Prisons &
Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mark Scott a prisoner at HMP Rochester on 17 March 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Mark Scott died on 17 March 2018 at HMP Rochester of a drug overdose. A high level of prescribed medication was found in his system, along with psychoactive substances (PS), which together caused his death. He was 49 years old. I offer my condolences to Mr Scott's family and friends.

Mr Scott suffered from chronic back and hip pain for which he was prescribed pain relief medication. In addition, he used PS in order, he said, to cope with his pain. His pain caused him distress and on several occasions, he was monitored under Prison Service suicide and self-harm procedures (known as ACCT).

The clinical reviewer considered that prison doctors prescribed suitable pain relief medication and that Mr Scott's clinical care was of a good standard.

It is unclear how Mr Scott obtained the significant amount of medication that was found in his system. There were suspicions that he had been concealing some of his medication in the past, possibly to trade it, and it is clear that this was a continuing risk. It is also possible that he was buying trafficked prescription medication from other prisoners. Substance misuse staff reviewed Mr Scott frequently and discussed the dangers of using PS at the same time as his prescription medication but he continued to use them.

My investigation found some deficiencies in the management of ACCT procedures. It also found that there was a short delay in attending to Mr Scott when he was found unresponsive, because the unlock procedures were not carried out properly. I am satisfied, however, that this did not affect the outcome for Mr Scott.

I am concerned that illicit substances, including PS and trafficked prescription medication, were readily available to Mr Scott. Rochester has a local drug strategy but staff did not always act in accordance with it. I am also 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 **January 2019**

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Summary

Events

1. In January 2017, Mr Mark Scott was sentenced to two and a half years in prison for causing serious injury by dangerous driving. He was moved to HMP Rochester on 27 February.

2. Mr Scott suffered from chronic back, hip and leg pain for which prison GPs prescribed appropriate pain relief medication and referred him to specialists. He also had a history of mental health and substance misuse problems.

3. Despite receiving ongoing support from the prison's substance misuse team, Mr Scott took psychoactive substances (PS). He told staff that it helped him cope with his pain.

4. On 9 February 2018, a prison GP stopped Mr Scott's medication for 24 hours after he was found under the influence of PS. In response, he threatened to cut his throat and prison staff started suicide and self-harm procedures (known as ACCT). On 13 March, prison staff closed the ACCT as Mr Scott said that he had stopped using PS and he did not report any thoughts of suicide or self-harm.

5. On 17 March, at 4pm, an officer unlocked Mr Scott's door. A few minutes later, a prisoner found Mr Scott collapsed in his cell and alerted the officer. The officer went to the cell, saw Mr Scott was unresponsive and, at 4.03pm, called a medical emergency code.

6. Prison and healthcare staff arrived and started cardiopulmonary resuscitation (CPR). Paramedics arrived at 4.22pm and at 4.55pm, pronounced that Mr Scott had died.

7. The post-mortem examination found that Mr Scott died of drug toxicity caused by a mix of two pain relief medications (oxycodone and pregabalin) and PS. The report said that taken together, these substances would cause respiratory depression and hypoxic brain damage. Heart disease was given as a contributory factor.

Findings

8. The clinical reviewer considered that doctors prescribed suitable pain relief medication to Mr Scott and his clinical care was good. Substance misuse staff reviewed him frequently and discussed the dangers of using PS in addition to his prescribed medication. We are satisfied that staff did what they could to address his use of PS.

9. Although Mr Scott was prescribed both oxycodone and pregabalin, it is unclear how Mr Scott obtained the dangerously high amount of oxycodone that was found in his system when he died. There had been suspicions that Mr Scott had been concealing his pregabalin, possibly with a view to trading it, and we are satisfied that the prison dealt with this appropriately. He may have concealed and stockpiled his oxycodone, although there is no evidence of this, or – and this

seems more likely - he may have obtained additional oxycodone illicitly from other prisoners.

10. Mr Scott was subject to ACCT monitoring in the week prior to his death. As his low mood and substance misuse issues were primarily due to problems with his physical health, we are concerned that the ACCT reviews were not multi-disciplinary.

