

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Neville McNair a prisoner at HMP Lewes on 16 June 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 Neville McNair died of probable heroin toxicity on 16 June 2018, at HMP Lewes. He would have been 52 years old the following day. I offer my condolences to Mr McNair's family and friends.

Mr McNair had a history of substance misuse in the community. He declined to engage with substance misuse services at Lewes and was suspected of diverting his prescribed medication. The investigation found no evidence that Mr McNair deliberately took an overdose with the intention of ending his life.

We found deficiencies in the emergency response. I am concerned that the inexperienced prison officer who found Mr McNair unresponsive in his cell did not understand when it is appropriate to enter a cell in a medical emergency. There was also a delay before the control room called an ambulance and a further delay before ambulance paramedics were able to reach Mr McNair's cell.

I am also concerned about the apparent availability of illicit drugs at Lewes, and that individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. In my view there is 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
Prisons and Probation Ombudsman

May 2019

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Summary

Events

1. On 23 March 2018, Mr Neville McNair was remanded to HMP Lewes.
2. Mr McNair had a leg ulcer, and a history of psychiatric issues and of using illicit substances. He was thought to be under the influence of an unknown substance on arrival at Lewes.
3. When he arrived at Lewes, a nurse referred Mr McNair to the mental health in-reach team and he had regular input from them. However, despite apparently using drugs, no one referred him to substance misuse services.
4. In April, he was suspected of diverting (selling or sharing) his prescribed medication (which included morphine for pain relief). His morphine prescription was stopped as a result. He self-harmed in a superficial way when his morphine was stopped. Staff started suicide and self-harm prevention measures, known as ACCT, for two days but closed the ACCT when Mr McNair's risk was considered to have reduced.
5. At the same time, Mr McNair approached the substance misuse service and asked to be referred. The substance misuse team tried to see him on three occasions that month, but Mr McNair did not make himself available. He was finally seen on 1 May when he said things had changed for him and he no longer needed the service's help.
6. Also in April, Mr McNair told a mental health nurse that he was feeling suicidal and that he was struggling on the wing and was being bullied for his medication. He was moved to a different wing the next day and staff subsequently reported that he had settled well and that his mood was brighter.
7. On the evening of 16 June, a nurse gave Mr McNair his prescribed medication at 6.40pm, before an officer locked him in his cell for the night. Mr McNair was chatty and bright and did not appear to be under the influence of drugs.
8. An hour later, an officer conducting a roll check saw Mr McNair on his knees in his cell. The officer called Mr McNair's name and banged on the door but he did not get a response. The officer's radio reception was not clear so he ran 30 metres down the wing to summon help from staff. He and another officer then entered the cell and the other officer called an emergency code blue. Prison healthcare staff attended quickly and tried to resuscitate Mr McNair.
9. The control room log states that the code blue was called at 7.39pm, but it does not say when an ambulance was called. The ambulance service's log says they did not receive a call until 7.45pm, and that paramedics arrived at the prison at 7.55pm but were not allowed into the prison until 8.03pm. Staff and paramedics were unable to resuscitate Mr McNair and at 9.02pm, it was confirmed that Mr McNair had died.
10. The post-mortem investigation concluded that heroin toxicity was the probable cause of death.

Findings

11. There is no evidence to suggest that Mr McNair deliberately took a drug overdose with the intention of killing himself.
12. Mr McNair declined to work with substance misuse services while at Lewes. His morphine prescription was stopped appropriately in April 2018 when it was suspected that he was diverting his morphine to sell to other prisoners.
13. Healthcare staff did not always submit intelligence reports when they suspected that Mr McNair was under the influence of illicit drugs or diverting his prescription medication.
14. We are concerned about the easy availability of drugs at Lewes. Although the prison has a substance misuse strategy, more needs to be done to reduce supply and demand.
15. We are satisfied that the care Mr McNair received for his physical health (predominantly a leg ulcer) was equivalent to that which he could have expected to receive in the community.
16. Mr McNair received regular input from the mental health team, but we identified some procedural deficiencies in the operation of ACCT procedures.
17. A newly recruited officer who found Mr McNair did not immediately call an emergency code or believe he could enter a cell alone in any circumstances.
18. According to ambulance service records, staff in the control room did not call an ambulance for six minutes after the medical emergency code blue was broadcast and the paramedics' access to the prison was delayed by eight minutes.

