

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Kevin Hilton a prisoner at HMP Whitemoor on 30 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 Kevin Hilton died on 30 December 2017 of a blood clot in the lung at HMP Whitemoor. Mr Hilton was 31 years old. I offer my condolences to Mr Hilton's family and friends.

Around three weeks before he died, on 8 December, Mr Hilton suffered extensive burn injuries when he set himself alight while smoking psychoactive substances (PS) in his cell. He received treatment in hospital and was returned to Whitemoor's healthcare unit on 16 December. On the morning of 30 December, nurses found him unresponsive and despite resuscitation attempts by prison healthcare staff and ambulance paramedics, he was pronounced dead.

The investigation found that Mr Hilton's clinical care was equivalent to that which he could have expected to receive in the community. Healthcare staff managed his burn injuries well and frequently encouraged him to mobilise without using a wheelchair.

I am, however, concerned that on 8 December, when Mr Hilton was discovered on fire, staff delayed entering his cell until the fire service arrived, despite the fire having been put out almost 20 minutes before. This caused an unnecessary delay in Mr Hilton receiving emergency medical treatment.

The pathologist noted that tissue damage from burn injuries, and the immobility that may follow, can lead to blood clots. It may, therefore, be said that Mr Hilton's use of PS ultimately resulted in his death. Whitemoor has a local drug strategy that it is working to implement but we are concerned that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is now an urgent need for national guidance on the best measures to combat this serious problem and I have made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service in a previous investigation. I have also written to the Prisons Minister setting out my 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.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman

April 2019

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Summary

Events

1. In January 2006, Mr Kevin Hilton was given an indeterminate sentence for robbery. He was moved to HMP Whitemoor on 27 March 2017. Mr Hilton had a history of challenging behaviour and substance misuse problems.
2. From 16 October to 4 December 2017, staff observed Mr Hilton apparently under the influence of psychoactive substances (PS) on three occasions. Healthcare staff saw him each time, but he declined support from the prison's substance misuse team.
3. On 6 December, Mr Hilton was taken to the prison's segregation unit after punching an officer. On 8 December, at around 9.20pm, an officer found Mr Hilton collapsed on the floor of his cell and went to a nearby office to call an emergency medical code. When she returned, she noticed that Mr Hilton had turned over and that his T-shirt was alight. An operational support grade (OSG) inundated the cell with a water misting hose and the fire was put out at 9.23pm. Several officers, a prison manager and a dog handler arrived shortly afterwards. However, no one entered Mr Hilton's cell until the fire service arrived at 9.41pm. Mr Hilton resisted medical treatment and had to be restrained and sedated before paramedics could safely transfer him to Peterborough City Hospital.
4. The next morning, hospital staff transferred Mr Hilton to a specialist burns unit at Broomfield Hospital, Essex, where he underwent several operations. Mr Hilton was returned to the prison's healthcare unit on 16 December. Over the next two weeks healthcare staff monitored Mr Hilton frequently, created a care plan, prescribed appropriate medication and liaised with hospital specialists when required.
5. On 30 December, at around 8.45am, two nurses arrived at Mr Hilton's cell to issue his medication. One of them looked through the observation panel and noticed that he appeared not to be breathing. She called out Mr Hilton's name and an officer, who was in the office opposite, arrived straightaway. The officer unlocked the cell door and called an emergency medical code at 8.50am. In the meantime, a nurse retrieved the emergency equipment and entered Mr Hilton's cell. Nurses started cardiopulmonary resuscitation (CPR) and continued until paramedics arrived at 9.02am. Resuscitation attempts were unsuccessful and at 9.35am, a paramedic pronounced that Mr Hilton had died.
6. The post-mortem examination found that Mr Hilton died of pulmonary thromboembolus (the sudden obstruction of a lung artery due to a dislodged blood clot) caused by deep vein thrombosis (a blood clot that develops within a deep vein). The pathologist noted that tissue damage from burn injuries and the immobility that may follow, can predispose thrombosis.

Findings

7. The clinical reviewer considered healthcare staff managed Mr Hilton's significant burn injuries well. Staff managed his wounds appropriately and encouraged him to mobilise without using a wheelchair. We are satisfied that he received a

standard of care equivalent to that which he could have expected to receive in the community.