11. We are concerned that the officer who unlocked Mr Scott's cell on the afternoon he was discovered did not look through the observation hatch and failed to identify that he was unresponsive on the floor.

12. We are concerned at the availability of illicit substances at Rochester, including PS and diverted medication. Although Rochester has a comprehensive drug strategy, we found that staff did not always take the appropriate actions in line with the strategy in respect of Mr Scott's drug misuse and suspected diversion of medication.

13. It is clear that more needs to be done to limit the supply and demand for drugs. In our view there is now an urgent need for HMPPS to issue national guidance on this to prisons, rather than leaving individual establishments to develop their own local strategies on a piecemeal basis.

Recommendations

- The Governor should ensure that staff are fully aware of the actions they are required to take to comply with the local drug strategy and in particular, that they act appropriately in response to intelligence on the trading of prescribed medication and illicit drug misuse.
- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that staff:
  - hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews; and
  - set an appropriate frequency of observations that reflect the prisoner's risk and review it when the level of risk changes.
- 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

14. The investigator, issued notices to staff and prisoners at HMP Rochester informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

15. The investigator obtained copies of relevant extracts from Mr Scott’s prison and medical records.

16. The investigator interviewed seven members of staff and one prisoner at Rochester on 22 May 2018.

17. NHS England commissioned a clinical reviewer to review Mr Scott’s clinical care at the prison. They attended joint interviews with the investigator on 22 May.

18. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. One of the Ombudsman’s family liaison officers, contacted Mr Scott’s sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Scott’s sister wanted to know:

    - as much as possible about the events leading up to Mr Scott’s death;
    - why the officer who unlocked Mr Scott’s cell did not notice he was unwell;
    - who found Mr Scott and raised the alarm; and
    - what the prison did when they were unable to contact her.

20. Mr Scott’s sister received a copy of the initial report. She did not make any comments.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report had been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP /YOI Rochester

22. HMP Rochester is a training and resettlement prison holding 695 adult and young adult male prisoners. The prison was due to close for redevelopment at the end of 2017, but this was subsequently delayed without any specific timescales given. Oxleas NHS Foundation Trust is responsible for delivering primary physical and mental health services in the prison.

HM Inspectorate of Prisons

23. The most recent inspection of HMP / YOI Rochester was in October 2017. Inspectors reported that illicit drugs remained a major challenge, but that the prison was better focused on these issues. Managers and staff were aware of the main threats relating to illicit drugs, but more needed to be done to ensure all staff knew their role in addressing security matters. Inspectors reported that the lack of officer supervision of medicine queues was a concern. There was no supervision in the new health care centre and it was inconsistent in the old health care centre, where opiate substitution treatment was administered. This created too many opportunities for bullying and the diversion of medication.

24. Inspectors reported that although ACCT documentation had improved, staff did not always follow up care plans effectively and case reviews were usually not multidisciplinary.

Independent Monitoring Board

25. 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 March 2018, the IMB reported that the availability of drugs, particularly psychoactive substances, continued to be the main issue for safety and security at the prison. They also reported that safer custody meetings were held frequently, and ACCT reviews were, in the main, completed properly.

Previous deaths at HMP / YOI Rochester

26. Mr Scott was the second prisoner to die at Rochester since March 2015. There has been one death since. There are no significant similarities with the circumstances of the other deaths.

Assessment, Care in Custody and Teamwork

27. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner’s most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been

completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm, to self, to others and from others (Safer Custody).

Psychoactive Substances (PS)

28. 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.

29. 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.

30. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

31. On 27 January 2017, Mr Mark Scott was sentenced to two and a half years in prison for causing serious injury by dangerous driving and was sent to HMP Lewes. He was moved to HMP Rochester on 27 February.

32. Mr Scott suffered from several health conditions including high cholesterol and chronic back and leg pain. He had also sustained serious injuries in a car accident connected to his offence and had a total hip replacement in December 2016. However, despite treatment, his hip frequently dislocated and caused him significant pain. Mr Scott had reduced mobility and primarily used a wheelchair to get around. He smoked cigarettes and had a history of mental health and substance misuse problems.

