, and unacceptable that he did not try to contact her by another means until long after Mr Black's death, by which time she had found out from another source.

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

December 2018

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Summary

Events

1. On 8 March 2018, Mr Neil Black was convicted of theft, offences against public order and possessing an offensive weapon. He was remanded to HMP Birmingham.
2. At his initial health screen, Mr Black told a nurse that he used heroin, crack cocaine, cannabis and alcohol. He also told her that he was an intravenous drug user and had deep vein thrombosis (DVT - a blood clot) in his right leg.
3. Over the next four days, healthcare staff frequently noted that Mr Black had a high pulse rate. They infrequently noted his blood oxygen saturation but noted that he looked unwell, that he had a swollen leg and was hot and sweaty.
4. On 12 March, an integrated drug treatment system (IDTS) nurse saw Mr Black in his cell. She noted that he looked unwell. His pulse rate was very high, he had low blood oxygen saturation, a raised temperature and a mild cough. The nurse asked for a primary care nurse to come to Mr Black's cell. Two primary care nurses arrived and saw that Mr Black was struggling to breathe. Because Mr Black's oxygen saturation level was very low, they gave him oxygen. A nurse radioed for an ambulance to come urgently, and Mr Black went to hospital.
5. Mr Black had tests, scans and intravenous antibiotics but his condition deteriorated. On 19 March, he was moved to the Intensive Care Unit. At 12.50pm on 31 March, Mr Black died of multiple organ failure.

Findings

6. The care that Mr Black received at Birmingham was not equivalent to that which he could have expected to receive in the community. When a prison GP found that Mr Black had a high pulse rate, he did not ask healthcare staff to monitor him more frequently and staff did not check on him again that day. The clinical reviewer said that Mr Black showed early signs of sepsis. Healthcare staff should have monitored him in addition to the five-day IDTS observations that they completed. Healthcare staff infrequently checked Mr Black's blood oxygen saturation levels.
7. Since Mr Black's death, Birmingham has implemented the use of the National Early Warning Score (NEWS) system (a system for identifying patients at risk of clinical deterioration or death, and so prompting a more timely clinical response). We therefore make no recommendation to address the deficiencies in Mr Black's clinical care.
8. We are concerned that prison staff missed a number of opportunities to tell Mr Black's family when he became seriously ill and even when he died. When Mr Black's aunt telephoned the prison in the family liaison officer's absence, staff were unable to give her any information about Mr Black's death which caused her unnecessary frustration and anxiety. As no deputy family liaison officer was appointed, no-one was able to deal satisfactorily with queries when the family liaison officer was not available.

9. The family liaison officer did not know that only some telephones at the prison could connect international phone calls. This caused a serious delay in informing Mr Black's mother of his illness and subsequent death.
10. Although Mr Black tested positive for cocaine, cannabis and PS when he went to hospital on 12 March, there is no other evidence that he had used any of these substances in prison. These drugs can stay in the system for several days after use. We cannot, therefore, say whether Mr Black had used illicit drugs during the five days he was at HMP Birmingham. We therefore make no recommendation.

Recommendations

- The Governor should ensure that when a prisoner is seriously ill or is diagnosed with a terminal illness, a family liaison officer and a deputy family liaison officer are promptly appointed to act as points of contact and support for the prisoner's next of kin.
- The Governor should ensure that family liaison officers are aware which telephones within the prison can be used for making international telephone calls.

The Investigation Process

11. The investigator issued notices to staff and prisoners at HMP Birmingham informing them of the investigation and asking anyone with relevant information to contact him.
12. The investigator visited Birmingham on 16 April. He obtained copies of relevant extracts from Mr Black's prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Black's clinical care at the prison. The clinical reviewer jointly interviewed two members of staff with the investigator on 6 June.
14. 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.
15. One of the Ombudsman's family liaison officers contacted Mr Black's mother, to explain the investigation and to ask if she had any matters that she wanted us to consider. Mr Black's mother was concerned that the prison had not contacted her before his death.
16. Mr Black's father registered an interest with the Coroner. He asked the following questions:
 - How did Mr Black present to staff before he was admitted to hospital?
 - How was Mr Black able to access needles in prison?
 - What was the outcome of Mr Black's two health screenings after he went to prison?
 - Did the prison's mental health team see Mr Black?
 - What records did the prison receive from Mr Black's GP?
17. We shared the initial report with the Prison Service. There were two factual inaccuracies and this report has been amended accordingly. Their action plan has been appended to this report.
18. Mr Black's mother received a copy of the initial report. She did not identify any factual inaccuracies.