8. Although staff promptly put out the fire on 8 December, we are concerned that officers did not enter his cell until the fire service arrived, almost 20 minutes later.
9. We are concerned at the availability of PS at Whitemoor, a high security prison, and it is particularly troubling that Mr Hilton was able to access and use PS in the segregation unit, one of the most secure and closely overseen parts of the prison.
10. Despite Whitemoor's comprehensive local drugs strategy, it is clear that more needs to be done to limit supply and demand. In our view there is now an urgent need for HMPPS to put in place a properly resourced national drugs strategy to help prisons combat this serious problem, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis.
11. The investigation also found that a prison manager did not debrief staff following Mr Hilton's death.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations.
- The Governor should ensure that appropriate resources are focused on preventing illicit substances entering the segregation unit.
- The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Whitemoor informing them of the investigation and asking anyone with relevant information to contact him. Three prisoners responded.
13. The investigator obtained copies of relevant extracts from Mr Hilton's prison and medical records.
14. The investigator interviewed nine members of staff and three prisoners at Whitemoor on 22 and 23 January 2018.
15. NHS England commissioned a clinical reviewer to review Mr Hilton's clinical care at the prison. The clinical reviewer joined the investigator for interviews on 23 January.
16. We informed HM Coroner for Cambridgeshire and Peterborough District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. One of the Ombudsman's family liaison officers contacted Mr Hilton's grandmother, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Hilton's grandmother wanted to know:
 - why staff moved Mr Hilton to the segregation unit;
 - how he set himself on fire in a smoke free prison and what happened;
 - whether a care plan was in place to manage his burn injuries;
 - what happened during the emergency response on 30 December; and
 - why she was told that Mr Hilton died of a cardiac arrest?
18. The initial report was shared with Mr Hilton's family's legal representative. They did not raise any further issues, or comment on the factual accuracy of the report.
19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan is annexed to this report.

Background Information

HMP Whitemoor

20. HMP Whitemoor is a high security prison, which holds around 450 men serving long sentences. Healthcare is provided by Northamptonshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Whitemoor was in March 2017. Inspectors reported that although more men in their survey than in similar prisons said that it was easy to obtain drugs and alcohol, random mandatory drug testing positive rates were relatively low at 4.5%. The positive rate for psychoactive substances (PS) was 9%, which indicated an emerging problem. Too many suspicion tests were not being completed.
22. Inspectors reported that there were not enough nurses to provide therapeutic responses and while recruitment was underway, the lack of capacity was exacerbated at times by mental health nurses assisting with general healthcare duties.

Independent Monitoring Board

23. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 May 2017, the IMB reported that improvements to healthcare staffing levels and services had been introduced. They commented that illicit substances, including PS, were freely available on the wings and that suspicion based drug testing did not always take place due to staff shortages. Prisoners in the segregation unit were frequently unable to benefit from a consistent or foreseeable regime due to high occupancy levels.

Previous deaths at HMP Whitemoor

24. Mr Hilton was the fifth prisoner to die at Whitemoor since December 2014. Three of the previous deaths were from natural causes and two were self-inflicted. There has been one death since, from natural causes. We have previously raised a concern about a delay in entering a cell in a medical emergency.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.
28. 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 has told us that HMPPS plan to issue a national drug strategy in the autumn of 2018.

Segregation units

29. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. They can also make applications to attend corporate worship once a week, subject to an approved risk assessment. The segregation unit at Whitemoor has 36 cells.

