

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andre Alexis a prisoner at HMP Onley on 1 December 2017

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 Alexis collapsed on 1 December 2017 at HMP Onley and died shortly after arriving at hospital. He was 37 years old. I offer my condolences to Mr Alexis' family and friends.

Mr Alexis died of a heart attack, which might have occurred a week or more before his death. Toxicology tests showed that he had synthetic cannabinoids in his system and, the post-mortem concluded that, although this was not the primary cause of death, it probably precipitated death in an already damaged heart.

It became clear during the investigation that staff knew that Mr Alexis was taking illicit drugs. However, he was not referred to substance misuse services and minimal security intelligence was generated. As a result, a vulnerable man was able to access dangerous illicit drugs without effective challenge or support.

I am concerned that the prison's substance misuse strategy does not set out what staff should do when they suspect a prisoner is misusing drugs. I note the efforts which the prison is making to address the risk of illicit substances and I stress the need for this to continue.

I am also concerned that there was a delay in calling an ambulance.

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
Acting Prisons and Probation Ombudsman

August 2018

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Summary

Events

1. On 29 July 2017, Mr Andre Alexis was sent to HMP Wormwood Scrubs after being charged with possession of a firearm and theft. He had a history of substance misuse problems and had been diagnosed with cannabis dependence. Mr Alexis also had a history of mental health problems, had been diagnosed with schizoaffective disorder and had been detained under the Mental Health Act several times, most recently in January 2017.
2. On 7 July, Mr Alexis refused to take his mental health medication and told a mental health nurse that it stopped him from sleeping. The mental health team monitored Mr Alexis and encouraged him to take his medication.
3. On 27 July, Mr Alexis was sentenced to three years and six months imprisonment. From August to October, staff noted incidents where Mr Alexis was found talking to himself or to objects. On 4 September, a psychiatrist assessed Mr Alexis and noted that he did not want to take his medication and said he did not have any mental health problems.
4. On 18 October, Mr Alexis was sent to HMP Onley. A nurse assessed him in reception and referred him to the mental health team but they did not refer him to the substance misuse team. Mr Alexis told a prison GP that he did not want to take his mental health medication and the mental health team continued to monitor him and speak to him about taking his medication. A psychiatrist assessed Mr Alexis and noted he did not have psychotic symptoms.
5. On 17 November, Mr Alexis argued with the prisoner in the cell next door. An officer started violence reduction procedures but no further action was taken. That night, an emergency code was called for Mr Alexis' cellmate after he was suspected to have taken illicit substances. Staff suspected that Mr Alexis was also under the influence of drugs and called healthcare staff and submitted an intelligence report. Healthcare staff assessed Mr Alexis but did not refer him to the substance misuse team.
6. Shortly after 4.45pm on 1 December, Mr Alexis collapsed on the stairs on the wing. Two minutes later, an officer called an emergency code and officers put him in the recovery position. Healthcare staff arrived and tried to resuscitate him. The control room called an ambulance sometime between 4.53 and 4.56pm. At 5.07pm, paramedics arrived and the ambulance took Mr Alexis to hospital at 6.02pm. At 7.05pm, hospital staff recorded that Mr Alexis had died.

Findings

7. Prison staff were aware that Mr Alexis took illicit substances but there is no evidence that he was referred to the substance misuse team and only one intelligence report was submitted about Mr Alexis' suspected drug misuse. No follow up action was taken.

8. Although staff suspected that Mr Alexis might have been in debt because of drug use and started violence reduction procedures, no further actions were taken to investigate this to determine if support or any intervention was needed.
9. We agree with the clinical reviewer that the mental health care Mr Alexis received at Onley was equivalent to that which he could have expected to receive in the community.
10. There was a delay of at least six minutes between an officer calling an emergency code and control room staff calling an ambulance.

