Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Joseph Sullivan a prisoner at HMP Onley on 6 September 2016

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 Joseph Sullivan died on 6 September 2016 of heart disease, contributed to by drug use, at HMP Onley. Mr Sullivan was 51 years old. I offer my condolences to Mr Sullivan's family and friends.

The investigation found that the clinical care Mr Sullivan received was not equivalent to that he could have expected to receive in the community. In particular, he was not monitored for cardiac risk, although he presented with several risk factors, including smoking and a history of drug use. This drug abuse was not effectively addressed. There were also weaknesses in morning unlock procedures.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2017**

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Summary

Events

1. Mr Joseph Sullivan was admitted to HMP Hewell on 13 April 2016, on remand. He was sentenced to 22 months imprisonment for dangerous driving on 17 May. Mr Sullivan was known to use NPS while in Hewell and, on at least one occasion, the prison called paramedics to assess him. He was transferred to HMP Onley on 15 June.

2. At his reception health screen, a nurse noted that Mr Sullivan smoked cigarettes, and was prescribed methadone to treat both pain relief and substance misuse issues. Hewell had switched Mr Sullivan from dihydrocodeine for pain relief to methadone. The prison was aware of his NPS use and doctors kept his methadone prescription to a low dose, to prevent any harmful interaction. On 11 August, Mr Sullivan was suspected of being under the influence of a substance and he freely admitted to using illicit substances. He was removed from drug misuse services two weeks later following a change back to dihydrocodeine.

3. Mr Sullivan reported chest and arm pain in the evening of 5 September, but was walking, breathing and talking without any problems. Officers assessed him and decided not to call the out of hours doctors service. He said he would go to see healthcare staff in the morning.

4. A member of night staff saw Mr Sullivan overnight, once when he was awake and twice in his bed. He noticed nothing concerning about Mr Sullivan. On the morning of 6 September, an officer checked all prisoners in their beds, and another officer unlocked Mr Sullivan's cell at 7.50am and thought he was asleep. The officer did not try to gain a response. Another prisoner found Mr Sullivan unresponsive in bed at about 8.15am and raised the alarm. There were clear signs of death and so healthcare staff did not try to resuscitate Mr Sullivan. A doctor pronounced him dead at 8.43am.

Findings

5. The investigation found that the clinical care Mr Sullivan received was not equivalent to that he could have expected to receive in the community. He was not monitored for cardiac risk, although he presented with several risk factors, including smoking and a history of drug use.

6. The night before Mr Sullivan died, he reported being unwell. Although staff did not call the out of hours doctors service, this is understandable. It is apparent that night staff checked on him, but did not record doing so. Officers did not routinely check on prisoners' welfare, either at the roll count or when they unlocked cells. This is against Prison Service policy.

7. Mr Sullivan's drug use, including NPS, was not satisfactorily addressed at Onley despite clear evidence of usage at Hewell and his admission of using illicit substances. Mr Sullivan was discharged from drug misuse services two weeks earlier and only received these services as long as he was using methadone for pain relief, rather than in light of intelligence and self-reporting of drug abuse. The post-mortem report concluded he had used NPS in the days before he died,

and indicates he may have used methadone which he was not prescribed. A prisoner told staff after Mr Sullivan's death that he had taken NPS the day before he died.

Recommendations

- The Head of Healthcare should ensure that prisoners are assessed for cardiac risk factors in line with NICE guidelines.
- The Governor and Head of Healthcare should ensure that there is an effective protocol in place so all staff are aware of how to respond when a prisoner reports sudden chest pain.
- The Governor should ensure that prisoners identified as using illicit drugs, including NPS, are referred to drug treatment services and that there is an active response to security intelligence, as part of an effective drug supply reduction strategy.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

The Investigation Process

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

9. The investigator obtained copies of relevant extracts from Mr Sullivan's prison and medical records.

10. The investigator interviewed 9 members of staff at Onley on 13 October 2016. She interviewed two further members of staff and one prisoner by video conferencing on 25 October.

11. NHS England commissioned a clinical reviewer to review Mr Sullivan's clinical care at the prison. She conducted joint interviews with the investigator at the prison.

12. We informed HM Coroner for Northamptonshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Sullivan's sister, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She wanted clarification of the circumstances, and to know if Mr Sullivan had requested help during the night before he died, and if officers checked on him.