Key Events

30. On 13 January 2006, Mr Kevin Hilton was given an imprisonment for public protection (IPP) sentence for robbery with a minimum term of 742 days. (Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release. Mr Hilton's tariff expired on 24 June 2008.) Mr Hilton spent time at several prisons before arriving at Whitemoor on 27 March 2017.
31. At an initial reception screen on 28 March, a nurse noted that Mr Hilton had a learning disability and was prescribed naproxen (an opiate based pain relief medication) for nerve damage to his right hand. On 4 April, a prison GP saw Mr Hilton for a review and recorded that he had a history of substance misuse. He examined Mr Hilton's right hand and changed his medication to amitriptyline (an antidepressant medication that can also be used to treat chronic nerve pain). The prison's substance misuse team offered Mr Hilton support on 24 April, but he declined.
32. Over the next five months, Mr Hilton had minimal contact with healthcare staff and often failed to collect his prescribed medication. Records show that prison staff started disciplinary proceedings against him on at least three occasions for possessing illicitly brewed alcohol and for damaging his cell.
33. On 16 October and 11 November, a nurse saw Mr Hilton for a review after prison staff noticed that he appeared under the influence of psychoactive substances (PS). Mr Hilton denied using illicit substances on both occasions and healthcare staff kept him under observation. Prison staff submitted intelligence reports and noted that several prisoners, including Mr Hilton, had recently presented with the same symptoms. Records show that staff recommended a mandatory drug test (MDT) for all the prisoners suspected of being involved.
34. On 23 November, a substance misuse manager saw Mr Hilton for a review after he tested positive for PS. Mr Hilton signed a disclaimer stating that he did not want support and the substance misuse manager sent him a harm reduction leaflet about the dangers of PS. On 4 December, a nurse attempted to examine Mr Hilton after prison staff suspected he had used PS, but he declined. After Mr Hilton's death, other prisoners told the investigator that Mr Hilton often took PS and that he would do crazy things to get it, like letting prisoners punch him in the kidneys, because he did not have any money.
35. On 6 December, at around 2.30pm, Mr Hilton refused to return to his cell. Prison staff made several attempts to persuade him but he failed to comply and punched an officer in the face. Staff restrained Mr Hilton and took him to the prison's segregation unit. At 3pm, a nurse conducted an initial health screen and assessed Mr Hilton as clinically suitable for segregation. At 4.30pm, a prison manager reviewed the health screen and authorised his ongoing segregation.

Events on Friday 8 December

36. At 10.50am, a prison manager held a disciplinary hearing (known as an adjudication) and, due to the seriousness of the assault, referred Mr Hilton's case

to the police for further investigation. At 4pm, another prison manager authorised for Mr Hilton to remain segregated until 11 December.

37. At around 9.15pm, an officer heard a smoke alarm on the ground floor landing. She went to check the cell and a prisoner told her that it was nothing to do with him. When she went back upstairs, she heard groaning as she passed Mr Hilton's cell and opened the observation panel. She noticed Mr Hilton face down on the floor and, suspecting he was having a fit, she went to a nearby office and called an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) at 9.21pm.
38. The officer returned to Mr Hilton's cell followed by a nurse, who was on the segregation unit issuing medication, and opened the observation panel. She noticed that Mr Hilton had turned over, that his T-shirt was alight and next to him was a taper. (Prisoners use tapers to smoke PS in the absence of traditional lighting methods, such as lighters. They are made by tightly rolling toilet tissue, which is then set alight using electric wires or a plug socket.) CCTV shows that the officer immediately retrieved a nearby water misting hose and passed it to an operational support grade (OSG), who inundated the cell via the inundation point (a removable bung that allows a hose to be used to spray water into a cell without opening the door) at 9.22pm. Records indicate that he extinguished the fire at 9.23pm.
39. At 9.24pm, a prison manager and supervising officer (SO) arrived. The SO looked in the cell and noticed that Mr Hilton was by the back wall and not moving. At 9.25pm, the prison manager alerted control room staff about the fire and asked for the fire service to attend. The SO remained outside the cell with the OSG and noticed that Mr Hilton started to move around his cell, shouting incoherently, before collapsing in front of the door.
40. In the meantime, additional staff, including a dog handler, arrived on the unit. Several staff put on respiratory protective equipment (RPE) and paramedics arrived at 9.36pm. The cell door remained locked and paramedics spoke to Mr Hilton through the observation panel. The fire service arrived at 9.41pm and prison staff immediately opened the cell door. At 9.42pm, prison and fire service staff moved Mr Hilton onto the wing landing for greater accessibility.
41. Records show that Mr Hilton started to resist attempts by paramedics to treat his injuries and the SO used a standard handcuff to restrain him. Additional paramedics arrived shortly afterwards and Mr Hilton continued to display difficult and aggressive behaviour. He resisted treatment and made several threats towards staff, which resulted in the paramedics having to sedate him for safety. At 11.06pm, paramedics transferred Mr Hilton to Peterborough City Hospital and four officers escorted him restrained by a standard handcuff and an escort chain.

Events from Saturday 9 December to Friday 29 December

42. On 9 December, Mr Hilton was transferred by ambulance to a specialist burns unit at Broomfield Hospital, Essex. Records show that he told escort officers that he took PS that he had obtained in the prison chapel. Hospital staff admitted Mr Hilton and he had several operations to treat significant burn injuries to his chest,

arms and face. Healthcare staff at Whitemoor maintained frequent contact with the hospital for updates on his condition.