Background Information

HMP Birmingham

19. 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 Black's death but is now managed by HMPPS. Birmingham and Solihull Mental Health Foundation Trust continue to provide 24-hour healthcare services at the prison and sub-contract Birmingham Community Healthcare NHS Trust to provide primary care services, including a 15-bed healthcare unit.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Birmingham during the week of 30 July 2018, and 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 calendar days. Key findings from the inspection included that:
 - Levels of violence had increased and were the highest for any local prison in the country over the last 12 months.
 - 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 and refusing to leave their cells because they lived in fear of violence. Inspectors noted that virtually nothing was being done to support them.
 - There was a tenuous lack of control, and wing staff often did not know where their prisoners were.
 - 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 at Birmingham. The trafficking of illegal substances was blatant. It was shocking that many staff did not seem prepared to tackle substance misuse.
 - Many staff lacked confidence and competence in key prison skills. Wings were poorly supervised and prisoners routinely disregarded rules, even to the extent of using drugs openly.
 - Living conditions were as poor as seen anywhere in recent years and staff and managers appeared to have become accustomed to the decay in standards.
21. Following the Inspection and the Urgent Notification, HM Prisons and Probation Service (HMPPS) took over the management of Birmingham, and we therefore now direct our recommendations to the new Governor of Birmingham.

Independent Monitoring Board

22. 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 June 2017, the IMB reported that waiting times to see a GP were comparable to those in the community.

Previous deaths at HMP Birmingham

23. Mr Black was the twenty-fourth prisoner to die from natural causes at Birmingham since March 2015, including eighteen prisoners who died from natural causes. We found no similarities between these cases and Mr Black's death.

Psychoactive Substances (PS)

24. 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.
25. 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.
26. 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

27. On 8 March 2018, Mr Black was convicted of theft, offences against public order and possession of an offensive weapon and remanded to Birmingham.
28. At his initial health screen, Mr Black told a nurse, an IDTS nurse, that he used heroin, crack cocaine, cannabis and alcohol. He told her that he was an intravenous drug user and had DVT in his right leg which had been diagnosed three weeks ago in hospital. The nurse noted that he had a prescription of clexane, a blood thinning drug for the DVT.
29. Mr Black told the nurse that he did not have any mental health issues but she noted that he was tearful and she believed that this was because of withdrawal symptoms. Mr Black told her that the death of his daughter had caused him to start taking drugs.
30. The healthcare department did not have Mr Black's community medical records.
31. The Head of Healthcare said that when a prisoner was identified as a problematic drug user, including those who are dependent on opiates, on reception, he would be located on the substance misuse wing for a period of stabilisation and healthcare staff would complete clinical observations twice a day for the first five days in line with the IDTS protocols.
32. A prison GP prescribed Mr Black diazepam for drug detoxification and alcohol misuse and enoxaparin for his DVT.
33. At 11.24am on 9 March, a prison GP saw Mr Black. Mr Black told him that he had used 10 bags of heroin a day, that he had last injected into his groin three days ago and used a similar amount of crack cocaine. He told the prison GP that he also drank six litres of strong cider a day and that he last drank alcohol three days ago. He said that he did not use psychoactive substances (PS) but took cannabis. The prison GP noted that Mr Black had a high pulse rate of 130 beats per minute. (The normal heart rate for men is 60-100 beats per minute.) He prescribed him methadone (a heroin substitute), thiamine (a vitamin) and vitamin B. Healthcare staff did not complete any more observations that day.
34. On 10 March, a nurse saw Mr Black in the morning as part of his IDTS observations and noted that he looked unwell. Mr Black would not tell the nurse how he felt and refused to have his blood pressure taken.
35. On 11 March, a detoxification nurse saw Mr Black in the morning as part of his IDTS observations. She noted that his lips were dry and that he might be dehydrated. She noted that Mr Black had low blood pressure (85/47) and a high pulse rate (122 beats per minute). She told Mr Black to drink lots of fluids and referred him to the primary care nurses because he had a swollen leg. The primary care nurses told Mr Black to drink fluids.
36. Later that day, a nurse saw Mr Black and noted that he was hot and sweaty and that his pulse rate was very high (156 beats per minute). She noted that she thought that he may have a pulmonary embolism (a blood clot on the lungs). The nurse noted that she discussed the case with two primary care nurses who were