33. At an initial reception screen, a nurse recorded that Mr Scott had a history of misusing benzodiazepines (medications that act as a sedative). He was given various medications, including antidepressants, antipsychotics and medication to reduce his cholesterol, which he was allowed in-possession. Prison staff allocated Mr Scott a cell on the prison's substance misuse wing, as it was the most suitable cell for a disabled prisoner. The next day, a prison GP reviewed Mr Scott's pain relief medication and prescribed pregabalin (an anti-epileptic medication that can also be used to treat nerve pain) and oxycodone (an opiate based pain relief medication). Mr Scott had to collect these two medications from healthcare staff daily.

34. On 3 March, a substance misuse worker, saw Mr Scott for an initial assessment. Mr Scott stated that he used cannabis and benzodiazepines in the community and that he did not feel his substance misuse was under control. She noted that Mr Scott appeared motivated to stop using drugs and completed a care plan.

35. On 7 March, a prison GP reviewed Mr Scott's medication and made an orthopaedic referral for a specialist opinion on his hip. On 6 April, the GP saw Mr Scott for an examination and recorded that he continued to report chronic back and hip pain. He increased Mr Scott's oxycodone and made a physiotherapy referral. On 18 April, a physiotherapist saw Mr Scott for an assessment and suggested a series of exercises.

36. On 19 April, Mr Scott requested a mental health review as he felt his quetiapine (an antipsychotic medication) was not working. Three days later, prison staff noticed that he appeared under the influence of an illicit substance and submitted an intelligence report. On 24 April, Mr Scott failed to attend an appointment with a mental health nurse as staff suspected that he had taken an illicit substance. Intelligence records show that Mr Scott made several phone calls to his sister throughout March and April requesting that she transfer money into several different accounts. Intelligence suggested that the transfers were related to drug payments.

37. On 27 April, Mr Scott received a total of 40 additional days to his sentence through the disciplinary process for three separate incidents including refusing a mandatory drug test (MDT) and being found in the possession of a tattoo gun and a USB charger.

38. On 9 May, a nurse saw Mr Scott for a review after he had fallen over in his cell and sent him to hospital. Hospital staff diagnosed a dislocated hip and suggested an operation but Mr Scott refused treatment and self-discharged. On 18 May, healthcare staff referred Mr Scott to social services for an occupational health assessment. A prison GP made another orthopaedic referral on 27 May, after hospital staff advised that the process had to start again.

39. On 2 June, a mental health nurse completed a questionnaire with Mr Scott that indicated he was anxious and depressed and added him to the waiting list for an antidepressant. On 5 June, a locum GP requested staff book a GP appointment to discuss the use of an antidepressant. On 3 July, the locum GP saw Mr Scott for a review and he reported difficulty sleeping due to pain, declined an antidepressant and asked for sleeping tablets. However, they did not consider that he could prescribe sleeping tablets as Mr Scott was already on a significant amount of sedating medication and noted a need to chase up Mr Scott's orthopaedic referral to see if anything could be done to alleviate his pain.

40. On 4 July, Mr Scott submitted a formal complaint stating that healthcare staff were doing little to support him. On 22 July, a healthcare manager met with Mr Scott to discuss his concerns. She wrote to Mr Scott later the same day, explaining that she had requested an additional mattress while he waited for a specialist one and had updated his social services referral to include a commode to fit over the toilet and a more suitable wheelchair.

41. On 10 August, a consultant orthopaedic surgeon saw Mr Scott for a review at hospital and referred him to another hospital. The consultant noted that he had concerns over Mr Scott's emotional wellbeing and recommended a mental health review.

42. On 21 August, a substance misuse worker saw Mr Scott to review his care plan and he reported feeling low due to having to wait for a raised toilet seat and an orthopaedic mattress. He said he was anxious about the possibility of further surgical treatment to his hip and the substance misuse worker started suicide and self-harm procedures, known as ACCT.