Recommendations

- The Governor and Head of Healthcare should ensure substance misuse strategies provide guidance for staff on the process to follow when prisoners appear to be under the influence of or are suspected of using illicit substances, including submission of intelligence reports, referral to substance misuse services or for mandatory drug testing, and how to access clinical support and advice.
- The Governor should ensure that all information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated and victims are effectively supported.
- The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

The Investigation Process

11. 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.
12. The investigator visited HMP Onley on 6 December 2017. She obtained copies of relevant extracts from Mr Alexis' prison and medical records.
13. NHS England commissioned a clinical reviewer to review Mr Alexis' clinical care at the prison.
14. The investigator and clinical reviewer interviewed six members of staff at Onley on 12 February 2018. The investigator interviewed a further four members of staff by phone on 20 February, 19 March and 8 May 2018. The investigator wrote to the prisoner who shared a cell with Mr Alexis at Onley to request an interview but he declined to be interviewed. Another prisoner declined to be formally interviewed.
15. 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.
16. The investigator contacted Mr Alexis' father to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Alexis' father received a copy of the initial report. He wrote to us raising a number of issues that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence.
17. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not raise any factual inaccuracies. The action plan has been annexed to this report.

Background Information

HMP Onley

18. 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

19. The most recent inspection of HMP Onley was in August 2016. Inspectors reported that there had been a dramatic decline in standards since the last inspection and that Onley had become an unsafe prison. The number of assaults had tripled since the last inspection and too little had been done to make the prison safer. There was no comprehensive violence reduction strategy and little had been done to understand trends or causes or to address these problems.
20. Inspectors also found that drugs were easily available and supply reduction was weak. There was no comprehensive drug supply strategy and the current strategy did not specifically address the problem of psychoactive substances, which was difficult to understand given the impact it was having on the prison. Substance misuse services were reasonably good.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their latest annual report, for the year to July 2017, the IMB reported that security and safety remained a concern but new approaches introduced in the later part of the reporting period had begun to have a positive impact. These included a management effort to reduce the backlog of intelligence reports and act on information received, cell searches which have recovered mobile phones and illicit substances and measures to tackle staff corruption.

Previous deaths at HMP Onley

22. Mr Alexis' death is the second of three deaths at Onley since 2016. Similar issues were raised in one of these investigations where it was identified that Onley missed several opportunities to engage with the prisoner and to address, monitor and reduce his substance misuse and there was no evidence that prison staff acted on their suspicions that the prisoner might have been frequently using psychoactive substances.

Psychoactive Substances (PS)

23. 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.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and their dangers, including their 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.
25. 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

26. On 29 June 2017, Mr Andre Alexis was sent to HMP Wormwood Scrubs after being charged with possession of a firearm and theft. Mr Alexis had previously been detained in a young offender institution but this was his first time in an adult prison.
27. Mr Alexis had a history of substance misuse and had been diagnosed with cannabis dependency. He told the nurse in reception that he did not want to be referred to the substance misuse team because he did not want to stop taking cannabis.
28. Mr Alexis also had a history of mental health problems and had been diagnosed with manic-type schizoaffective disorder (a mental disorder in which a person experiences a combination of schizophrenia symptoms, such as hallucinations or delusions, and mood disorder symptoms). He had been detained under the Mental Health Act a number of times, most recently in January 2017. The reception nurse referred Mr Alexis to the mental health in reach team and noted that he had been taking flupentixol (an anti-psychotic medication that is given as a long-acting injection once a month) and last took it a week ago. A mental health nurse assessed Mr Alexis who said that he did not have any mental health symptoms and felt well, but was having trouble sleeping because of his mental health medication. She noted there was no evidence of psychosis.
29. On 3 July, a pharmacist noted that Mr Alexis had raised cholesterol because of his diet and prescribed atorvastatin (a medication that helps to lower cholesterol and decrease the risk of a heart attack).
30. On 6 July, the mental health in-reach team referred Mr Alexis to a psychiatrist. The next day, the psychiatrist prescribed flupentixol after noting that Mr Alexis' injection was overdue. Mr Alexis said that he did not want to take this medication because it was giving him sleeping problems. A nurse spoke to Mr Alexis about his medication but he still would not take it, so she noted that she would speak to him about it again in a few days. She spoke to Mr Alexis about taking his medication again on 11 July and 18 July but he continued to refuse to take it.
31. On 22 August, 23 August and 5 October, staff noted that Mr Alexis was displaying some bizarre behaviour including hearing 'mocking voices', talking and laughing to himself, talking to the TV and machinery in the laundry. Staff in the laundry said that Mr Alexis often closed his eyes and did not respond when spoken to, so it was not safe to have him working with machinery. A workshop instructor suspended Mr Alexis from the workshop until he could be assessed by the mental health team. Mr Alexis told the instructor that he did not want to speak to healthcare staff because they would section him under the Mental Health Act and the only medication that helped him was natural herbs or street drugs. Mr Alexis then became aggressive and agitated.
32. Healthcare staff reviewed Mr Alexis and referred him to the mental health team. A nurse explained to Mr Alexis that it was not safe for him to work with machinery unless he was well and taking his medication but he became upset and said he did not need medication.

