Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Karl Barton a prisoner at HMP Wymott on 30 July 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*

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 Karl Barton died on 30 July 2017 at HMP Wymott. Mr Barton died as a result of a lack of oxygen to the brain and cardiac arrest, due to the use of psychoactive substances (PS). He was 40 years old. I offer my condolences to Mr Barton's family and friends.

Mr Barton had a history of substance misuse in the community. In the first few years of his sentence, he worked very hard to remain drug-free. In spite of risk management and support, he relapsed in July 2016 and started using PS.

The investigation found that the last time prison staff found Mr Barton under the influence of PS, they did not follow the expected procedures for managing him. I am also concerned that, although he seemed motivated to take additional substance misuse courses, the prison was unable to facilitate this within a reasonable time, as staff wrongly believed that his pay would be reduced.

There was a significant delay in calling an ambulance when Mr Barton was found. Although this did not affect the outcome for Mr Barton, it is crucial that an ambulance is called immediately when a prisoner is unresponsive.

I am increasingly concerned by the number of deaths my office investigates in which PS has played at least some part and since Mr Barton's death, at least two other deaths at Wymott have been linked to PS. I repeat my view that 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 earlier in the year 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**

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Summary

Events

1. On 31 March 2010, Mr Karl Barton was remanded to prison, charged with wounding and possessing an offensive weapon. He was later convicted and sentenced to Imprisonment for Public Protection, with a minimum period to serve of four years and 357 days. On 11 March 2011, he was transferred to HMP Wymott.

2. Mr Barton had a history of substance misuse, but was motivated to remain drug-free. During his first few years in prison, he progressed well and moved to HMP Kirkham, an open prison, on 20 May 2016. Despite receiving support and interventions through the substance misuse team, Mr Barton relapsed and began to use PS. He was returned to Wymott on 31 August.

3. Mr Barton discussed his drug use with his offender supervisor and the substance misuse team. He wanted further support and to join a substance misuse programme, but was told that this would not be possible until he had completed education courses that he had already started.

4. On 4 December, Mr Barton was found under the influence of PS. This was addressed, in line with the prison's local drug strategy. He was demoted under the privileges scheme; had a joint meeting with a substance misuse worker and a prison manager; and attended a PS workshop a few days later. On 12 January 2017, Mr Barton was again found to have taken PS. No further drug use was recorded after this date, but it was noted that staff were trying to find a solution to enable him to access substance misuse courses.

5. At around 5.00pm, on 29 July, one of Mr Barton's friends found him unwell after taking PS, but he did not report this to staff. Officers who saw him shortly afterwards and during the late evening count of prisoners said they did not notice anything untoward when they spoke to him.

6. At 5.18am on 30 July, Mr Barton was found unresponsive in his cell. A nurse and other staff attended the emergency, but they did not attempt cardiopulmonary resuscitation, as rigor mortis was evident.

Findings

7. Wymott has a comprehensive and up to date substance misuse strategy, with distinct processes for managing prisoners suspected of, or testing positive for PS. Staff generally complied with the procedures in Mr Barton's case. However, on 12 January, they monitored him during the day, but did not follow the other prescribed steps. For long-term benefits to the prisoner, it is important to apply the process consistently.

8. The investigation also found that Mr Barton was unable to access potentially beneficial courses provided by the substance misuse team and that staff wrongly believed his pay would have been reduced if he took a substance misuse course while in education. Although prison staff and the substance misuse team intended to find a solution together, this was not resolved before Mr Barton's

death. We do not know whether this would have helped him, but it seems unreasonable that someone who was well motivated to engage with interventions was denied the opportunity to pursue this.

9. The support officer who found Mr Barton unresponsive, immediately called an emergency code and additional staff quickly arrived. The incident log noted that an ambulance was called straightaway. However, ambulance service records showed that the first call was received at 5.30am, just over 10 minutes after the emergency was called. We have been unable to resolve this discrepancy in the timings. Although this did not affect the outcome for Mr Barton, such a lengthy delay is unacceptable and could be critical in future cases.