43. The focus of the ACCT process was on Mr Scott's frustration about a lack of equipment which was addressed through the caremap. On 26 August, a mental health team manager saw Mr Scott for a review. She noted that his limited independence and chronic pain were the main triggers for his low mood and advised him to book a GP appointment if he felt that medication would improve his mood. There is no record that he did so. On 24 September, prison staff closed the ACCT as Mr Scott was displaying a more positive attitude and did not report any thoughts of self-harm or suicide

44. On 25 September, prison staff observed Mr Scott under the influence of illicit substances and submitted an intelligence report. Three days later, a nurse saw Mr Scott for a review and recorded that the primary healthcare team were doing all they could to manage his hip pain. She recorded that Mr Scott's low mood was likely to pass once social services had assessed him and, with his agreement, she discharged him from the mental health team.

45. On 10 October, an occupational therapist from social services saw Mr Scott for an assessment and said that she would order several pieces of equipment to increase his mobility and to make him more comfortable. On 2 November, an Associate Practitioner fitted pressure relieving equipment to Mr Scott's wheelchair and noted that although he remained anxious about future hospital appointments, he appeared happier.

46. On 9 November, prison staff found Mr Scott unresponsive in his cell and called an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing difficulties). A nurse made her way to Mr Scott's cell and when she arrived, he was conscious and sitting in his wheelchair crying. Mr Scott said that he had had enough of his pain and staff offered him reassurance. She noted that Mr Scott had a pulse rate of 125 bpm (normal being 60-100bpm) and asked prison staff to monitor him overnight. There is no record of any reason for his presentation on his health record or that healthcare staff considered submitting an intelligence report.

47. On 10 November, an officer started ACCT procedures. At his assessment interview the next day, Mr Scott told staff his hip pain was making him depressed and he had taken PS out of frustration. Staff completed an intelligence report about his PS use. Records show that Mr Scott also said that he occasionally gave seroquel (an antipsychotic medication), that he had in possession, to other prisoners. There is no record that staff considered a medication review or arranged for a MDT

48. On 17 November, a nurse responded to a code blue and noted that Mr Scott was lying on the floor unresponsive. After he regained consciousness, she recorded a normal blood pressure reading (102/71 mmHg) and an oxygen saturation level of 61-85% (normal being 95-100%). She issued oxygen via a mask and monitored him until paramedics arrived to conduct an assessment. There is no record that staff documented a reason for Mr Scott's presentation or submitted an intelligence report.

49. On 24 November, a substance misuse worker saw Mr Scott for a substance misuse review and he reported using psychoactive substances (PS) as a way of coping with his health issues. She explained the impact that PS use could have on future surgical treatment and recorded that she felt he lacked the motivation to address his substance misuse. On 18 December, she saw Mr Scott for a follow-up review, discussed a housing referral and noted that he did not report any thoughts of suicide or self-harm. Two days later, prison staff closed the ACCT.

50. Over the next few weeks, staff submitted several intelligence reports saying that Mr Scott had been trying to conceal his pregabalin by not swallowing it at the medication hatch. On 30 January, a prison GP saw Mr Scott for a review and issued him with a final warning, telling him that his pregabalin would be reduced and then stopped, if staff caught him diverting medication again.

51. At around 10am, on 9 February, a nurse examined Mr Scott after prison staff found him unresponsive in his cell. He suspected that Mr Scott had taken an illicit substance and gave him oxygen. At 11.06am, a prison GP stopped Mr Scott's medication for 24 hours because of the health risks of taking PS at the

same time and requested urgent blood tests. In response, Mr Scott threatened to cut his throat and an officer started ACCT procedures.

52. On 10 February, a prison manager conducted a first ACCT case review and assessed Mr Scott as a low risk of harm to himself (on a scale of low, raised and high). She set five observations during the night between 8pm and 8am and two conversations during the day. On 16 February, a prison manager held a second ACCT case review and assessed Mr Scott's risk of harm to himself as raised. She set five observations between the hours of 6pm and 8am, along with two conversations during the day as before.