33. On 4 September, a psychiatrist reviewed Mr Alexis with a mental health nurse. She noted that Mr Alexis was calm but was unable to talk about what happened when he was unwell. He said that he was not depressed but was a little down thinking about a long sentence ahead. Mr Alexis told the psychiatrist that he did not want to take his medication. The psychiatrist noted that Mr Alexis would be reviewed by the mental health in-reach team and the mental health nurse would continue to monitor him.
34. On 6 October, Mr Alexis was sentenced to three years and six months imprisonment for possession of a firearm and theft. The same day, a prison doctor reviewed Mr Alexis and noted that he was expecting a longer sentence so was 'over the moon'. When asked about his coping mechanism in prison he said 'well – better than mental health hospital'.
35. On 13 October, staff noted that other prisoners were complaining about Mr Alexis' personal hygiene, that his cell was dirty and he would be better in a cell on his own.

HMP Onley

36. On 18 October, Mr Alexis was sent to HMP Onley. A nurse assessed Mr Alexis in reception. She noted that he had a history of mental ill-health and had misused drugs in the past. She referred Mr Alexis to the mental health team but did not refer him to the substance misuse team. On 24 October, a prison doctor prescribed atorvastatin.
37. On 30 October, a prison doctor assessed Mr Alexis and noted that he had not taken his flupentixol. Mr Alexis said, 'I don't really need it, I have been doing fine'. The doctor told Mr Alexis to avoid illicit drugs like PS and notified the mental health team that Mr Alexis had schizoaffective disorder but was not taking his medication. The same day, the mental health team at Wormwood Scrubs told a nurse that Mr Alexis had refused to take his medication and they were worried about him having a relapse. On 2 November, a nurse prescriber noted that Mr Alexis had not attended his mental health appointment so she booked him an appointment with the psychiatrist to review his medication.
38. On 3 November, a mental health nurse assessed Mr Alexis on the wing. She noted that Mr Alexis seemed settled in his mood and mental state but did not seem to know when he was unwell, even when he had been admitted to hospital. Mr Alexis said he did not see the need for medication or his past hospital admissions, and only took his medication when he left hospital because it was a condition of his discharge. The nurse noted that Mr Alexis needed further assessment and that the mental health team would monitor his mood. Mr Alexis said he was willing to engage with mental health services in groups or one to one and to be reviewed by the psychiatrist.
39. On 6 November, a psychiatrist assessed Mr Alexis. Mr Alexis told him that he was not having any mental ill-health symptoms. The psychiatrist noted that Mr Alexis did not show any psychotic features and spoke to him about taking his medication. Mr Alexis said he did not want to take it. The psychiatrist explained the advantages and disadvantages of not taking his medication and told Mr Alexis to avoid illicit drugs, especially PS.