Recommendations

- 1) The Governor should ensure that staff manage prisoners identified as at risk of suicide and self-harm in line with national guidelines, including:
 - ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risk to themselves and progress should be considered and documented at each review.
 - All caremap actions have been completed before ACCT monitoring is stopped.
 - Post-closure reviews are completed within seven days of closure and the outcome documented in the ACCT.
- 2) The Governor should ensure that staff are reminded of the national and local policies on entering cells during medical emergencies.

- 3) The Executive Director of Performance in HMPPS should ensure that POELT training accurately reflects national policies on entering cells during medical emergencies.

- 4) The Governor should ensure that:
 - control room staff call an ambulance immediately when a medical emergency is called; and
 - arrangements are in place to escort ambulance personnel to medical emergencies as quickly as possible.

- 5) The Head of Healthcare should ensure healthcare staff file intelligence reports where they suspect a prisoner is engaging in behaviour relating to substance misuse and/or the diversion of medication.

- 6) 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

19. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
20. The investigator interviewed three members of staff from Lewes on 4, 5 and 10 February 2019.
21. NHS England commissioned a clinical reviewer to review Mr McNair's clinical care at the prison.
22. We informed HM Coroner for East Sussex of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
23. The investigator contacted Mr McNair's partner, to explain the investigation and to ask if she had any matters they wanted the investigation to consider. Mr McNair's partner did not respond to our letter.
24. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies, and this report has been amended accordingly.

Background Information

HMP Lewes

25. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services. HMP Lewes has a healthcare centre with a full-time senior medical officer, which makes use of specialist NHS facilities when needed. Healthcare is provided on a 24-hour basis; there is a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics. The Forward Trust provides substance misuse services.
26. Following an inspection by HM Inspectorate of Prisons in 2016, Lewes was placed in special measures and remains in special measures at the time of writing (February 2019). 'Special measures' means that HM Prisons and Probation Service has determined a prison needs additional, specialist support to improve performance.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Lewes was in January 2019, but this report has not yet been published. During the previous inspection in December 2015/January 2016, the inspectors found that staff in the healthcare inpatient unit provided prisoners with complex health needs with care, but a lack of custody staff affected the development of a therapeutic regime.
28. Inspectors also said that 36% of prisoners reported that drugs were easy to get hold of at the prison, which was an increase from 29%. More prisoners reported that they had develop a drug problem since entering the prison and this was apparently another increase although no figures are quoted. ACCT procedures at the prison did not adhere to guidelines and were also heavily criticised.

Independent Monitoring Board

29. 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 July 2017, the IMB reported a number of problems including a very restricted regime, a steady flow of drugs, an increase in violence to staff and prisoners and cancellations of healthcare appointments and clinics because of low staffing levels.

Previous deaths at HMP Lewes

30. Mr McNair's was the sixteenth death since June 2015. Of the previous deaths, none were drug-related, three were self-inflicted and twelve from natural causes. There has since been one further self-inflicted death and one from natural causes.
31. We have made recommendations about delays entering cells, emergency response and ACCT procedures before.

ACCT

32. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
33. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
34. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

35. On 23 March 2018, Mr Neville McNair was remanded to HMP Lewes charged with theft, damage to a vehicle and failing to stop.
36. On 23 March, a nurse conducted Mr McNair's reception health screen. She recorded that he had a leg ulcer and asthma. Mr McNair's speech was slurred during the consultation, but she recorded that Mr McNair said he did not have a problem with alcohol or drug use. (It was later identified that his leg ulcer was a result of historical intravenous drug use.) Mr McNair said that he was on prescribed medication but that he had problems reading the labels and was confused about when to take them.
37. Mr McNair also told a nurse that on 15 February, following a mental breakdown, he had driven his car into a parked van and had been admitted to an Acute Care Centre in Chichester (a unit providing acute inpatient psychiatric care). He said that he felt much better now, but the nurse made a referral to the mental health in-reach team.
38. On 24 March, a GP prescribed morphine (which Mr McNair took to alleviate pain), pregabalin (used to treat nerve pain, epilepsy and anxiety) and olanzapine (an antipsychotic drug), and recorded that he was reducing his prescription of promethazine (an antihistamine, also used as a sleeping pill). He thought the drowsiness Mr McNair had presented with the day before was probably down to him being over-sedated, so he did not prescribe diazepam (a tranquiliser) even though Mr McNair had arrived with a box of it.
39. On 24 March, a nurse did not give Mr McNair his morphine because she considered he was intoxicated. She recorded that his speech was slurred, his eyes heavy and his movements were very slow. On 25 March, a nurse also recorded that he had not given Mr McNair his morphine because he appeared intoxicated.
40. On 26 March, a nurse recorded that he saw Mr McNair for wound care and cleaned and re-dressed his leg ulcer. A GP reduced his morphine prescription from 20mg to 10mg twice a day because of the associated risks when combining it with pregabalin (as both have a depressant effect on the central nervous system).
41. A Mental Health Nurse saw Mr McNair the same day, and recorded Mr McNair was not experiencing hallucinations or hearing voices and that, although he had had suicidal thoughts in the past, he had protective factors in place. He also recorded that Mr McNair had harmed himself during previous periods in custody, had a substance misuse history and that he appeared sedated during the assessment. Mr McNair said his ulcerated leg was a result of his past intravenous heroin use but that he was in 'recovery'. He also said he was still under the Acute Care Centre mental health team and he had regular involvement with them.
42. Mr McNair said he regularly had low mood and fleeting thoughts of ending his life but the fact he was a father prevented him from acting on these thoughts. The Mental Health Nurse considered Mr McNair's mood was flat but recorded that it