14. Mr Sullivan's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

15. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Onley

16. HMP Onley is a resettlement prison serving the Greater London area. It holds approximately 742 adult male prisoners. Northamptonshire Healthcare NHS Foundation Trust provides health services including primary care, mental health and substance misuse services. A GP is on duty during normal working hours.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Onley was in June 2012. Inspectors reported that substance misuse services were generally good, but a higher percent of prisoners tested positive for illicit substances then at other establishments. Prisoners who had addictions to substances other then opiates, reported difficulties in accessing the services. Safer custody dealt well with bullying and self-harm. Health care provision was good, with good partnership working and a range of clinics.

Independent Monitoring Board

18. 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 February 2016, the IMB reported that substances were trafficked into the prison through visits, and by drones and by drops over the prison walls.

Previous deaths at HMP Onley

19. Mr Sullivan is the fourth prisoner to die of natural causes at HMP Onley since January 2012. There has been one self-inflicted death. In that case, we also made a recommendation about the use of NPS, although the circumstances were different.

New Psychoactive Substances (NPS)

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

21. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

22. NOMS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and NOMS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

23. Mr Joseph Sullivan was remanded to HMP Hewell on 13 April 2016. He was sentenced to 22 months imprisonment for dangerous driving on 17 May.

24. While Mr Sullivan was in Hewell there were several incidents when prison staff recorded he was under the influence of NPS. Mr Sullivan said that other prisoners would give him cigarettes which they had spiked with NPS without his knowledge. Another prisoner told staff in front of Mr Sullivan, that he knew he was taking NPS. Staff recorded that they warned him about the risks of taking cigarettes from other prisoners, and of the use of NPS. During one incident, paramedics attended to assess him, but did not take him to hospital.

25. Mr Sullivan reported issues with bullying in Hewell, and requested a transfer to another prison. Two prisons declined to admit him because of his NPS use. HMP Onley accepted the transfer, and admitted him on 15 June.

26. At Mr Sullivan's reception health screen that day, a nurse noted that he smoked cigarettes and took methadone replacement therapy for drug misuse, as well as for pain relief. Mr Sullivan reported a history of various accidents causing pain, and he had previously admitted to now being addicted to pain relief medication. A prison GP reviewed him the next day. She noted that, because of possible negative side effects of NPS and methadone interacting, doctors in Hewell had quickly reduced his methadone treatment from 40mls to 15mls. Mr Sullivan reported being unhappy with this. The GP kept him on 15mls for the same safety reasons, and planned to review him in a month.

27. A substance misuse services recovery worker introduced herself to Mr Sullivan on 23 June. She was unable to complete the review that day because Mr Sullivan made inappropriate comments, and stated he was using methadone for pain relief and not for substance misuse issues. She told the investigator that she felt Mr Sullivan was avoiding answering the questions she asked. She did not complete the review before Mr Sullivan died. He cancelled his substance misuse services physical check on 25 July.

28. From 30 July, Mr Sullivan told officers he was staying in his cell because he wanted to avoid getting into trouble. It is recorded that he had a disagreement with other prisoners on the wing. Safer custody officers monitored the situation. However, there is no evidence that other prisoners bullied Mr Sullivan, or that there were any specific incidents with other prisoners that made him stay in his cell.

29. On 11 August, Mr Sullivan saw a nurse and a prison GP for drug addiction therapy. Mr Sullivan admitted to using illicit substances when he could. The GP noted that he appeared to be under the influence of a substance, and had a homemade weapon (a knuckle duster). He asked her for an increase in his methadone dosage. She did not increase his methadone, and planned to wait and see how he coped before changing his prescription. She was concerned about the improvised weapon, and reported it to an officer. Urine testing for drug use was completed, and Mr Sullivan's results were negative for illicit substances.

30. Mr Sullivan began to mix with others on the wing again, from 22 August. On 25 August, a prison GP changed his medication from methadone to dihydrocodeine (an alternative pain relief). He was withdrawn from the drug misuse services, as he was now being clinically treated only for pain. Between June and August, he requested ibuprofen 15 times but not at times close enough together to prompt a review.