40. On 7 November, a nurse noted that Mr Alexis would be reviewed by the mental health team at least once a month. He noted that he planned to provide support to Mr Alexis to increase his awareness of his mental health symptoms and relapse indicators and encourage him to attend to his personal care, cell cleaning and appropriate social interaction. He noted that the psychiatrist would review Mr Alexis to discuss taking his medication and that he would encourage Mr Alexis to go to weekly mental health groups to increase his social interaction and to monitor his mood and mental state. He noted that Mr Alexis had been added to the severe mental illness register (a register of people who have been diagnosed with severe and enduring mental illness and whether they require ongoing support or monitoring).
41. On 16 November, Officer A officer noted that Mr Alexis had been talking to himself on more than one occasion and thought he might be hearing voices. She spoke to the mental health team who told her that they were monitoring him.
42. On 17 November, Officer B noted that a large group of prisoners had gathered around Mr Alexis' cell, including the prisoner from the cell next door who was arguing with Mr Alexis. Mr Alexis was very aggressive so prison staff told him to calm down and put him in his cell for his own safety. Officer B started procedures under the Custodial Violence Management Model (CVMM). (CVMM is a tiered model for individualised care and case management of prisoners whose behaviour is dangerous, disruptive, and/or significantly challenging to manage whilst in custody. The first tier involves monitoring the prisoner, and the second tier provides interventions for those prisoners who require greater input and oversight.) No further action was taken under CVMM procedures.
43. At 5.10pm that afternoon, prison staff called a code blue (an emergency code indicating that a prisoner is unconscious or having difficulty breathing) after they found Mr Alexis' cellmate under the influence of an illicit substance. Mr Alexis' cellmate was not responding when staff first arrived but later recovered and staff cancelled the ambulance. A nurse examined Mr Alexis and recorded that he also appeared to be under the influence of an illicit substance. Staff noted that it was possible that Mr Alexis had been affected by second-hand smoke because a member of staff had also had become unwell after being in the cell for a long time.
44. The next day, staff submitted an intelligence report about the argument between Mr Alexis and the prisoner in the cell next to his. The report noted that Mr Alexis had insulted his neighbour through the wall. It also noted that Mr Alexis had mental health problems and came across as vulnerable, and that staff were trying to move him to a different wing but Mr Alexis did not want to move to another wing. It was recorded that other prisoners had complained about Mr Alexis making noises at night and keeping everyone awake and that staff had warned him to stop doing this.
45. Officer B spoke to Mr Alexis and the prisoner in the cell next door who said the incident the day before had been resolved. Staff observed them and noted they were fine for the first hour but were then seen 'squaring up to each other'. Staff put Mr Alexis and the other prisoner in their cells. Mr Alexis said that his neighbour had pulled his beard and staff were not doing anything about it and he

was putting in a complaint. Staff suggested to Mr Alexis that he move wings but he refused. Staff noted that they planned to move Mr Alexis to another wing for his own safety when space could be found because he did not get on with a lot of prisoners.