43. On 16 December, Mr Hilton was returned to the prison's healthcare unit. A nurse saw him for a review and noted that he had sustained 15% full thickness burns (burns that destroy both layers of skin and may penetrate more deeply into underlying structures) and that he was using a wheelchair to mobilise. Later the same day, a nurse prescriber prescribed medication requested by hospital specialists, which included oxycodone and morphine (opiate based pain relief medications) and tinzaparin (an anticoagulant medication that reduces the formation of blood clots).
44. On 17 December, a nurse took Mr Hilton's clinical observations and noted that he had an elevated temperature of 38.5°C (normal being 37°C) and a fast pulse of 119bpm (normal being 60-100bpm). She contacted Broomfield's burns unit and staff suggested an emergency transfer to hospital, in case of infection. However, a prison manager told her that he did not have enough officers to facilitate an escort. The nurse contacted an out of hours GP, who reiterated the need for a transfer, and she arranged for an ambulance that was already at the prison and no longer required, to take Mr Hilton to Peterborough City Hospital. Three officers escorted him using an escort chain. Mr Hilton was returned to prison the next day, as his observations had returned to normal.
45. On 20 December, an officer opened Mr Hilton's cell to check on his general wellbeing. Mr Hilton started to cry and said that he could not cope with the unbearable pain of his burns and had had enough. The officer started suicide and self-harm procedures, known as ACCT. A prison GP saw Mr Hilton for a review and changed his prescription of morphine to liquid oxycodone, to prevent itching and to see if his pain improved. The following day, prison staff closed the ACCT following an assessment, as Mr Hilton said he did not intend to end his life.
46. Over the next week, healthcare staff monitored Mr Hilton's condition frequently and prison staff escorted him to his outpatient appointments at Broomfield's burns unit. Records show that Mr Hilton kept removing his dressings despite advice to keep them in place. Nurses created a generalised wound care plan and replaced his dressings when required. Records show that staff issued appropriate medication and frequently encouraged Mr Hilton to walk instead of relying too much on his wheelchair.
47. On 29 December, at 11am, a nurse saw Mr Hilton for a review and noted that he had removed his dressings and had smelly wounds. She took his clinical observations and completed a National Early Warning Score assessment (NEWS – a scoring system to assess clinical deterioration in patients). Based on Mr Hilton's observations, she scored him '6' (medium clinical risk) and requested an urgent GP appointment.
48. At 2.31pm, a prison GP saw Mr Hilton for a review and noted that he had fluid on his chest wounds and a yellow pus-like discharge from a wound on his left elbow. He contacted Broomfield's burns unit for advice and prescribed flucloxacillin (an antibiotic) as directed. At 2.44pm, a nurse observed Mr Hilton moving around his cell, changed his dressings and took his observations. She gave him a NEWS score of '0' (low clinical risk). At 9.03pm, a nurse issued Mr Hilton oxycodone.

There is no record that Mr Hilton pressed his cell bell or reported any concerns to staff overnight.

Events on Saturday 30 December

49. On 30 December, at around 7.45am, an OSG heard a groaning noise coming from one of the cells on the healthcare unit. She told the investigator that she initially thought it was a prisoner who had similar burn injuries to Mr Hilton and had been experiencing nightmares throughout the night. However, when she went to check, she noticed that the noise was coming from Mr Hilton's cell. She said she opened the observation panel and monitored Mr Hilton until he settled down. She told nurses that Mr Hilton had also had a nightmare.
50. At around 8.45am, two nurses went to Mr Hilton's cell to dispense his morning medication. A nurse opened the observation panel and saw Mr Hilton did not appear to be breathing. She called out to Mr Hilton and an officer, who was in the office opposite, realised something was wrong and arrived immediately. The officer unlocked the door and called an emergency code blue at 8.50am.
51. In the meantime, the nurse retrieved the emergency equipment, including a defibrillator, and entered Mr Hilton's cell. She noted that although he was warm to touch, he was not breathing and did not have a pulse. Both nurses started cardiopulmonary resuscitation (CPR) and continued until paramedics arrived at 9.02am. Paramedics took over the resuscitation attempt but were unsuccessful and at 9.35am, pronounced that Mr Hilton had died.