Recommendations

- The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.
- The Governor should ensure that prison staff and the substance misuse team are aware of the prisoner pay policy.
- The Governor should ensure that prisoners with substance misuse problems can promptly access appropriate support.
- The Governor should ensure that staff in the control room call an ambulance immediately when a medical emergency code is received.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wymott informing them of the investigation and asking anyone with relevant information to contact him/her. No one responded.

11. The investigator visited Wymott and obtained copies of relevant extracts from Mr Barton's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Barton's clinical care at the prison.

13. The investigator and clinical reviewer jointly interviewed four members of staff and two prisoners at Wymott on 28 September 2017.

14. Our investigation was suspended while waiting for the cause of death and the clinical review report. This delayed the initial report.

15. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation, who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

16. The investigator wrote to Mr Barton's daughter to explain the investigation and to ask if there were any matters she wanted the investigation to consider. She did not reply.

17. 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.

Background Information

HMP Wymott

18. HMP Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Indigo Locum Agency provides GP services and out of hours care, including 24-hour nursing cover.

HM Inspectorate of Prisons (HMIP)

19. The most recent inspection of Wymott was in October 2016. Inspectors reported that the substance misuse strategy had improved, with effective communication and links between the safer prisons, security, offender management and drug strategy teams. Security and drug strategy meetings were well attended and detailed information sharing took place between relevant departments.

20. Inspectors found that all new arrivals were screened for substance misuse problems and about two thirds of prisoners had received support for drug and alcohol problems. Details in security information reports, prisoners' records and police reports were used to inform interventions. There was a broad mix of individual and group support activities, as well as good peer support. Dedicated nurses and visiting specialist substance misuse consultants assisted the drug services team and treatment regimes were flexible and reviewed regularly. Relationships between the psychosocial and clinical teams were excellent.

Independent Monitoring Board

21. 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 May 2018, the IMB reported that the standard of healthcare was poor and frequently fell below that which could be expected in the community. The Board also noted that increased bullying and debt had led to violence. The use of PS had resulted in injuries to prisoners and a high number of requests for ambulances, but improved strategies for dealing with such incidents had reduced the number of call-outs towards the end of the reporting year.

Previous deaths at HMP Wymott

22. Mr Barton's death was the 14th at Wymott since January 2016 and there have been seven subsequent deaths. In a death subsequent to Mr Barton's, we made a recommendation about calling an ambulance promptly when an emergency code is called.

23. Post-mortem reports in some of the most recent deaths at Wymott on which we have yet to report also indicate use of illicit substances.

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.

Incentives and Earned Privileges Scheme (IEP)

27. Each prison has an incentives and earned privileges (IEP) scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell, the ability to earn more money in prison jobs and wear their own clothes. There are four levels: entry, basic, standard and enhanced.

Key Events

28. On 31 March 2010, Mr Karl Barton was remanded to HMP Preston. He was subsequently convicted of wounding with intent and possession of an offensive weapon. On 15 October, Mr Barton was sentenced to Imprisonment for Public Protection, with a minimum period to serve of four years and 357 days.

29. Mr Barton had a history of drug misuse from a young age, using mostly crack cocaine and amphetamines. This was not recorded at his reception health screen, which noted that he appeared to be fit and well with no concerns about his health.

30. On 11 March 2011, Mr Barton transferred to HMP Wymott's Therapeutic Community to complete offending behaviour courses. (The Therapeutic Community focusses on building social relationships and using structured days and activities to help residents to support each other in their recovery from drug and alcohol misuse.)

31. During 2011, prison staff found that Mr Barton had received 'white powder' in his mail and, a few months later, he admitted to using Subutex (a heroin substitute). By November, he had committed to remaining drug free and provided regular negative drug tests. Staff described him as positive and responsible, with a good work ethic. He maintained good relationships with staff and other prisoners and kept his distance from those who caused trouble.

32. On 25 June 2013, Mr Barton temporarily transferred to HMP Risley to take a specific offending behaviour course. At his health screen, he reported historic use of crack, amphetamines and ecstasy. No illicit drug use was recorded at Risley.

33. Mr Barton returned to Wymott on 20 May 2014. In August, he successfully applied to become a peer mentor with Discover Drug and Alcohol Recovery Service, the prison's substance misuse service. He also completed the Smart Recovery Programme.

34. On 11 February 2016, it was noted in Mr Barton's personal record that information had been received naming him as using PS and Subutex, but not selling it.