happy that he did not have a pulmonary embolism as he was prescribed blood thinning medication.

37. In the evening a nurse saw Mr Black who said that he did not have an appetite. She noted that his blood pressure was normal (103/65) but his pulse rate was still high (111 beats per minute). She did not record Mr Black's oxygen saturation level.
38. At 10.40am on 12 March, a dual qualified primary care and IDTS nurse recorded that she had seen Mr Black in his cell as part of his IDTS observations. She noted that he looked unwell, and that he had not eaten his food for the past few days as there were plates of uneaten food on the floor. She noted that his pulse rate was very high (143 beats per minute), his blood oxygen saturation level was low (84%), he had a slightly raised temperature and a mild cough. She was unable to take his blood pressure. Mr Black said that he had a pain in his lower, right leg. She was unable to examine his leg properly because he was groaning in pain. Mr Black also said that he was cold and pulled the blanket up to his head.
39. The nurse asked wing staff to call the healthcare first responder immediately. She informed a prison GP who advised that Mr Black should be sent to hospital immediately. Another nurse later recorded that she was present when the other nurse called the prison GP.
40. Two nurses went to the cell and saw that Mr Black was struggling to breathe. One of the nurses said that Mr Black's oxygen saturation level was very low (74%) so she asked a nurse to get the oxygen, which she did. She said that Mr Black's pulse rate and temperature were high but that his blood sugar level was normal. She said that she was unable to take his blood pressure and he refused to sit up which would have helped him to breathe more easily.
41. At 10.43am, a nurse radioed for an ambulance to come urgently to the prison. The ambulance arrived within seven minutes. Paramedics and healthcare staff advised Mr Black that he had to go to hospital but he was initially reluctant and it took some time before paramedics were able to examine him. At 11.44am, Mr Black went to hospital. Two prison officers escorted him and used an escort chain.
42. On arrival at hospital, Mr Black gave a urine sample which tested positive for cocaine, cannabis and PS. The sample also tested positive for the following prescribed drugs: methadone, diazepam, desmethyldiazepam, chlordiazepoxide, dihydrocodeine, paracetamol, lidocaine, clarithromycin, benzylpenicillin and nicotine. Mr Black had been prescribed methadone, diazepam and nicotine. We cannot confirm whether or not the hospital administered the other drugs (painkillers and antibiotics) to him.
43. A Chemistry Laboratory Manager, noted that Mr Black's cocaine use was probably not recent because the level of cocaine detected in the sample was low. She said that the cocaine stayed in the system for several days after use, and for a habitual user, might be detected for over five days. She noted that there is no official data about PS and the length of time that they are detectable in body fluids. The hospital consultant who saw Mr Black said that they had previously

had positive results for PS up to five days after use but typically, positive results were seen up to three days after use. She noted that cannabis was detectable between three to 30 days after use.