1 December 2017

46. At 4.45pm on 1 December, Officer B was supervising prisoners as they lined up to collect their evening meal on the wing. She saw Mr Alexis sitting on the stairs near the queue of prisoners and went to tell him to move off the stairs. Before she could speak to him, she was distracted by some prisoners pushing each other. She turned around to manage the situation but then heard a slapping sound and prisoners in the queue shouted, 'Miss, Miss, quick, he's banged his head.'
47. Officer B ran to Mr Alexis and told the prisoners gathered around him to give them some space. She noted that Mr Alexis was making a howling noise. The officer tried to put him in the recovery position but he was very stiff. She thought that he had taken PS so she checked his airway and made sure he had not bitten his tongue. As she was doing this, she shouted to Officer A to call a code blue over the radio. At 4.47pm, Officer A called a code blue.
48. A prisoner banged on the glass window of the office near the servery and gestured to Officer C to come quickly. Officer C went to the stairs and saw Mr Alexis lying on the floor on his left side with his legs still on the stairs. He noted that there were over 30 prisoners in the area waiting to get their evening meal so he took Mr Alexis by the arms and moved him to a clear space so that staff could start CPR. Officer B helped Officer C to move Mr Alexis by holding his legs. Officer C said that Mr Alexis was very tense, his muscles were clenched tight and he was making a howling noise. He was also thrashing around so it was difficult to put him in the recovery position. Mr Alexis clamped his head down on his chest and the howling noise stopped. Officer C was worried about his airway so he pulled Mr Alexis' head back and held his forehead. Mr Alexis started to make the howling noise again and Officer B and Officer C held Mr Alexis in the recovery position.
49. A nurse attended and took the emergency bag to the wing. At 4.51pm, Officer D told the control room that healthcare staff were with Mr Alexis and that the incident was 'under control'.
50. The nurse said that when she arrived, she saw Mr Alexis lying on his left side with two officers and some prisoners gathered around him. She tried to get a response from Mr Alexis, put a monitor of his finger to measure his oxygen levels and noted that his heart rate was high and he was unresponsive, limp, pale and his hands were cold. She asked the officers to move the prisoners away so Officer B left Mr Alexis to start locking prisoners in their cells.
51. The second emergency bag arrived and the nurse inserted an airway to give Mr Alexis oxygen. Staff helped to manage Mr Alexis' airway and held the oxygen monitor in place and the nurse noted that he had agonal breathing (agonal breathing, which may sound like gasping or moaning, is the body's last attempt to

give oxygen to vital organs). After about two minutes, Mr Alexis stopped breathing and staff started CPR. The nurse attached the defibrillator to Mr Alexis.

52. Ambulance records indicate that the prison called for an ambulance at 4.56pm, however control room records indicate that an operational support grade (OSG) called an ambulance at 4.53pm. The OSG said that he was working with another OSG in the control room and between the time the code blue was called and when the ambulance was called, they were managing another incident in the prison along with general radio traffic. He said that he did not know what was happening on I Wing, but when he heard the incident was 'under control', he thought that took away the urgency.
53. At 4.57pm, the control room asked staff for more information about Mr Alexis in order to tell the ambulance service. At 5.02pm, Officer D provided further information through the control room. A doctor arrived and helped to give Mr Alexis fluids. Staff followed instructions given by the defibrillator, which initially told them to continue CPR, and then advised to shock Mr Alexis.
54. Ambulance records indicate that the ambulance arrived at the prison at 5.07pm. The officers continued CPR. Paramedics intubated Mr Alexis (put a tube in his windpipe to give him oxygen) and gave him some adrenalin. At 6.02pm, paramedics took Mr Alexis to hospital but at 7.05pm hospital staff recorded that Mr Alexis had died.

Contact with Mr Alexis' family

55. At 10.05pm, the prison family liaison officer, the acting governor and another member of staff visited Mr Alexis' father at his home to tell him that his son had died. They offered condolences and support. The prison contributed to the costs of Mr Alexis' funeral, in line with national guidance. On 20 December, Mr Alexis' father and brother visited the prison, viewed his cell and met the Governor.

Support for prisoners and staff

56. After Mr Alexis' death, two prison managers 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.
57. The prison posted notices informing other prisoners of Mr Alexis' death, and offering support.

Post-mortem report

58. The post-mortem report indicated that Mr Alexis died of a heart attack, which might have occurred at least a week prior to his death, and toxicological testing indicated that Mr Alexis had synthetic cannabinoids (a form of PS) in his system.
59. The report concluded while illicit substances were not the primary cause of death, on the balance of probabilities, their presence 'most likely precipitated death in an already damaged heart'.