35. Following re-categorisation to category D (the lowest security category), Mr Barton moved to HMP Kirkham, an open prison, on 20 May. At the outset, it was identified that he would need support due to historic substance misuse. He engaged with Inspire, a drug support service, and a comprehensive risk assessment was completed. He signed up for the 12 steps programme, weekly sessions at Alcoholics Anonymous (AA), Narcotics Anonymous (NA) and the Saturday Support Group. His substance misuse key worker subsequently completed a risk management plan identifying Mr Barton's risks and triggers and actions to be taken to manage the risk.

36. In July, Mr Barton admitted to smoking PS several times and asked to be placed on Enhanced Behaviour Monitoring (EBM) for support and to manage his risk. His Offender Supervisor was unsure whether EBM was suitable and warned him

that a repeat of this was likely to result in a return to a closed prison. Mr Barton acknowledged that he had a lot to lose and said he would not do it again. Drug tests taken after his admitted use of PS were negative but, at that time, Inspire had no specific tests for PS. In August, after three further episodes of suspected PS use, Mr Barton was considered unsuitable for open conditions. On 31 August, he returned to a standard residential wing at Wymott.

37. At his reception health screen the following day, Mr Barton told a nurse that he had used PS in the last month and wanted support. A few days later, he completed a self-referral to the Building Futures substance misuse service.

38. On 13 September, Mr Barton discussed the circumstances surrounding his relapse and return to closed conditions with his offender supervisor. They agreed he would engage with Discover to revisit prevention strategies and apply for a move to the Psychologically Informed Planned Environment (PIPE - a unit designed specifically to create a safe and supportive environment, to help offenders reduce risk-taking behaviours and maintain the benefits gained from interventions). On 26 September, Mr Barton was assessed for the Building Futures programme and given harm minimisation advice. However, due to a commitment to an English course, he was told that he would be unable attend group sessions until December.

39. An intelligence report submitted on 3 November, indicated that Mr Barton and 16 other prisoners were believed to be under the influence of PS. A mandatory drug test (MDT) was suggested, but there is no evidence as to whether this was conducted during that month. There were no references to this event in his medical or personal record.

40. On 4 December, wing staff saw Mr Barton falling over on the landing. They broke his fall and radioed a code blue (a medical emergency indicating a prisoner is unconscious or has breathing difficulties). Mr Barton was initially unresponsive, but regained consciousness quickly. Healthcare staff managed him in the prison and he did not go to hospital. In line with the prison's robust recovery policy, Mr Barton was immediately demoted to the 'basic' regime under IEP and referred to the Discover substance misuse team.

41. On 7 December, one of the Discover team and a custodial manager, had a meeting with Mr Barton to discuss his admitted use of PS. He said that he was willing to engage with the Building Futures programme. However, the Discover team member noted that they would not be able to work with him until he had finished his education course.

42. Mr Barton attended a PS workshop on 8 December and a recovery action plan was completed the next day. A random MDT, taken on 19 December 2017, was negative and Mr Barton was reinstated to the 'standard' regime two days later.

43. On 12 January 2017, officers found Mr Barton in the library under the influence of PS and called an emergency code. A nurse examined him. She had no concerns about his breathing and he did not need to go to hospital, but she asked wing staff to check him regularly. Another nurse went to see him a few hours later and she was satisfied that he was well.

44. On 28 January, a nurse attended an emergency call for Mr Barton. When she arrived, he stood up and was visibly flinching when moving. He reported pain in his right lung when breathing in and said he had been kicked in his ribs over a week before. A doctor and a nurse reviewed him the next day.

45. Mr Barton returned to the PIPE unit in May and was upgraded to 'enhanced' status under IEP. Staff noted that he had settled quickly and was supportive to other prisoners. He engaged and contributed well in group sessions and was open about his difficulties.

46. On 26 May, one of the Building Futures team noted that Mr Barton was unable to participate in their sessions as he was doing an NVQ course, but he wanted to provide regular drug tests to show his motivation and commitment. A drug test that day was negative. On 31 May, he told his keyworker in the PIPE unit that he would complete his NVQ in a month and had applied for the relapse prevention programme. (A further entry on 7 July, noted that there was an outstanding meeting with the Building Futures and education teams to discuss whether there was any flexibility to allow Mr Barton to attend workshops. A previous meeting had been cancelled due to staff sickness.)