44. On 15 March, the Head of Security reviewed the level of Mr Black's restraints. Because he was very ill and had a severe infection, she authorised officers to remove his restraints, which they did.
45. On 19 March, a nurse made a retrospective entry in Mr Black's medical records. She noted that she and another nurse had attended a call at Mr Black's cell at approximately 11.00am on 12 March. She noted that Mr Black had cellulitis of his right leg and his leg was hot to touch. Mr Black refused to sit up and would not move. His oxygen saturation levels had dropped to 75% and he was maintained on oxygen until the paramedics arrived. She said that Mr Black did not want to go to hospital but that she made the decision to send him out against his wishes 'due to sepsis and mental capacity'.
46. Healthcare staff regularly contacted the hospital to obtain updates about Mr Black's condition.
47. Mr Black received intravenous antibiotics but his condition deteriorated. On 19 March, he was moved to the Intensive Care Unit. On 31 March, Mr Black signed an order to say that he did not want to be resuscitated if his heart or breathing stopped. At 12.50pm, Mr Black died of multiple organ failure.

Contact with Mr Black's family

48. On 21 March, the Head of Safer Custody appointed an intelligence analyst as the family liaison officer. Mr Black had not given Birmingham details of a next of kin and the hospital recorded this as the prison chaplaincy as given by Mr Black. The family liaison officer looked through Mr Black's previous sentences at the prison and found a telephone number for his mother in the Republic of Ireland. He telephoned the number but it appeared to be disconnected. On 28 March, the family liaison officer went on leave. No deputy family liaison officer had been appointed to take over his role in his absence.
49. After Mr Black died on 31 March, the Coroner's officer told the Head of Safer Custody that on 3 April, he had spoken to Mr Black's mother who had found out that Mr Black had died from his ex-girlfriend. The Coroner's officer gave the Head of Safer Custody a telephone number for Mr Black's mother, which was the same number that the family liaison officer had telephoned on 21 March.
50. On 5 April, the family liaison officer returned to work, having been told that Mr Black had died. He then realised that some prison telephones could not connect international telephone numbers, and called her again from a telephone that worked. He left a message on the answer phone.
51. On 9 April, the family liaison officer found out that Mr Black's aunt had repeatedly tried calling the prison while he had been on leave. He telephoned Mr Black's mother twice but there was no reply. He left another message on the answer phone.

52. On 10 April, the family liaison officer received a telephone call from Mr Black's aunt who was very angry and frustrated by the lack of contact from the prison. She said that the safer custody department, the chaplaincy department and an intelligence manager had not responded to her calls. She said that a safer custody officer had laughed on the telephone to her. The family liaison officer apologised on behalf of the prison.
53. On 13 April, Mr Black's father telephoned the family liaison officer. He told him that he no longer had contact with Mr Black's mother, and had registered an interest in Mr Black's death with the Coroner.
54. Mr Black's funeral took place on 13 April. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

55. The Director posted notices informing staff of Mr Black's death and offering support. The staff care team also offered support.
56. The prison posted notices informing other prisoners of Mr Black'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 Black's death.

Post-mortem report

57. A post-mortem examination found that the cause of Mr Black's death was multiple organ failure. This was caused by streptococcal sepsis (a severe infection) complicated by a pulmonary abscess and empyema (both lung infections) and endocarditis (infection of the lining of the heart), which were in turn caused by an infected intravenous drug injection site with venous thromboembolism (a blood clot).

Findings

Clinical care

58. The clinical reviewer concluded that the healthcare Mr Black received at Birmingham was not equivalent to that which he could have expected to receive in the community.
59. Healthcare staff identified and noted that Mr Black had recently been diagnosed with DVT and was prescribed blood thinning treatment. The day after Mr Black arrived at Birmingham, a prison GP noted that he had a high pulse rate but took no action. He should have asked the healthcare team to monitor him.