Findings

Psychoactive substances (PS)

Reducing supply

60. In its most recent inspection of Onley in 2016, HMIP found that drugs were easily available and supply reduction was weak. Inspectors also found that there was no comprehensive drug supply strategy and the current strategy did not specifically address the problem of PS.
61. Onley's current 'Drug and Alcohol Strategy/Policy' was issued in May 2017. It outlines the prison's approach to reducing the entry, demand, supply and usage of substance misuse, as well as providing support for those with drug or alcohol related issues. The policy lists a number of strategies designed to reduce the supply of drugs including searching, drug detection dogs, information sharing, mandatory drug testing, intelligence gathering and medication management. It also states that suspicion testing or targeted testing will be conducted where there are grounds of reasonable suspicion that a prisoner is using drugs, and highlights the integrated drug treatment service as part of the strategy for reducing demand for illicit substances.
62. The Head of Security told the investigator that Onley had taken a number of measures recently to reduce the supply of drugs in the prison. He said that they recently locked down the wings to conduct searches and found illicit substances. He said that I Wing, where Mr Alexis was located, was the first wing locked down as part of this process and illicit substances and mobile phones were found. Other recent measures that were implemented included a blanket ban on mail followed by targeted photocopying of mail on wings where intelligence reports indicated illicit substances were a problem. The prison also worked with the National Crime Agency as part of a joint operation to search staff. One member of staff was suspended following this operation and another was under suspicion.
63. As the prison is already taking steps to address the supply of PS, we do not make a recommendation, but stress the need for continuing effort to reduce supply and demand for illicit substances and for all staff to be aware of the risks of the use of PS.

Actions to address suspected substance misuse

64. Onley's Drug and Alcohol Strategy/Policy does not adequately set out the process staff should follow when they suspect a prisoner is under the influence of illicit substances. Prison staff told the investigator that if they suspected a prisoner was under the influence of an illicit substance, they would contact healthcare staff and submit an intelligence report. Staff said that healthcare staff would normally make a referral to substance misuse services. That did not happen in Mr Alexis' case.
65. The PPO published a learning lessons bulletin on 'Prisoner Mental Health' in January 2016. In this bulletin we identified that difficulties in coping with mental health problems can be made worse when a prisoner also has to cope with difficulties of battling substance dependence. Given the effect that PS can have

on mental health and the deterioration in Mr Alexis' mental health while at Onley, a review by the substance misuse team would have provided another opportunity to engage with Mr Alexis and provide support.

66. Mr Alexis had a history of taking illicit drugs in the community, had been diagnosed with cannabis dependency and had told staff that he did not want to stop taking drugs. Officer B told the investigator that staff knew that Mr Alexis was 'into his drugs' and that other prisoners had told her that Mr Alexis smoked drugs. She said that Mr Alexis' TV went missing after the incident on 17 November and she thought he had sold it for drugs. Officer A also said that other prisoners had told her to watch Mr Alexis because they thought he was under the influence of illicit substances. Officer A said that they never saw any signs that Mr Alexis was under the influence. Staff did not submit intelligence reports about what prisoners had told them or about Mr Alexis' TV going missing. They also did not refer him for mandatory drug testing or to the substance misuse team.
67. Officer C also told the investigator that he was aware that Mr Alexis smoked PS. He said that when he responded to the emergency code for Mr Alexis' cellmate on 17 November, Mr Alexis was clearly under the influence of an illicit substance, which was confirmed by healthcare staff. Although Officer C submitted an intelligence report, there is no evidence Mr Alexis was referred to the substance misuse team or for mandatory drug testing in response to this incident.
68. We are concerned that prison staff were aware that Mr Alexis took illicit substances but there is no evidence that he was referred to the substance misuse team and the only intelligence report that was submitted about Mr Alexis was on 17 November. This issue was identified in another PPO investigation at Onley where it was found that staff did not act on their suspicions that a prisoner may have been using PS frequently and missed several opportunities to engage with the prisoner and to address, monitor and reduce his substance misuse. We make the following recommendation:

The Governor and Head of Healthcare should ensure substance misuse strategies provide guidance for staff on the process to follow when prisoners appear to be under the influence of or are suspected of using illicit substances, including submission of intelligence reports, referral to substance misuse services or for mandatory drug testing, and how to access clinical support and advice.