5 – 6 September 2016

31. On 5 September, Mr Sullivan pressed his cell bell (reported to be about 10.30pm) and an Operational Support Grade (OSG) responded. Mr Sullivan said that he had chest pains, and the OSG radioed for the Custodial Manager (CM) to attend the cell. The CM and two officers went to see Mr Sullivan, and went into the cell. The officers reported that Mr Sullivan said that he had chest and arm pain. He told them that he had been to the gym for the first time in three months that day. He was moving around and talking without difficulty. The CM told Mr Sullivan that he did not appear to be an emergency, and so he would not call an ambulance. He considered calling the out of hours service with the option of a doctor attending in the next few hours. Mr Sullivan instead asked for some paracetamol, and told the officers he would go to see healthcare staff in the morning. All the officers agreed not to call the out of hours doctors service as Mr Sullivan did not seem that unwell.

32. The CM went to collect some paracetamol, which he returned with and gave to Mr Sullivan. Later, sometime after midnight, the OSG saw Mr Sullivan because he handed Mr Sullivan some cigarette papers that another prisoner handed to him through their cell observation panel. The OSG reported that he saw Mr Sullivan again at about 3.00am, when the light was on is his cell and he looked to be lying on his side, asleep. The OSG saw him again at 5.30am. He reported the cell light was off at this time and Mr Sullivan looked to be sleeping in the same position.

33. On the morning of 6 September, an officer did a roll count (checking prisoners are in their cells through the observation panel) after 7.20am and reported no concerns. She thought Mr Sullivan was asleep. Another officer unlocked the cell, between 7.50am and 8.10am. She reported that she unlocked the cells and checked that prisoners were there, but did not try to get a response. She saw that Mr Sullivan appeared to be asleep.

34. After unlock, prisoners collect their medication in two groups. Mr Sullivan was usually in the first group to collect his medication. Nurses usually ask officers to collect the prisoners who do not attend. There was a delay and another prisoner asked who they were waiting for. When told one of the prisoners was Mr Sullivan, he chose to go and get Mr Sullivan, because they knew each other.

35. The prisoner knocked on Mr Sullivan's door and got no response. He went into the cell, telling Mr Sullivan to get up. When he got to the bed, he saw that Mr Sullivan's face was a strange colour. He left the cell and shouted to an officer that Mr Sullivan was dead.

36. The officer attended and called an emergency code blue, recorded at 8.16am. Two nurses arrived quickly. They noted that Mr Sullivan was stiff and cold to the

touch, and his blood had pooled where he was lying, which are both signs of death. They did not attempt to resuscitate him because it would have been futile. A prison GP pronounced him dead at 8.43am.

37. A prisoner subsequently wrote a note and passed it to officers, reporting rumours he had heard in the prison. It stated that other prisoners on that wing had said Mr Sullivan had taken a lot of NPS that day and was 'very high'.

Contact with Mr Sullivan's family

38. The prison appointed an officer as the family liaison officer, and he went to Mr Sullivan's mother's house, with a governor and a chaplain. They informed Mr Sullivan's sister of his death and offered ongoing support.

39. Mr Sullivan's funeral was on 19 September, and the prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

40. After Mr Sullivan's death, the deputy governor 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.

41. The prison posted notices informing other prisoners of Mr Sullivan'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 Sullivan's death.

Post-mortem report

42. The post-mortem report concluded that Mr Sullivan died of ischaemic heart disease. His arteries showed severe narrowing, and there was evidence of previous heart injury (lack of oxygen to the heart muscle).

43. There were some prescribed medications present in his blood stream (methadone, dihydrocodeine and paracetamol) which did not contribute to his death. The post-mortem reports that the presence of methadone meant it could have been taken several days (it does not specify how many) before Mr Sullivan died. There was also evidence that he had used NPS, and it may have contributed to his death, although the pathologist could not be certain.

Findings

Clinical care

44. The clinical reviewer concluded that the care that Mr Sullivan received was not equivalent to the care he could have expected to receive in the community. In particular, his risk of heart disease was not monitored despite him presenting with risk factors, including his age and substance misuse. His ongoing substance misuse and use of ibuprofen would have affected the health of his heart. Mr Sullivan was booked in for a 'well man' clinic during his time at Onley, which he did not attend. Another review was not organised and a cardiac assessment was not planned. We make the following recommendation:

    The Head of Healthcare should ensure that prisoners are assessed for cardiac risk factors in line with NICE guidelines.

