

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Darren McGuin a prisoner at HMP Lindholme on 22 February 2018

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 Darren McGuin died on 22 February 2018 at HMP Lindholme of a pulmonary embolism (blood clot in the lung). He was 38 years old. I offer my condolences to Mr McGuin's family and friends.

Three types of prescription drugs, none of which had been prescribed to Mr McGuin, were found in his system, and the post-mortem report concluded that his substance misuse was a factor in his death.

The investigation found that Mr McGuin's clinical care was equivalent to that he could have expected to receive in the community. He received good support with his substance misuse but unfortunately chose to stop engaging with the substance misuse services.

There were delays in the emergency response on the morning Mr McGuin died. The officer who unlocked him did not check on his welfare as she should have done, which led to a short delay in her realising he was unresponsive and calling a medical emergency code. Neither the officer nor the other prison staff who responded, attempted to resuscitate Mr McGuin. It was not until a nurse arrived that anyone started resuscitation attempts. There was also a delay before an ambulance was called.

Mr McGuin was able to obtain a range of prescription-only drugs that had not been prescribed to him at Lindholme. I am 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. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service. We have also written to the Prisons Minister setting out our 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

June 2019

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Summary

Events

1. On 24 November 2016, Mr Darren McGuin was sentenced to eight years and four months in prison for burglary offences. On 26 October 2017, he was moved to HMP Lindholme.
2. Mr McGuin had a long history of drug use. He was under the care of the Substance Misuse Service (SMS) at Lindholme initially, but by December he had stopped attending appointments.
3. In the meantime, in November, Mr McGuin's mail was read and a letter was found that he had written to an associate asking for drugs to be sent to him, and on 21 December, he failed a mandatory drugs test.
4. At around 8.15am on 22 February, an officer unlocked Mr McGuin's cell so he could attend work. She saw him lying on his bed in his clothes. She returned a few minutes later, realised he was unresponsive and radioed a medical emergency code. Other officers arrived and tried to find a pulse, but did not start cardiopulmonary resuscitation (CPR). A nurse started CPR when she arrived a few minutes later. Ambulance paramedics continued resuscitation attempts but at 8.57am, they declared that Mr McGuin had died.
5. The post-mortem examination showed that Mr McGuin had died from a pulmonary embolism (blockage of an artery in the lungs). Three types of opiate drugs were found in his system, none of which had been prescribed to him. The pathologist considered that his drug misuse had contributed to his death.

Findings

6. The clinical reviewer concluded that the clinical care Mr McGuin received at HMP Lindholme was equivalent to that he could have expected to receive in the community. She was satisfied that he received good support with his substance misuse.
7. We are, however, concerned that intelligence about Mr McGuin's involvement with drugs was not shared with the SMS.
8. The officer who unlocked Mr McGuin did not check on his welfare by getting a response from him as she should have done. As a result, there was a delay of a few minutes before a medical emergency code was called. Lindholme was unable to produce a copy of its local policy on unlock procedures.
9. We consider that prison staff should have started CPR as soon as Mr McGuin was found unresponsive, rather than waiting for healthcare staff to arrive.
10. The prison was unable to provide evidence that the emergency medical bags were being checked regularly.
11. We are concerned about the easy availability of illicit prescription drugs at Lindholme. Although the prison has a substance misuse strategy, more needs to be done to reduce supply and demand.

Recommendations

- The Head of Healthcare should ensure staff know how to make referrals to the mental health team, and do so where appropriate.
- The Governor should ensure that intelligence and other information about individual prisoners' involvement with drugs is shared with the SMS team.
- The Governor should ensure that, when staff unlock a cell, they satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor should produce a local policy on unlock procedures setting out what is expected of staff, in line with national guidance.
- The Governor should ensure that staff administer basic life support as needed until healthcare staff arrive.
- The Head of Healthcare should ensure that all healthcare staff understand the procedures for responding to a medical emergency code.
- The Head of Healthcare should ensure emergency bags are checked weekly and records kept.
- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
13. The investigator obtained copies of relevant extracts from Mr McGuin's prison and medical records.
14. NHS England commissioned a clinical reviewer to review Mr McGuin's clinical care at the prison.
15. We informed HM Coroner for South Yorkshire East District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
16. One of the Ombudsman's family liaison officers contacted Mr McGuin's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They did not raise any specific issues within the PPO's remit.
17. Mr McGuin's family received a copy of the initial report. They had a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
18. The initial report was also shared with HM Prison and Probation Service (HMPPS). HMPPS did not raise any factual inaccuracies and their action plan has been annexed to this report.