Violence reduction

69. Onley's Violence Reduction policy issued in June 2017, says that following a violent incident, a Violence Reduction Investigation Report (VRIR) can be completed which acts as a referral to the Safer Custody Team. The Safer Custody Team will then decide if monitoring or intervention is required under the CVMM.
70. On 17 November, Officer B completed a VRIR for Mr Alexis and the prisoner in the cell next to his. The Safer Custody Lead said that they had a significant number of VRIRs submitted around that time and, as a result, they were behind in their investigations. She said that due to workload issues and because Mr

Alexis' VRIR was assessed as being low priority, no further action was taken before he died.

71. Several officers said that they thought Mr Alexis was vulnerable but did not think he was being bullied or threatened and that he could look after himself. Officer B said that staff spoke to Mr Alexis on a number of occasions about whether he felt safe or was under any pressure on the wing because he was a vulnerable character and if he were taken advantage of, he may not see what was happening. She also said that she thought he had sold his TV for drugs. Officer B told the investigator that Mr Alexis had been offered a wing move but wanted to stay in his cell, which would be unusual if someone was in debt.
72. Officer A thought that Mr Alexis may have been vulnerable because of his mental health issues. Officer C said that he thought Mr Alexis may have been vulnerable because of his PS use and that he did not have the money to pay for this and may get into debt. Officer C said that he never had any concerns that Mr Alexis was in debt or about his safety while he was at Onley, but supported Mr Alexis moving to a single cell because of his hygiene issues.
73. Staff suspected that Mr Alexis might have been in debt due to his drug use and if CVMM procedures had been followed, staff could have monitored him to investigate this further and determine if support or intervention was required. We make the following recommendation:

The Governor should ensure that all information about bullying, intimidation, debt and the use of drugs is fully coordinated and investigated and victims are effectively supported.

Mental health care

74. Mr Alexis had a history of mental health problems that were identified when he first arrived in prison and a reception nurse referred him to the mental health team. Although Mr Alexis refused to take his mental health medication and his mental health declined while at Onley, the mental health team provided ongoing support in monitoring his mental state and encouraging him to take his medication. A mental health nurse also planned to work with Mr Alexis so that he could recognise the symptoms of his mental illness. He said that although Mr Alexis would not recognise his mental illness, he was willing to participate in groupwork. The clinical reviewer found that healthcare provided to Mr Alexis was equivalent to that which he could have expected to receive in the community. We make no recommendation.

Emergency response

75. PSI 03/2013 on Medical Emergency Response Codes requires staff to use a code blue or equivalent code in a medical emergency and for the control room to call an ambulance immediately after an emergency code is used. The PSI is clear that prisons should not wait for healthcare staff or a duty manager to decide whether an ambulance is needed and that an ambulance can be cancelled later if not needed.

76. A code blue was called by Officer A at 4.47pm. Control room records indicate an ambulance was called six minutes later, while ambulance service records indicate that they received a call from the prison nine minutes later. This means that there was a delay of at least six minutes between Officer A calling the code blue and control room staff calling an ambulance.
77. At 4.45pm, Officer D told the control room over the radio that the incident was under control. He said that he radioed the incident was under control because they had enough staff on scene dealing with the incident, healthcare staff were on scene and no further response from staff was needed.
78. An OSG in the control room said that when he heard that the incident was under control, he thought it was less urgent. He said that he was managing another code blue in the prison and was also dealing with non-urgent radio traffic. He told the investigator that prison staff do not take emergency codes seriously and often contact the control room about non-urgent matters when they know they are dealing with an incident.
79. Although we cannot say that it affected the outcome in this case, in an emergency, even a short delay in calling an ambulance can have a significant impact on a person's chance of survival. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all prison and healthcare staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies as outlined in the local Medical Emergency Response Code Protocol so that staff efficiently communicate the nature of a medical emergency, and there is no delay in calling, directing or discharging ambulances.

**Prisons &
Probation**

Ombudsman
Independent Investigations