53. On 21 February, an orthopaedic surgeon reviewed Mr Scott at hospital and diagnosed chronic hip dislocation with sciatic nerve dysfunction and numbness. He recommended blood tests and a computerised tomography (CT) scan, before making a decision on further treatment. After Mr Scott returned from hospital a prison manager, held an ACCT case review. He recorded that although Mr Scott said he was hoping for a more progressive resolution for his hip pain, he recognised that he might be expecting too much too soon. They explored suicidal thoughts and Mr Scott said that he was not actively seeking to end his life.

54. On 23 February, a substance misuse worker saw Mr Scott for a review and he reported feeling low in mood. He said that he was worried about being permanently reliant on a wheelchair and that he often had thoughts of self-harm at night. He offered Mr Scott harm reduction advice, made an entry in his ACCT record and notified prison staff.

55. On 13 March, prison staff decided to close the ACCT as Mr Scott appeared positive, stated that he had stopped using PS and did not report any thoughts of suicide or self-harm. Two days later, on 15 March, a substance misuse worker saw Mr Scott for a review and he told her that he no longer felt it was a necessity for him to use PS. He indicated concern about not having anywhere to live after his release and she told him that she would continue to enquire about appropriate housing.

Events on Saturday 17 March

56. At 12pm, an officer locked Mr Scott in his cell. He told us there were no issues to report. A prisoner told us that he had been having a joke with Mr Scott a few minutes before and that he had no concerns about him.

57. At 4pm, the officer unlocked Mr Scott's door without looking through the observation hatch and moved onto the next cell. Minutes later, a prisoner found Mr Scott collapsed face down on the floor of his cell and alerted the officer. He made his way to the cell, saw Mr Scott was unresponsive on the floor and called a code blue at 4.03pm. He told the investigator that he tried to move Mr Scott into the recovery position to clear his airway.

58. Two nurses were administering medication in the older of the prison's two healthcare departments (located within a short distance of the substance misuse wing) when they heard the code blue over the radio. One nurse made his way to Mr Scott's cell, arriving at 4.06pm, while the other nurse continued with the

medication round. The nurse told us that Mr Scott was unconscious, face down on the floor when he arrived and that he suspected another 'spice' (PS) incident. He helped the officer move Mr Scott onto his side and, while doing so, he noticed that Mr Scott's body was cold to touch.

59. The nurse requested healthcare assistance using a radio and asked the officer to collect a defibrillator before starting cardiopulmonary resuscitation (CPR). In the meantime, a prison manger arrived and assisted with resuscitation while the nurse put the defibrillator pads on Mr Scott. The defibrillator did not detect a shockable rhythm and the prison manager and the nurse alternated chest compressions. At around 4.10pm, the nurse left Mr Scott's cell to collect additional equipment. Within minutes, he returned to the cell with more equipment and the nurse, who had not felt safe leaving the healthcare department on her own.

60. A clinical healthcare manger and a nurse responded to the other nurses call for assistance, but it took over ten minutes for them to arrive from the newer of the two healthcare departments at the other end of the prison due to the adverse weather conditions. They saw prison staff escorting an ambulance on their way to Mr Scott's cell, and arrived at 4.22pm, around the same time as the paramedics. Paramedics took over the resuscitation attempt but were unsuccessful and at 4.55pm, they declared that Mr Scott had died. Prison staff found a half-smoked cigarette and a dismantled vape device (an electronic cigarette) in Mr Scott's cell.

Contact with Mr Scott's family

61. At 5.15pm, a prison manager, appointed a Supervising Officer (SO) as family liaison officer (FLO) and he identified that Mr Scott had named his sister as his next of kin. At 6.25pm, the SO and a prison manager left Rochester for Mr Scott's sister's address in East Sussex. They arrived at 7.51pm, but there was no answer at the door. They waited or 20 minutes and spoke to a neighbour, but were unable to establish her whereabouts.

62. At 8.15pm, the SO and prison manager decided to return to Rochester and tried calling the telephone number they had for Mr Scott's sister every 20 minutes. Records show that they intended to turn back if they established contact with her. At 10.15pm, shortly after arriving back at the prison, the prison manager informed Kent police that they had not been able to contact Mr Scott's sister and they arranged for Sussex police to continue trying throughout the night.