Background Information

HMP Lindholme

19. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm.
20. In August 2018, Lindholme was selected to be part of the '10 Prisons Project', which seeks to improve safety, security and decency at the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Lindholme was in October 2017. Inspectors noted at the previous inspection in March 2016, that the safety of the prison was significantly compromised by the ready availability of drugs and the consequent debt, bullying and violence. There had been some improvement in safety at Lindholme, and HMIP was able to lift the assessment from 'poor' to 'not sufficiently good'. However, this improvement was because of changes in reception and first night arrangements. Inspectors noted this was not a reflection of any decrease in the amount of violence or the threat posed to the prison by illicit drugs, which remained severe.
22. Over two-thirds of prisoners said that it was very easy or quite easy to get illicit drugs, and almost half to get alcohol. Over a quarter said that they had developed a drug problem while at Lindholme, which was far worse than at similar establishments. The availability and use of psychoactive drugs remained a serious problem. Inspectors noted the substance misuse meeting was only held once every two months and attendance was poor, with no representation from the security department. There was no detailed supply reduction action plan and a lack of a coordinated approach between all key stakeholders. Although inspectors accepted that the lengthy perimeter of the prison was difficult to defend, they found there was a need for a comprehensive, coordinated, drug supply reduction plan.

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 most recently published annual report for the year ending 31 January 2018, the Board noted that despite the efforts of the prison, the geography of Lindholme with its lengthy perimeter fence to defend, and the large proportion of prisoners linked to organised crime, made drug use difficult to combat. 75% of prisoners said drug use was a serious issue at the prison.

Previous deaths at HMP Lindholme

24. Mr McGuin was the 12th prisoner to die at Lindholme since February 2015. Of the previous deaths, four took their own lives, four died from natural causes, and three were drug-related. There have been six deaths since (three were drug-related, two

took their own lives and one is awaiting classification). We have made recommendations about unlock procedures and mental health referrals before.

Key Events

25. On 24 November 2016, Mr Darren McGuin was sentenced to eight years and four months imprisonment for burglary, theft and receiving stolen goods. In December, he was moved to HMP Lindholme and then In April 2017 to HMP Berwyn, before being moved back to Lindholme on 26 October.
26. On 26 October, a nurse conducted Mr McGuin's first night screen. He noted that Mr McGuin had a Body Mass Index (BMI) of 36.4 (severely obese). His blood pressure was within normal range. Mr McGuin had a long history of substance misuse. The nurse referred him to the Substance Misuse Service (SMS) and made a mental health referral. (The mental health team at Berwyn had seen Mr McGuin and planned a follow-up appointment, but he had moved before this took place.)
27. Also on 26 October, a prison GP prescribed Mr McGuin mirtazapine (an antidepressant) and olanzapine (an antipsychotic). On 27 October, he was prescribed methadone (a synthetic opiate drug used as a replacement for heroin). (His blood pressure and heart were regularly monitored as some of these medications can depress the circulatory system – there were no concerns.)
28. On 30 October, a social worker visited Mr McGuin's wing to conduct a mental health review but he was not available. She noted that the appointment needed to be rebooked. There is no record that this happened, but he was seen regularly by the SMS team instead and discussions about his mental health were documented.
29. On 2 November, a recovery worker in the SMS team conducted an initial substance misuse assessment. She noted that Mr McGuin had a history of misusing substances including heroin and was currently prescribed methadone. A urine screen was negative for all substances except for methadone which he was prescribed.
30. Mr McGuin said that he was feeling very stable, and an increase in his mental health medication had helped. He felt that once he detoxified from methadone he would not need any further SMS work. (His methadone regime was being gradually reduced by 2mls every fortnight from 6mls per day.) Mr McGuin and the SMS recovery worker also discussed toxicity and low tolerance issues and Mr McGuin demonstrated a good understanding. A drug screen was negative. Mr McGuin said that he wanted to be drug-free by Christmas 2017 and that he believed this was achievable with the right support.
31. On 14 November, a nurse noted that Mr McGuin's methadone prescription had been successfully reduced, and he hoped to have finished the course by Christmas. The nurse noted that the plan was to start him on loxefidine on 20 November (a drug that helps with heroin and other opiate withdrawal).
32. On 19 November, staff filed an intelligence report after Mr McGuin's mail was read and a letter was found asking an associate to send him drugs.
33. On 23 November, Mr McGuin met his new SMS key worker. He said that once he had completed his loxefidine course, he might not need any further support. His SMS key worker asked him to discuss the matter again once he had finished the

course and made him an appointment for 5 December. However, Mr McGuin did not attend this appointment even though his key worker checked with the wing that he had been given a movement slip and therefore had the opportunity to attend. She rebooked an appointment for 18 December but he did not attend.