47. A security intelligence report submitted on 9 June, named two prisoners supplying PS on the PIPE unit and indicated that Mr Barton had been approached to use drugs.

48. On 12 July, a substance misuse team member wrote to Mr Barton's offender supervisor. She said that they needed to find a solution to enable Mr Barton to attend drug services group sessions. They had been unable to invite him, as prisoners were penalised by having their pay reduced if they did not attend education and there were also implications for their status on the privileges scheme. Mr Barton attended PIPE unit structured group meetings in July. He contributed well and was helpful and supportive to others.

49. On 27 July, Mr Barton saw a stop smoking advisor, as he wanted to stop smoking. She gave him advice and provided nicotine replacement patches and a nicotine inhalator.

50. During the evening of Saturday 29 July, two officers saw Mr Barton playing cards with a group of other prisoners. They noticed nothing different about him and he did not appear unwell. The officers locked up the prisoners on the wing between 4.00 and 4.30pm. They were then unlocked to collect their evening meal.

51. At around 5.00pm, a prisoner, Prisoner A was told by another (unnamed) prisoner to check if Mr Barton was all right. Although not said explicitly, he deduced that he was under the influence of something. He said that as he had never dealt with that type of situation before, he asked Prisoner B, a prisoner and friend of Mr Barton, to go and check.

52. When Prisoner B went into the cell, he found Mr Barton on his bed curled up in the foetal position. He sat him up, gave him some water and had words with him about using PS. He stayed for five or ten minutes. By the time he left the cell, Mr Barton was able to drink the water without assistance, but he was still slurring his words. He did not report this to staff for fear of being labelled a 'grass'.

53. Sometime between 5.00 and 5.15pm, an officer locked up Mr Barton for the night and saw him lying on his bed watching television. Prisoner A was nearby and saw the officer look in the cell before locking him up, so assumed that he was all right.

54. At around 9.00pm, a support officer counted the prisoners on the wing. He said afterwards that he was sure that Mr Barton had responded when he said goodnight to him.

55. A prisoner who was in a neighbouring cell said that during the night he heard Mr Barton's chair scrape against the floor, followed by a heavy thud and something clattering on the floor. He was not sure of the time, but thought it might have been around midnight, or in the early hours of Sunday morning.

56. At 5.18am on 30 July, while completing the morning count of prisoners, the support officer could not see Mr Barton in his bed. On further examination, he noticed a small pool of blood had seeped through the cell door. There was no response when he shouted to Mr Barton, so he radioed a code red (an emergency code indicating a severe loss of blood). He said that his colleague arrived within 40 seconds, shortly followed by more staff.

57. As the support officer was lying immediately behind the door, staff used the anti-barricade tool to open it outwards. A nurse said that Mr Barton was on his side, cold and unresponsive, with bleeding from his nose and mouth and no signs of life. She tried to place him on his back, but there was evident rigor mortis, so she did not attempt to resuscitate him. She radioed to request an ambulance at 5.22am, in case this had not been done. An officer also contacted the control room to double check. Paramedics arrived at 5.54am and confirmed Mr Barton's death at 5.55am.

Contact with Mr Barton's family

58. The deputy governor and a prison manager visited Mr Barton's former partner, his nominated next of kin. They informed her of Mr Barton's death, offered support and explained the processes to be followed.

59. The prison's family liaison officer spoke to Mr Barton's offender manager and other family members to establish Mr Barton's legal next of kin. Unfortunately, she was given incorrect telephone details for his daughter, so was unable to get through. On 2 August, Mr Barton's daughter telephoned the prison. She complained to the lead prison chaplain, that she had heard about her father's death through other people. He apologised, explained the reasons why they had been unable to contact her and the processes to be followed. Over the following weeks, the family liaison officer kept in touch with Mr Barton's daughter and his ex-partner, providing information and support.

60. In line with Prison Service policy, the prison contributed to the costs of the funeral, which was held on 17 August. The prison held a memorial service on 25 August.