was hard to get a true picture because he appeared to be under the influence of an unknown substance. He considered that Mr McNair had good insight into his illness and planned to discuss him at the next mental health team allocations meeting, with a view to assessing him when he was not under the influence of drugs.

43. On 3 April, a pharmacy worker recorded that another prisoner told her at the medication hatch that Mr McNair was diverting and selling his morphine. An intelligence report was completed (either by a pharmacy worker or a prison officer supervising the hatch).
44. On 3 April, the mental health team discussed Mr McNair at their allocations meeting. It was recorded that he had had a month-long admission to the Acute Care Centre and that they considered that his presentation was linked to substance misuse. He had been due to be reviewed by the community crisis team when he was remanded to prison. A nurse arranged to see Mr McNair again the next day.
45. On 4 April, a nurse recorded that he had seen Mr McNair. He appeared to be clear and alert and talked about his difficult family relationships and his concerns about an up-coming court appearance. The nurse recorded that Mr McNair said he sometimes thought he heard voices telling him to kill himself but that he was able to ignore these. He also had thoughts of hanging himself in his cell but wanted to be there for his family. Mr McNair also said that he was having difficulty eating and sleeping. The nurse planned to discuss his case at the multi-disciplinary team meeting. There is no record that this meeting took place or that Mr McNair was discussed.
46. The same day, a pharmacy worker recorded that Mr McNair did not comply with the medication hatch mouth check. (This is to ensure that prisoners swallow their medication when it is given to them and do not try to hide it with a view to stockpiling it or selling it to other prisoners.) Mr McNair was unable to speak coherently and would not lift his tongue, saying he did not like showing his bad teeth.
47. On 6 April, a pharmacy worker again recorded Mr McNair did not cooperate with the medication hatch's mouth check.
48. On 8 April, a nurse recorded that Mr McNair had requested an asthma inhaler and as the records showed he previously had had a prescription for it, the nurse prescribed salbutamol. He sent a task to the GP to review.
49. On 9 April, a GP reviewed the pharmacy worker's journal entries about Mr McNair's behaviour at the medication hatch. He noted her concern that Mr McNair was selling his morphine. He also considered other entries by staff about Mr McNair's presentation and behaviour. He recorded he would not re-prescribe morphine and he referred Mr McNair to the safer prescribing committee.
50. On 9 April, the pharmacy worker recorded that, once again, Mr McNair had not cooperated with the mouth check at the medication hatch. Officers said they had seen him spit a capsule out as he walked away from the hatch. The pharmacy

worker tasked a GP to review Mr McNair in the light of his repeated behaviour at the medication hatch.