34. On 21 December, Mr McGuin tested positive for drugs after a mandatory test. Staff filed an intelligence report.
35. Mr McGuin did not attend his SMS appointments on 5, 16 and 25 January 2018. On 25 January, his key worker withdrew him from the SMS service.

Events of 22 February 2018

36. On 22 February, at approximately 6.30am, an operational support grade (OSG) did the morning roll check. He said that he could not recall any issues.
37. Between 8.10am and 8.15am, an officer began unlocking the wing. She unlocked Mr McGuin's door and shouted to him to get ready for work. Mr McGuin was lying on his bed but was dressed. She noticed something white near his nose which she thought was a tissue.
38. She pulled the door to and continued unlocking the rest of the landing. Afterwards, she stood at the end of the landing briefly and answered a couple of prisoners' queries before walking round the landing again to make sure prisoners who had not responded to her were up and getting ready and leaving the wing for work.
39. When the officer got to Mr McGuin's cell, she noticed he had not moved so she asked him if he was getting up to attend work. He did not respond so she entered the cell thinking he was in a deep sleep. As she walked round the bed she called him again and shook his arm but he did not respond. She realised that he had white foam around his nose, not a tissue. She said she called a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties) at 8.19am.
40. The ambulance service told the clinical reviewer that they received a call for an ambulance at 8.23am and it was upgraded to an emergency ambulance at 8.26am.
41. Another officer responded to the code blue and tried to wake Mr McGuin but could not get a response. He could not find a pulse and noted Mr McGuin's lips were blue. A senior officer arrived and could not find a pulse either. A custodial manager also arrived at the cell.
42. A nurse arrived at approximately 8.23am. Prison staff told her Mr McGuin was unresponsive and they were struggling to find a pulse. She said she needed the emergency bag immediately. An officer who had just arrived at the cell to see if any more assistance was required, left to fetch the bag from the medication room on the same floor, and to ask the healthcare worker dispensing medication to come to the cell.
43. The nurse commenced cardiopulmonary resuscitation (CPR) and the pharmacy technician (who had been dispensing medication) arrived with the green bag and assisted her, as did another nurse. The defibrillator advised 'no shock'. Communications room staff asked the officer who found Mr McGuin unresponsive

to provide more information for the emergency services which she did. A prison manager also arrived at the cell.

44. Paramedics arrived at 8.37am. They continued resuscitation attempts and administered adrenaline. Mr McGuin did not respond and paramedics confirmed his death at 8.57am.

Contact with Mr McGuin's family

45. The prison assigned a custodial manager as the family liaison officer (FLO), and on 22 February she visited the next of kin to break the news of Mr McGuin's death. She stayed in touch with the family to offer advice and support.
46. Mr McGuin's funeral was on 9 March and the FLO and a prison manager attended. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

47. After Mr McGuin's death, a prison 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.
48. The prison posted notices informing other prisoners of Mr McGuin'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 McGuin's death.

Post-mortem report

49. The coroner provided a copy of the post-mortem report. The pathologist found that Mr McGuin died as a result of a massive pulmonary embolism (a blood clot in an artery in the lung). He said that this can occur at any time, without provocation, but that the most likely cause in Mr McGuin's case was poor mobility as a consequence of his drug-taking.
50. Toxicology tests showed a number of prescription medications in Mr McGuin's system: tramadol (an opiate pain killer which is often abused for its heroin-like effects), dihydrocodeine (also an opiate pain killer) and buprenorphine (an opiate used to treat opiate addiction but also widely abused). All these drugs are illicitly traded in prisons.
51. None of the drugs found in Mr McGuin's system were at levels normally associated with death, but the dihydrocodeine was at a much higher level than the normal therapeutic range. Mr McGuin was not prescribed dihydrocodeine, tramadol or buprenorphine.