Support for prisoners and staff

61. After Mr Barton's death, a senior 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.

62. The prison posted notices informing other prisoners of Mr Barton'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 his death.

Post-mortem report

63. The report of the post-mortem examination concluded that the cause of Mr Barton's death was:

    1a hypoxic brain injury
    1b cardiac arrest
    1c synthetic cannabinoid toxicity
    2 ischaemic heart disease.

64. The pathologist commented:

    "Whilst the toxic effects of synthetic cannabinoids [PS] are similar to that of cannabis the effects can be much more pronounced and as well as causing tachycardia [abnormally fast heart rate], hypertension, sedation and altered cognition they are associated with respiratory depression and sudden cardiac arrest likely to be related to the development of a fatal ventricular arrhythmia [abnormal heartbeat]. Other arrhythmic changes include prolongation of the QT interval [when the heart muscle takes longer than normal to recharge between beats] and these drugs can lead to myocardial infarction [a heart attack] occurring in patients without any obvious coronary pathology.

    In this case Mr Barton had pre-existing evidence of coronary artery disease and the combination of this with ingestion of synthetic cannabinoids has likely resulted in a fatal ventricular arrhythmia and his cardiac arrest."

Findings

Psychoactive substances at HMP Wymott

65. During an inspection in October 2016, prisoners told HMIP that drugs were freely available. In their inspection survey, 63% of respondents said it was easy to get illegal drugs, which was higher than at comparable prisons (43%). Prisoners and staff were aware of the dangers of PS and said that it was available on the wings. A supply reduction strategy and a specific action plan were in place to reduce the use of PS, monitored by a well-attended drug strategy committee. Inspectors also found that suspicion drug testing was too low, as testing staff were unavailable, but this had increased in line with requests.

66. Our investigation found that Wymott revised and reissued their substance misuse strategy in August 2018. The strategy outlines a number of measures to reduce the demand and supply of illicit drugs. The document includes a protocol for the management of prisoners suspected of misusing PS and a "Robust Recovery Package" with a flowchart for staff, concisely setting out the actions to be taken.

67. We acknowledge that Wymott has a drug strategy in place and staff are working hard to implement it. Nevertheless, it appears that Mr Barton was able to obtain drugs without difficulty and it is clear, therefore, that more needs to be done to reduce both the supply and the demand for PS.

68. Wymott 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.

69. 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. We also wrote to the Prisons Minister earlier this year, raising concerns about the high number of drug-related deaths we were investigating. In response, the Chief Executive has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018. We therefore make no recommendation on this issue.

Management of Mr Barton's substance misuse

70. Mr Barton had a history of substance misuse in the community. Between 2011 and early 2016, apart from two recorded lapses, he remained drug-free. He engaged well with prison staff, as well as the drug and alcohol recovery service, who advised him of the risks of taking illicit drugs and harm minimisation strategies. He seemed positive and motivated.

71. Mr Barton began using PS in July 2016, after a move to an open prison. On his return to Wymott, staff continued to support him and took firm action when they found him under the influence of PS in December.

72. Staff seemed to be unaware that Mr Barton had continued to use PS in 2017, but other prisoners appear to have known. One of his friends told the investigator

that two or three weeks before his death, Mr Barton had asked him to buy an ounce of tobacco, possibly to get him out of debt. When his canteen arrived a week later, he gave him the tobacco, but later found him in his cell 'out of his face again'. He was annoyed and challenged Mr Barton, as he thought that he had used the tobacco to buy PS. He denied this and said that it had been given to him. He told him that he would not buy it for him again and that he should repay the ounce. Mr Barton admitted to him that he had used PS regularly on his previous wing, but had cut down after he moved to the PIPE.

73. A few hours after Mr Barton's death, two entries in the prison's intelligence system indicated that he had smoked PS with another prisoner the previous afternoon. Another security entry said that prisoners had told staff to put a stop to drugs entering the wing by checking CCTV footage to see where all the canteen (goods ordered by prisoners) was being delivered.

74. Further intelligence reports submitted on 1 and 2 August, suggested that during the afternoon before his death, Mr Barton had been involved in a "£10 Spice bucket challenge" set by other prisoners. (If a prisoner succeeds in smoking all the PS provided in the challenge, they receive the equivalent amount of PS free.) There was speculation that Mr Barton might have accepted the challenge because of debt, but there is no evidence to corroborate this. There is also no substantive evidence to indicate that Mr Barton had been bullied, or was in debt.