51. On 10 April, a nurse recorded that Mr McNair had arrived in the healthcare unit for a wound check and that she found objects down the sides of his dressings. These included a vape apparatus and a pen. She treated his wound and replaced his dressings.
52. On 10 April, a nurse recorded that officers had called her to report Mr McNair had not received his morphine that morning and she told them it was because he was suspected of diverting it. She offered to come over and talk to him, but the officers said they would pass the message on. She was contacted again half an hour later by an officer and was told Mr McNair had cut himself because of the morphine issue.
53. An officer started ACCT procedures as Mr McNair had made small scratches on his arms because of the issues with his medication. The ACCT assessment identified that Mr McNair's risk factors were that he was worried about his upcoming court appearance; being taken off medication; and mobility issues with his current location. Hourly observations were arranged and a case review arranged for 12 April.
54. On 10 April, Mr McNair was discussed at a mental health team allocations meeting. The plan was for him to be taken on as part of a nurse's caseload.
55. On 11 April, a GP noted Mr McNair's morphine and pregabalin had recently been stopped because he was suspected of diverting medication. Mr McNair told the GP that he had simply been spitting some tissue out of his mouth as he had a loose tooth and had been using it to keep it firm. The GP noted that he thought Mr McNair was being honest and planned to discuss the matter again in the safer prescribing meeting.
56. The same day, Mr McNair approached a member of the Forward Trust (the substance misuse service) and said he would like to engage with them.
57. On 12 April, a senior officer recorded that Mr McNair had had his first ACCT case review along with a nurse from in-reach. Mr McNair was happier and he agreed to engage with the in-reach team about his mental health issues. The ACCT was closed, with a post-closure review planned for 19 April.
58. The nurse recorded that Mr McNair insisted that he had not been diverting his medication and that he said he had been in chronic pain since the morphine had been stopped. He said he struggled with hearing voices and low mood and the nurse discussed distraction techniques with him. The nurse recorded that he planned to see Mr McNair the following week to discuss working with him on the voices.
59. On the same day, a nurse recorded that Mr McNair was moving a lot without signs of severe pain but some stiffness.
60. The same day, Mr McNair was discussed at the safer prescribing meeting. A GP recorded he was to be offered symptomatic treatment if withdrawal became more troublesome. A nurse spoke to Mr McNair in his cell the same day, and they

discussed some of his concerns. The nurse reassured him they would get his leg ulcer sorted out.

61. On 16 April, a nurse saw Mr McNair again. He said he was in pain because his medication had been stopped and he was only able to go short distances. He said he was struggling on the wing, did not feel he could get to education, and still had low mood and suicidal thoughts although he would not act on them. He said he was also still anxious about his upcoming court appearance on 24 April. The nurse noted that he would see Mr McNair again the following week with a view to provide ongoing support.
62. On 17 April, an intelligence report was completed which said Mr McNair had reported that he felt at risk on the wing as certain individuals had pressured him to sell his prescribed medication. This information was linked to reports that he had been secreting his medication, and on 21 April, Mr McNair was moved to M wing, a standard wing.
63. On 27 April, a nurse saw Mr McNair who told him about his recent wing move and the reasons for it. The nurse recorded he planned to see Mr McNair the following week.
64. Mr McNair did not make himself available for the three appointments with the Forward Trust on 18, 26 and 30 April. When he was finally seen on 1 May he said things had changed for him and he no longer wished to engage.
65. On 4 May, a nurse recorded that he saw Mr McNair who said that he was much happier on M wing and with his medication (ibuprofen had been added to his regime on 17 April 2018). He said he had good friends on the wing and felt the best he had for a long time.
66. On 5 June, Mr McNair reported chest pain to a nurse. She took his observations, and his blood pressure was 127/72 and his pulse only 40 beats per minute (normal is between 60 and 100). She referred him for a GP review.
67. On 8 June, a GP saw Mr McNair to review his ulcer and his recent chest pain. He noted that his pulse was quite low (42 bpm) and referred him to a cardiology clinic. The doctor recorded that the ulcer was not too angry and was healing from the edges.
68. On 11 June, a nurse saw Mr McNair for wound care. On 12 June, staff noted that the hospital had been in touch to advise that they had received the urgent cardiology referral but they did not have an appointment until 31 July. After some negotiation, this was brought forward to 17 July, at a hospital.
69. On 14 June, a nurse recorded Mr McNair was seen for wound care. The same day, another nurse saw Mr McNair and discussed his upcoming court case with him. Mr McNair said he was unhappy about a psychological report that had been done as he did not feel it adequately summarised his mental health issues and only highlighted appointments that he had missed. The nurse read through the report with him and shared his opinion that it was, in fact, a rounded view of Mr McNair's issues, and Mr McNair eventually accepted that. Mr McNair said he had been working as a cleaner on the wing, which he enjoyed. The nurse

concluded that Mr McNair's mood was bright and there were no signs that he was in any way sedated.