Contact with Mr Hilton's family

52. Later that morning, the prison appointed an officer as family liaison officer (FLO) and she confirmed that Mr Hilton had named his grandmother as his next of kin. The FLO and another officer left Whitemoor at 11am, and arrived at Mr Hilton's grandmother's address in Hull at 3.05pm. The FLO broke the news of Mr Hilton's death and his grandmother asked if they knew how he died. The FLO told her that a doctor who had been involved in Mr Hilton's care said there was a possibility that it was a heart attack.
53. The FLO provided ongoing support to Mr Hilton's grandmother until his funeral, which took place on 22 January. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

54. The prison posted notices informing other prisoners of Mr Hilton'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 Hilton's death.
55. There is no record that managers debriefed staff following Mr Hilton's death to review what had happened and to offer them support.

Post-mortem report

56. The post-mortem examination found that Mr Hilton died of pulmonary thromboembolus (the sudden obstruction of a lung artery due to a dislodged

blood clot) caused by deep vein thrombosis (a blood clot that develops within a deep vein, usually in the leg). The pathologist noted that tissue damage from burn injuries can predispose thrombosis, as can the limited mobility which may follow such an event.

57. Toxicological hair analysis identified that Mr Hilton had taken mirtazapine (an antidepressant) before his death. This had not been prescribed to him and we do not know where or when he obtained it. No other drugs were identified but we note that this kind of toxicology test cannot detect PS. The pathologist also noted that Mr Hilton had a 2.5cm unexplained laceration above his left eyebrow.

Findings

Clinical care

58. The clinical reviewer considered that Mr Hilton received a good standard of care at Whitemoor, equivalent to that which he could have expected to receive in the community. Staff put in place a care plan, changed his dressings when required, prescribed anticoagulant medication to prevent against blood clots and regularly encouraged him to mobilise without a wheelchair. The clinical reviewer noted that healthcare staff prescribed and issued appropriate medication and that they sought specialist advice from Broomfield's burns unit when required.
59. The clinical reviewer makes several recommendations in her report that relate to other aspects of Mr Hilton's care, including in-possession medication reviews and individualised care plans. We do not repeat the recommendations here, but they will need to be addressed by the Head of Healthcare.
60. We are satisfied that, overall, Mr Hilton received a good standard of healthcare at Whitemoor.

Emergency response on Friday 9 December

61. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Whitemoor'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 or has severe burn injuries. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for a member of healthcare staff to attend.
62. PSI 24/2011, 'Management and Security of Nights', states that staff have a duty of care to prisoners, to themselves, and to other staff, and that preservation of life must take precedence over usual arrangements for opening cells. It says that where there is or appears to be immediate danger to life then a single member of staff can enter the cell alone, after performing a rapid dynamic risk assessment.
63. An officer responded promptly and called a code blue when she saw Mr Hilton collapsed on his cell floor. Although we consider that a medical code red would have been more appropriate in the circumstances, we recognise that the officer did not see any flames until Mr Hilton had turned onto his front. Control room staff called an ambulance immediately following the code blue and alerted the fire service, once requested. We are satisfied that there was no unnecessary delay in notifying the emergency services.
64. When the officer noticed that Mr Hilton had set light to himself, she quickly obtained the correct hose and the OSG appropriately inundated the cell. Although we are satisfied that staff took suitable action to put out the fire, we are concerned that they did not enter Mr Hilton's cell until the fire service arrived, 19 minutes later. At interview, a prison manager, who was the most senior person present, told us that, due to his level of risk, Mr Hilton was assessed as a 'level three' unlock, meaning that three officers and a supervising officer (SO) had to be present to open his cell.

65. At 9.28pm, CCTV shows the prison manager, an SO, an officer and two OSGs on the landing outside Mr Hilton's cell. A dog handler arrived two minutes later, but despite there being more than the required number of staff available to meet the unlock requirement, they remained outside, monitoring Mr Hilton through the observation panel. The prison manager told us that the incident where Mr Hilton had assaulted a member of staff two days earlier was fresh on their minds and that the staff outside the cell would have completed a dynamic risk assessment before deciding not to open the door. He said that he decided to leave the cell to act as a runner as he had all the keys.
66. While we appreciate the distress of seeing a prisoner in such circumstances and that officers must have regard for their own safety when considering whether or not to enter a cell, we do not understand why staff concluded that it was not safe to enter Hilton's cell given the number of staff available and the potential risk to life. By failing to follow PSI 24/2011 and immediately enter Hilton's cell, there was an unnecessary delay in treating Mr Hilton. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that staff enter cells as quickly as possible in life-threatening situations.