75. Wymott's local PS protocol includes a Robust Recovery Pathway. This specifies a number of steps to be taken in all instances of suspected PS use, such as consideration of a referral for the two-week Robust Recovery Intervention Programme, or other interventions. After the incident on 4 December 2016, staff referred Mr Barton to the drug and alcohol service, held discussions with him about his relapse and implemented the appropriate sanctions. However, we are concerned that when he used PS again on 12 January 2017, there is no evidence of action other than monitoring by healthcare and wing staff during that day. We make the following recommendation:

The Governor should ensure that prisoners suspected of using psychoactive substances, or other illicit substances, are managed in line with the local drug strategy.

76. Mr Barton's records contained several references to Mr Barton being unable to participate in Discover courses and that prisoners would receive no pay to attend such courses, or their pay would be reduced. The substance misuse team and the education department had planned to hold a meeting to find a solution for Mr Barton, but this was never resolved. The substance misuse coordinator told the investigator that Mr Barton's recovery plan would have been reviewed and tailored to his needs when he completed his education course.

77. The prisoner pay policy at Wymott states that those in employment, induction, courses or retired will receive weekly wages if they constructively participate in the regime. It also says that there should be an allowance for authorised absences from purposeful activity, such as offending behaviour courses. The learning, skills and activity manager told the investigator that prisoners can attend any course/programme that is required as part of their sentence plan, or for substance misuse issues, without a reduction of pay. She added that

sometimes pay had been docked in these circumstances through human error, but when notified this had been rectified and deductions refunded.

78. We recognise there can be a conflict between prisoners attending education courses and relapse prevention support. However, we consider that those struggling with substance misuse should be actively encouraged to attend support sessions. It seems incongruous to refer prisoners to the substance misuse service and then fail to facilitate access to possible interventions. In addition, some prison staff and some members of the substance misuse service misunderstood the policy and believed that prisoners would be penalised for choosing to attend substance misuse instead of education courses.

79. Mr Barton was keen to engage with the substance misuse team at a time when he was covertly using PS. We do not know whether the additional courses would have helped him, but we believe that he should have been given the opportunity to attend. It is disappointing that the prison did not give greater priority to enabling him to access much needed support. We make the following recommendations:

The Governor should ensure that prison staff and the substance misuse team are aware of the prisoner pay policy.

The Governor should ensure that prisoners with substance misuse problems can promptly access appropriate support.

Clinical care

80. The post-mortem examination revealed that Mr Barton had ischaemic heart disease which might have contributed in some way to his death. During his imprisonment, he had been diagnosed with high blood pressure, which is a risk factor for cardiovascular disease. The clinical review found that he had engaged well with healthcare staff and they had managed him in line with NICE guidelines.

81. The clinical reviewer considered that appropriate assessments and interventions took place to address Mr Barton's substance misuse. He was part of the planning and decision-making process and he actively participated in his treatment programmes. She concluded that he received a good standard of clinical care, at least the equivalent to that which he could have expected in the community.

Emergency response

82. PSI 03/2013 on Medical Emergency Response Codes sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors and directors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called immediately. Staff should ensure there are no delays in calling an ambulance and it should not be a requirement for a member of the healthcare team, or a manager to attend the scene before calling an ambulance.

83. When the support officer found Mr Barton unresponsive at 5.18am on 30 July, he immediately called a code red emergency and this should have prompted the control room to call an ambulance immediately. The night manager's log lists several actions at 5.20am, including calling an ambulance. The communications log noted that the code red was called 5.20am; staff at the cell requested an ambulance at 5.22am; and an ambulance was then called. It is understandable that there might be minor differences of a minute or two in recording timings when staff are focussed on the emergency procedures. However, the ambulance service records indicate that the call was actually received at 5.30am, at least ten minutes after Mr Barton was found. Although this did not affect the outcome, such a significant delay could have serious consequences in future emergencies. We make the following recommendation:

The Governor should ensure that staff in the control room call an ambulance immediately when a medical emergency code is received.

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