Events after Mr McGuin's death

52. During another PPO investigation at Lindholme, a prisoner alleged that the day before Mr McGuin's death, staff had ignored Mr McGuin's complaints of chest pain. Prison records suggest that prisoners claimed this had happened in the medication queue. The investigator tried to speak to the prisoner for more information but he refused to speak to her. She tried to contact the pharmacy technician who was on medication hatch duty on 21 February, but she was an agency worker who no longer works at the prison or for the agency.

Findings

Clinical care

53. The clinical reviewer was satisfied that the care Mr McGuin received at HMP Lindholme was of a good standard and equivalent to that which he could have expected to receive in the community.
54. The records indicate that Mr McGuin's blood pressure was regularly checked and he had electrocardiograms (ECGs - tests to monitor the heart's rhythm). This was necessary because the medication he was prescribed is known to depress blood pressure and heart rate. There were no concerns.
55. We have not been able to establish whether Mr McGuin complained of chest pains the day before his death. If he did tell staff, he should have been checked by healthcare. However, it appears that Mr McGuin felt well enough to go back to his cell and there is no evidence that he pressed his cell bell for assistance.

Management of Mr McGuin's substance misuse and mental health

56. Mr McGuin had a long history of substance misuse and he was immediately referred to the SMS team when he arrived at Lindholme. He was followed up regularly, and when he failed to attend appointments he was always offered alternative dates. However, after repeatedly failing to attend appointments, the service discharged him from their list. The clinical reviewer's opinion is that the service's persistence in trying to engage with Mr McGuin went above and beyond what they should be expected to offer.
57. Mr McGuin had a history of depression and schizoaffective disorder and personality disorder relating to poly-drug misuse. He was involved with the mental health teams at previous prisons and when he arrived at Lindholme he was due to be seen by social worker for a mental health review. He was not on the wing when she came to see him and she noted that the appointment should be rebooked. There is no record that this was done, although there are notes in the medical record that his mental health was discussed with members of the substance misuse team. However, we make the following recommendation:

The Head of Healthcare should ensure staff know how to make referrals to the mental health team, and do so where appropriate.

Intelligence and information sharing

58. It has been a feature of previous PPO reports where drugs have played a role in a prisoner's death, that information is often collected about an individual's involvement with drugs but this information is not shared appropriately and little action is taken.
59. Two intelligence reports were submitted about Mr McGuin's involvement in drugs at Lindholme. The first was on 19 November 2017, when it was found he had written a letter asking for drugs to be sent to him. The second was on 21 December, after Mr McGuin had tested positive for drugs after a mandatory test.

60. The investigator asked what action was taken after this information was collected, and was told Mr McGuin had his mail monitored. An adjudication took place in response to his positive drug results and ten days was added to his sentence (suspended).
61. The investigator also asked the SMS Lead if information about Mr McGuin's involvement with drugs was shared with her team. She said it was not, but that since February 2018, all intelligence reports were now shared with her team. However, as this is an important issue, we make the following recommendation:

The Governor should ensure that intelligence and other information about individual prisoners' involvement with drugs is shared with the SMS.

Emergency response

62. When a prisoner's cell is unlocked, officers should take active steps to check on the prisoner's wellbeing. 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".
63. Prison Service Instruction 75/2011 Residential Services states that:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the wellbeing 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."
64. Lindholme did not provide the investigator with a copy of its unlock policy, despite repeated requests, but did confirm that staff are expected to get a response from prisoners at unlock. A prison manager eventually provided a copy of an operational order dated 13 October 2017 instructing staff to conduct a welfare check during unlock.
65. On 22 February 2018, an officer unlocked Mr McGuin's door between 8.10am and 8.15am and shouted to him to get ready for work. She saw Mr McGuin was lying on his bed and dressed and she noticed something white near his nose which she thought was a tissue – but she did not get a response from him. Instead she pulled the door to and continued unlocking the rest of the landing, pausing to stop to answer prisoners' queries. She did another round to ensure that prisoners were getting ready for work and at this point discovered that Mr McGuin was unresponsive.
66. We appreciate that the officer might have thought all was well because Mr McGuin was dressed, and we recognise that she went back to check on him. However, not getting a response when she first unlocked Mr McGuin caused an unnecessary

delay in getting him assistance. We are also concerned that Lindholme were not able to provide a copy of its unlock policy. We make the following recommendations:

The Governor should produce a local policy on unlock procedures setting out what is expected of staff, in line with national guidance.