Emergency response on Saturday 30 December

67. When an OSG realised that the noise she heard was coming from Mr Hilton's cell, she promptly checked on him. At interview, the OSG told us that Mr Hilton was initially thrashing about on his bed making a groaning sound and that she watched him until he settled. She said that although she could not see whether Mr Hilton was breathing, she observed slight movement and said that he looked asleep. Considering that there was another prisoner on the wing with similar injuries who had been suffering nightmares and that the OSG monitored Mr Hilton, we are satisfied that this was appropriate.
68. Later that morning, a nurse quickly noticed that Mr Hilton was unresponsive and an officer called an appropriate emergency code. The control room immediately called an ambulance, in line with prison service instructions. We are satisfied that on this occasion, the emergency response was appropriate.

Psychoactive Substances

69. Mr Hilton presented to prison staff under the influence of PS on at least three occasions in October and November 2017. Staff submitted appropriate intelligence reports and arranged for a MDT. A member of substance misuse staff saw Mr Hilton for a review following a positive MDT and offered support, but he declined intervention. Mr Hilton may have been coerced by other prisoners to participate in dangerous and reckless acts to obtain PS, but there is no record that staff were aware of this before he died. We are satisfied that staff acted appropriately.
70. Mr Hilton told escort officers that he took PS prior to setting himself alight and that he had obtained it in the chapel. Although the chaplaincy database states that Mr Hilton did not attend the chapel between 6 and 8 December, a prisoner

told us that he saw him there during this period. Records indicate that the route between the chapel and the segregation unit is known for drug trafficking and that prisoners use gaps in cages surrounding the cell windows to pass illicit drugs to each other. At interview, a prison manager told us that all prisoners receive a full search (also known as a strip search) prior to entering the segregation unit. He said that staff conduct searches after prisoners return from certain areas, such as the visits hall or the chapel, but that they are not full searches. Therefore, we consider it likely that Mr Hilton obtained PS while he was in the segregation unit.

71. At their most recent inspection in March 2017, HM Inspectorate of Prisons reported that illicit drugs were readily available at Whitemoor. In July 2015, we published a Learning Lesson Bulletin about deaths associated with the use of PS. The bulletin identified the need for better awareness among staff of the dangers of PS; the need for more effective drug supply reduction strategies; and better monitoring by drug treatment services. It is important that prisons do all they can to address the use of illicit drugs.
72. We accept that Whitemoor has a drug strategy in place, which includes searches, search dogs, a BOSS chair (body orifice security scanner), MDTs and the use of structured intelligence sharing for identifying themes and trends. Nevertheless, the last HMIP report indicated that drugs are easily accessible to prisoners and Mr Hilton died as a consequence of taking PS. We are particularly concerned that Mr Hilton was able to obtain PS while in one of the most secure parts of the prison and make the following recommendation:

The Governor should ensure that appropriate resources are focused on preventing illicit substances entering the segregation unit.

Restraints, security and escorts

73. When prisoners must travel outside of the prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility.
74. When Mr Hilton went to hospital on 8 December, a prison manager authorised four officers to escort him using a standard handcuff to both wrists and an escort chain. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
75. At 10.15am, on 9 December, a prison manager reviewed Mr Hilton's risk assessment. He reduced his level of restraint to an escort chain and his staffing level to three officers. The risk assessment indicated that Mr Hilton presented a high risk to staff and to the public and cited his recent violent behaviour and illicit substance misuse. Prison healthcare staff did not object to the use of restraints, but suggested their removal during general anaesthetic. Staff kept Mr Hilton's risk assessment under review and removed his escort chain for surgery.

76. Mr Hilton went to hospital four more times between 17 and 27 December. His risk assessments recommended that three officers escort him due to his recent violent behaviour, and restrain him by an escort chain to his right wrist to avoid his burn injuries. We consider that cuffing arrangements were appropriately kept under review and decisions were proportionate to the assessed risk.

Support for staff

77. PSI 64/2011 requires a manager to hold a debrief after a prisoner's death, for all staff involved, including healthcare staff. It does not differentiate between prison and hospital deaths. The purpose is to offer support, allow staff to support each other and to discuss any lessons from how the situation was handled.
78. Our investigation found that a prison manager did not hold a debrief following Mr Hilton's death. We make the following recommendation:

The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

**Prisons &
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