63. On 18 March, at around 10am, the prison manager received confirmation from Sussex police that they had broken the news to Mr Scott's sister. At 10.45am, the prison manager phoned Mr Scott's sister to offer her condolences and to arrange a visit. The following day, the SO, the prison manager and the prison Governor, visited Mr Scott's sister at her home address. They offered their condolences and support.

64. The prison held a memorial service for Mr Scott on 20 March, which his sister attended. The SO continued to provide ongoing support to Mr Scott's sister until his funeral, which took place on 20 April. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

65. After Mr Scott’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.

66. The prison posted notices informing other prisoners of Mr Scott’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 Scott’s death.

Post-mortem report

67. The post-mortem report found that Mr Scott had died from multiple drug toxicity, with heart disease being a contributory factor. Toxicology analysis of Mr Scott’s blood found pregabalin present at therapeutic levels, oxycodone present at potentially fatal levels and PS. The report noted that, taken together, these substances would cause respiratory depression (dangerously shallow or slow breathing) and hypoxic brain damage (brain injury as a result of a lack of oxygen), with heart disease contributing to the body’s reduced resilience to the effects. The report also noted that when multiple drugs are taken together, they tend to be more potent at lower levels.

Findings

Clinical care

68. Mr Scott suffered from several long-term health problems and often reported chronic back and hip pain. Healthcare staff saw him for frequent reviews and appropriately referred him to an orthopaedic specialist for further intervention. The clinical reviewer considered that Mr Scott had good access to primary care and that GPs prescribed appropriate medication, as required.

69. When Mr Scott requested a mental health review in April 2017, staff responded promptly and assessed that his low mood was mainly associated with his pain and difficulty mobilising. Healthcare staff referred Mr Scott to social services for an assessment and provided additional equipment to make him more comfortable. The clinical reviewer considered that healthcare staff were attentive to Mr Scott's concerns and responded accordingly.

70. We are satisfied that Mr Scott received a good standard of clinical care at Rochester, equivalent to that which he could have expected to receive in the community.

Substance misuse

71. Mr Scott had a significant history of drug misuse and received ongoing support from the prison's substance misuse team. Staff facilitated one-to-one sessions in line with his care plan and saw him for reviews after he was observed under the influence of PS. We are satisfied that the substance misuse team provided a sufficient level of support to Mr Scott and that the substance misuse worker appropriately informed him about the dangers of taking PS together with his prescribed medication.

72. We consider it likely that Mr Scott was trading his pregabalin for PS. When staff observed him trying to conceal his pregabalin, a GP conducted a review and warned him that his pregabalin would be reduced and then stopped if he continued. We are satisfied that this action was appropriate.

73. We have been unable to establish how Mr Scott obtained the significant amount of oxycodone that was found in his blood after he died. He was not allowed this medication in his possession and was given it twice daily, along with his pregabalin. When interviewed, the substance misuse worker said she considered it very unlikely that Mr Scott had stockpiled his oxycodone. She said that he was clearly in pain and, in her view, would have taken his oxycodone when it was given to him. It is possible that he obtained extra oxycodone from other prisoners.

74. We are concerned that PS was readily available to Mr Scott. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Rochester. The investigation found that the prison is currently taking a number of measures to tackle the problem of PS, including the use of searches, search dogs, mandatory drug testing and mobile phone interrogation (a system that allows for the content of illicit mobile phones to be examined for the purpose of intelligence gathering). At

interview, the prison's drug strategy manager, told us that packages containing illicit substances thrown over the external wall was one of the biggest issues the prison faced. He said that to combat this threat, the prison had increased patrols of the perimeter and were establishing closer links with the police.

75. We accept that Rochester has a drug strategy in place and staff are working hard to implement it. Nevertheless, the HMIP report indicated that drugs are easily accessible to prisoners and the post-mortem report found that Mr Scott had used both illicitly traded prescription medication and PS at some point before his death. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for illicit substances, including PS.