The Governor should ensure that, when staff unlock a cell, they satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

67. Neither the officer who unlocked Mr McGuin, nor the officers who responded to the code blue call, started CPR. No one started CPR until a nurse arrived, four minutes after the code blue was called. We consider that when prison staff find a prisoner unconscious and not breathing, they should start CPR immediately and not wait for healthcare staff to arrive. We make the following recommendation:

The Governor should ensure that staff administer basic life support as needed until healthcare staff arrive.

68. PSI 3/2013, *Medical Emergency Response*, requires prisons to have a medical emergency response code protocol to communicate the nature of a medical emergency, ensuring staff take the relevant equipment to the incident, and to trigger the automatic calling of an ambulance.
69. Lindholme's local protocol, Notice to Staff 75/2017 issued on 26 June 2017, is clear that an ambulance should be called immediately when a medical emergency code is radioed, in line with PSI 3/2013. The notice also states that this has been agreed with the Yorkshire Ambulance Service NHS Trust, who have said they will always immediately despatch an ambulance even if some details (such as the name or age of the patient, or their specific symptoms) are not known.
70. In response to a request for a copy of the control room log for the morning of 22 February, Lindholme provided some pages dated 21 February and some dated 22 February. One of the pages dated 21 February records a code blue and subsequent ambulance call at exactly the same time we would have expected them to have been recorded on 22 February. It shows that a code blue was radioed at 8.19am, and an ambulance was called at 8.21am (altered from originally saying 8.23am). The officer who discovered Mr McGuin has said that she radioed a code blue at 8.19am on 22 February and the ambulance service have told us the call from the prison was received at 8.23am.
71. We think it is likely that the log has been misdated, and the prison have said they also think this is what happened. We note that in another investigation into a death that occurred shortly after Mr McGuin's, a member of control room staff had to be retrained after making errors on the log in that case. It seems that the same staff member was involved here, and we have sought assurances from the prison that the retraining took place and included a reminder that ambulances must be called immediately. They have confirmed that the individual was given a refresher on control room practices.

72. A nurse responded to the code blue. It is clear from her statement that she did not have an emergency bag with her, so she asked an officer to go and fetch one. The nurse has left Lindholme as has the officer who went and got the bag for her.
73. The investigator asked the current Head of Healthcare if she would normally expect an emergency responder to take the emergency bag with them and she said that she would. It is possible that the nurse did not have the bag with her because she was not actually in healthcare when she responded to the call and went straight to the scene by the most direct route. However, as it is not clear what happened, we make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff understand the procedures for responding to a medical emergency code.

74. The emergency bags should be checked every week by a senior nurse to ensure the equipment is present and working. The clinical reviewer asked to see the checklists for the bags. The Head of Healthcare, who was not in post at the time of Mr McGuin's death, was unable to trace the checklists for that day. We make the following recommendation:

The Head of Healthcare should ensure emergency bags are checked weekly and records of checks kept.

Lindholme's drug strategy

75. Lindholme has a substance misuse strategy, issued in August 2017. We note that the last HMIP report (inspection carried out in October 2017) criticised the infrequency of substance misuse meetings (every two months) and the lack of an attendee from the security department. The investigator asked the SMS Lead how often meetings are held now and she said that although their regional substance misuse meetings were held every two months, the prison holds a drug strategy meeting once a month.
76. It is unclear how Mr McGuin obtained the prescription drugs that were found in his system and which he had not been prescribed. They could have been smuggled into the prison, or prisoners who had been prescribed that medication could have diverted it and traded it. Lindholme's strategy covers diverted medication and says, 'Healthcare staff will conduct random checks on prisoners and their in-possession medication, paying particular attention to tradable medication.' The Deputy Head of Healthcare provided a copy of the policy document covering medication hatch procedures. The policy was issued in March 2016 and is due to be reviewed in March 2019. Section 5.8 'Procedures for Administering' makes it clear that prisoners must be observed taking their medication to ensure they are not able to hide it and trade it.
77. We are aware that Lindholme is one of ten prisons that has been selected for a pilot project to test ways of reducing the availability of drugs and levels of violence within prisons. We do not, therefore, make any recommendations of our own.
78. However, Lindholme is not alone in facing the problem of drugs – 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,

but 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.

79. In a number of recent investigations, we recommended that the Chief Executive of HMPPS should issue detailed national guidance on measures to reduce the supply and demand of drugs in prisons. The Chief Executive told us that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (March 2019), this strategy has still not been issued. We therefore repeat the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

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