45. When Mr Sullivan complained of chest pains, he did not seem particularly unwell and the pains did not appear to be severe. The clinical reviewer concluded that it was reasonable that officers did not call an ambulance or out of hours doctor as Mr Sullivan did not seem distressed and was seen walking around later that night.

46. Healthcare staff are present in the prison during the day, seven days a week, for up to 12 hours. Outside this time the prison relies on an out of hours doctor telephone service called M-Doc, and officers can also call the NHS helpline. In interview, officers said that, during the night shift, it was the responsibility of the Custodial Managers to contact the out of hours service for advice. Although it was the view of the clinical reviewer that the decision not to have called the out of hours service was reasonable in Mr Sullivan's case, it was evident from the responses of staff at interview that they were unclear how to react when a prisoner complained of chest pain. We therefore recommend that the Head of Healthcare and Governor ensure that a protocol is put in place so officers understand what to do when a prisoner complains of chest pain.

    The Governor and Head of Healthcare should ensure that there is an effective protocol in place so all staff are aware of how to respond when a prisoner reports sudden chest pain.

Illicit drugs and NPS

47. When Mr Sullivan was in HMP Hewell he used illicit drugs, including NPS, frequently. On some occasions, he became unwell after their use. When he was transferred to HMP Onley, this history was available in his records, and staff knew about it. An officer said she suspected Mr Sullivan was using illicit drugs but there are no records relating to this. There is a record of Mr Sullivan freely acknowledging his use of illicit substances to healthcare staff. Mr Sullivan's misuse of drugs and associated risks was both disclosed and apparent to staff, and the prison should have acted on this information and managed Mr Sullivan accordingly.

48. Officers reported that Mr Sullivan did not display any strange behaviour or appear to be under the influence of any drugs on 5 September. Information passed to staff subsequently by a prisoner suggested Mr Sullivan was 'high' and

had consumed NPS that day. This is consistent with the post-mortem report which states that Mr Sullivan had consumed NPS before he died.

49. It is concerning that Mr Sullivan did not interact with a recovery worker after a partially completed substance misuse review on 23 June. He saw a doctor on 11 August, two weeks before the prison removed him from substance misuse services, and reported that he took illicit substances. On 25 August, a doctor stopped Mr Sullivan's methadone prescription. The post-mortem report indicates he may have taken some, therefore illicitly, in the days before he died. It is troubling that the prison appears to have focussed on pain relief and did not address the evidence of drug abuse satisfactorily.

50. Onley missed several opportunities to engage with Mr Sullivan and to address, monitor and reduce his substance misuse. The decision to withdraw him from the drug misuse services caseload is hard to understand and there is no evidence that doctors acted on Mr Sullivan's report of substance misuse after they received a negative result for illicit substances, or that they passed information he disclosed about his drug abuse to prison staff. There is no evidence that prison staff acted on their suspicions that Mr Sullivan may have been frequently using NPS.

51. HMP Onley has an up-to-date drug reduction policy which highlights ways to reduce the amount of drugs entering the prison, but is silent on the issue of NPS. Staff at Onley apparently took little action on the one occasion Mr Sullivan was thought to be under the influence of a substance, and did not record any other instances of suspected use of illicit drugs or NPS. They did not monitor him for NPS use, despite his earlier history. The information available to the prison was not reported, logged or evaluated as security intelligence. The clinical reviewer is concerned that Mr Sullivan's dependency on medication was not addressed, and that he did not have effective access to supportive therapy, such as might be offered by the substance misuse services. Staff at Onley need to be vigilant to the signs of NPS use, record it and report it, and ensure prisoners are engaged in services. We make the following recommendation:

The Governor should ensure that prisoners identified as using illicit drugs, including NPS, are referred to drug treatment services and that there is an active response to security intelligence, as part of an effective drug supply and demand reduction strategy.

Unlocking cells in the morning

52. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that: "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead". Prison Service Instruction 75/2011 states that: "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock… Where prisoners are not necessarily expected to leave

their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

53. Neither officer tried to gain a response from Mr Sullivan, nor apparently any other prisoner, on the morning of 6 August. In interview, one officer said she knew about gaining a response but she did not do it as part of the daily routine. When asked in interview, it is apparent that other officers also do not routinely seek a response from prisoners when they unlock cells. It is clear that the prison needs to ensure the morning routine is in line with national policy. It would not have made a difference for Mr Sullivan, as it appears he had been dead a while, but in other circumstances it could be critical. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

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