76. Despite frequent intervention from the prison's substance misuse team, Mr Scott continued to take illicit drugs and was seemingly able to divert his prescribed medication. We consider that prison staff could have done more in response to intelligence that Mr Scott was involved in the illicit drugs market, particularly as there is no evidence staff conducted a cell search or considered other measures to restrict his access to illicit drugs. We are concerned that staff do not appear to have followed-up a request for an MDT or considered undertaking a prescribed medication spot check, as suggested in Rochester's drug strategy. We make the following recommendation:

The Governor should ensure that staff are fully aware of the actions they are required to take to comply with the local drug strategy and in particular, that they act appropriately in response to intelligence on the trading of prescribed medication and illicit drug misuse.

77. Rochester is not alone in facing this problem –the ready availability of drugs is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HM Prison and Probation Service (HMPPS) providing evidence-based advice on what works.

78. In a recent investigation, we recommended that the Chief Executive of 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.

ACCT procedures

79. PSI 64/2011 sets out the processes that should be followed when an ACCT is opened. These include that the first ACCT review must involve a member of healthcare and that subsequent case reviews must be multidisciplinary where possible.

80. There is no record that healthcare staff attended Mr Scott's first case review on 10 February. A prison manager, conducted the review and requested that a member of the substance misuse team attend on 16 February. However, there is

no record that healthcare or substance misuse staff attended or contributed to any of the following six case reviews. At interview, a prison manager told us that while efforts were made to ensure case reviews were multidisciplinary, the individual case manager is responsible for ensuring other agencies attend and those that are invited, are relevant to a prisoner's needs. In this case, we consider that multidisciplinary reviews would have been appropriate because Mr Scott's thoughts of self-harm and drug misuse were, in the most part, related to his physical health. We are, therefore, concerned that the reviews were not multidisciplinary.

81. We are concerned that, although staff assessed that Mr Scott's risk had increased from low to raised on 16 February, they did not increase the frequency of his observations. In fact, the frequency of observations effectively decreased as the time frame for completing Mr Scott's five overnight observations was increased by two hours. While we are satisfied that staff closed Mr Scott's ACCT when he no longer reported thoughts of suicide or self harm, we are concerned that the frequency of reviews and observations did not always appropriately reflect his level of risk.

82. Staff did not use the ACCT procedures to address Mr Scott's risks, needs and issues effectively. We consider that more could have been done to ensure that Mr Scott received appropriate support by increasing the frequency of his case reviews and observations in line with his risk and by making sure that healthcare and substance misuse staff attended at least one review. We make the following recommendation:

The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines, including ensuring that staff:

- **hold multidisciplinary case reviews, attended by all relevant people involved in a prisoner's care, with healthcare staff attending all first case reviews; and**
- **set an appropriate frequency of observations that reflect the prisoner's risk and review it when the level of risk changes.**

Unlock procedures

83. 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."

84. Additionally, 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."

85. When interviewed, an officer told the investigator that he was distracted by someone talking to him when he arrived at Mr Scott's cell and unlocked the door without looking through the observation hatch. While the failure to follow the correct unlock procedure is unlikely to have affected the outcome for Mr Scott given that another prisoner found him shortly afterwards, it is important that staff identify if a prisoner's life is at risk at the earliest opportunity. We therefore 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.

Emergency response

86. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Rochester'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. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for a member of healthcare staff to attend.

87. The officer responded promptly after a prisoner informed him that Mr Scott was unresponsive and called an appropriate medical code. The control room called an ambulance immediately, in line with national policy. In his statement, the officer said that he assessed the situation as being similar to those he had witnessed with Mr Scott previously and that he attempted to move him onto his side. The prisoner who found Mr Scott told the investigator that the officer acted swiftly and that he was concerned about causing further damage to Mr Scott's hip - which could explain why Mr Scott was still on his front when the nurse arrived, three minutes later.

88. At interview, the nurse told the investigator that two members of healthcare staff usually attend code blues. However, he said that, on this occasion, he decided to attend on his own with basic medical equipment as they were in the middle of doing the medication round. Additional healthcare staff responded to the nurses request for assistance, but were delayed by adverse weather conditions. We consider that the nurse acted appropriately by leaving a prison manager to continue CPR while he went to collect additional equipment.

89. The clinical reviewer concluded that the resuscitation was carried out in line with best practice guidelines.

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