NEWS system

60. Mr Black continued to have a high pulse rate and low blood pressure. Healthcare staff infrequently checked his blood oxygen saturation level and respiratory rate. The clinical reviewer concluded that Mr Black was showing early signs of sepsis which should have prompted healthcare staff to increase his observations. After 11.24am on 9 March, no further clinical observations were taken.
61. After an IDTS nurse saw Mr Black on 11 March, and suspected that he might have a pulmonary embolism, she discussed his condition with two primary care nurses who were not concerned, and no further action was taken. If she had used the National Early Warning Score (NEWS) system, she might have felt empowered to escalate her observations and concerns without seeking the advice of colleagues.
62. The Head of Healthcare, said that healthcare staff did not use the National Early Warning Score (NEWS) system at the time of Mr Black's death. We are concerned that the abnormal observations for Mr Black, recorded from 9 March, did not prompt more frequent clinical observations. If Mr Black had been sent to hospital sooner, he might have received intravenous antibiotics sooner which might in turn have changed the outcome for him.
63. The Head of Healthcare has told us that, since Mr Black's death, Birmingham has implemented and are using the NEWS system for prisoners with abnormal clinical observations so that the care of prisoners whose health is deteriorating is escalated appropriately. We therefore make no recommendation about this issue.

Contact with Mr Black's family

64. PSI 64/2011 on safer custody requires prisons to communicate with the next of kin of prisoners who are seriously or terminally ill. The Head of safer custody appointed a family liaison officer on 21 March, nine days after Mr Black went to hospital. We are troubled that prison staff missed a number of opportunities to contact Mr Black's family, as they should have done. On 12 March, when he was urgently taken to hospital, no one considered telling the family what had

happened. On 15 March, a prison manager reviewed Mr Black's health and authorised the removal of restraints because he was very ill and had a severe infection. We are again concerned that no one contacted Mr Black's family. Even when he was transferred to the intensive care unit at hospital, his family were not informed.

65. While we recognise that Mr Black did not provide details of a next of kin and that the prison appropriately made initial attempts to find contact details for Mr Black's mother, it is unacceptable that she did not have the opportunity to see Mr Black before he died, and that the prison did not break the news to her. We do not know how Mr Black's ex-girlfriend knew that he had died but we note that an article on 2 April, in the Birmingham Post, a local newspaper, referred to his death.
66. On 28 March, the family liaison officer went on leave and did not return to work until after Mr Black died. During his period of leave, Mr Black's aunt tried to speak to a member of staff from the prison. Because a deputy family liaison officer had not been appointed, prison staff said that they did not know to whom they should direct her telephone calls, and they made no attempt to find out in the family liaison officer's absence. She was understandably frustrated by Birmingham's lack of response. Had a deputy family liaison officer been appointed in line with the national instructions, this may well not have happened. There are no available recordings of the telephone contact between Mr Black's aunt and prison staff. We cannot therefore conclude whether or not the member of staff behaved inappropriately when she spoke to Mr Black's aunt. We make the following recommendation:

The Governor should ensure that when a prisoner is seriously ill or diagnosed with a terminal illness, a family liaison officer and a deputy family liaison officer are promptly appointed to act as a point of contact and support.

67. The family liaison officer's lack of knowledge about the prison telephone system had a significant impact on his responsibilities. He failed to tell Mr Black's mother that he was seriously ill in hospital because he was unaware that certain telephones in the prison did not connect international calls. In addition, he failed to try and contact her by an alternative means until long after Mr Black's death, by which time she had already found out from another source. We make the following recommendation:

The Governor should ensure that family liaison officers are aware which telephones within the prison can be used for making international telephone calls.

Illicit substances

68. When Mr Black went to hospital on 12 March, he tested positive for cocaine, cannabis and PS. We note that cocaine stays in the system for several days after use, that the low level detected in Mr Black's blood suggested that his cocaine use was probably not recent. We note that cannabis can stay in the

system for up to 30 days. We also note that positive results for PS might be seen up to five days after use.

69. We cannot therefore say whether or not Mr Black had access to or used any of these substances in prison or whether he took them in the community before he arrived in custody.
70. The investigation found that the prison is currently 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.
71. 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.
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 deaths she was investigating that were due, or linked, to the use of PS. The Chief Executive told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. Given these commitments and the difficulty in saying with certainty when Mr Black took the drugs detected in his system on his arrival in hospital, we make no recommendation.

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