Events of 16 June

70. On 16 June, at approximately 6.40pm, an officer accompanied a nurse, who gave Mr McNair his pregabalin medication. The officer said Mr McNair was in good spirits and nothing seemed out of the ordinary. Mr McNair said he had been sentenced recently and the officer said he would come back and talk to him about that the following afternoon. There was nothing about Mr McNair's presentation which concerned him. The officer then locked Mr McNair in his cell for the night.
71. Shortly before 7.40pm, another officer was conducting the evening roll check. He looked through the observation hatch of Mr McNair's cell and saw that he was crouched on his knees at the far end of his cell with his back to the officer. The officer banged on the cell door several times but did not get a response. He went to the office and asked the officer who had locked Mr McNair up to accompany him to the cell, explaining why en route.
72. Both officers went into the cell and checked for a pulse but there was none. Mr McNair was blue and not breathing. An asthma pump (which was later found to have been adapted for drug use) was on the floor next to him. One of the officers radioed an emergency code blue (indicating a prisoner has breathing difficulties or is unconscious) at 7.39pm, and two other officers quickly arrived. One of them checked for a pulse and commenced CPR.
73. Two nurses arrived and applied a defibrillator to Mr McNair. The machine confirmed that there was no pulse and that staff should continue with CPR, which they did.
74. The prison's control room log does not record when an ambulance was called, but the ambulance service's records show that they received a call at 7.45pm.
75. Paramedics arrived at approximately 7.55pm, and according to their own record log, they could not access the prison until 8.03pm. When they arrived at the cell, they continued with resuscitation attempts. At 9.02pm, the paramedics confirmed that Mr McNair had died.

Contact with McNair's family

76. At 10.45pm on 16 June, the prison appointed a family liaison officer (FLO). The Deputy Governor instructed her to wait until the morning to inform Mr McNair's family. On 17 June, Mr McNair's sister phoned the prison between midnight and 3.00am. She had heard that something had happened to Mr McNair and she wanted the details. She spoke to a Custodial Manager who was not content that the caller was who she said she was and on the advice of the duty governor, referred her to the press office. It is not known whether she spoke to them or not.
77. At a similar time, the FLO contacted the police for a check on the next of kin's address and received confirmation at 6.32am. The FLO and prison manager, broke the news to Mr McNair's next of kin and family just after 9.00am, the next

morning. The prison manager stayed in contact with the family offering advice and support.

78. Mr McNair's funeral was held on 13 July, and the FLO, prison manager and a member of the prison chaplaincy attended. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

79. We have not seen any hot debrief minutes (where the staff involved in the emergency response are given any opportunities to discuss any issues arising, and to offer support). We have been told that one took place but no minutes were taken. We have seen an email which refers to a hot debrief and reiterates who staff can contact for support.
80. The prison posted notices informing other prisoners of Mr McNair'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 McNair's death.

Post-mortem report

81. The post-mortem report concluded that the autopsy had failed to identify a definitive cause of death but that, as heroin was found in Mr McNair's system at levels that could be associated with fatality, heroin toxicity was most likely cause of death. Pregabalin and olanzapine were also present at therapeutic levels but were not considered to have contributed to his death. His leg ulcer and other medical conditions were also not considered to have been contributory.

Findings

Clinical care

82. Mr McNair had issues with chest pain and a leg ulcer which were appropriately investigated, monitored and managed. The clinical reviewer is satisfied that the care Mr McNair received at Lewes was equivalent to that which he could have expected to receive in the community.

ACCT procedures

83. We have identified some deficiencies in the operation of ACCT procedures in this case. Mr McNair was only briefly subject to ACCT monitoring between 10 and 12 April after a superficial self-harm incident. There appears to be no evidence to suggest that Mr McNair deliberately took a drugs overdose with the intention of ending his life, and we do not consider that the deficiencies in ACCT procedures impacted on his death. Nevertheless, we consider it is important to highlight them as learning for the prison.
84. It is a mandatory requirement under Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, that the first ACCT case review must identify the prisoner's risk factors and complete a caremap giving detailed and time-bound actions aimed at reducing those risks. ACCT plans must only be closed once all the actions on the caremap have been completed. Post-closure reviews must take place within seven days of closure.
85. The ACCT assessment, which was good, identified that Mr McNair's risk factors were that he was worried about his upcoming court appearance; being taken off medication; and mobility issues with his current location. The ACCT was closed the next day at the first review without any reference to these risk factors and a caremap was not completed. We consider that there was too much reliance on what Mr McNair said rather than an objective evaluation of his risks. The ACCT should not have been closed until Mr McNair's issues had been addressed.
86. A post-closure review was scheduled for 19 April, but there is no record that it took place. We make the following recommendation:

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

- **ACCT caremaps should have specific, meaningful actions aimed at reducing prisoners' risk to themselves and progress should be considered and documented at each review.**
- **All caremap actions have been completed before ACCT monitoring is stopped.**
- **Post-closure reviews are completed within seven days of closure and the outcome documented in the ACCT.**

Mental Health

87. Mr McNair was referred to the mental health in-reach team as soon as he arrived at Lewes on 23 March. He was assessed by a mental health nurse on 26 March, who recorded that Mr McNair's mood could be described as flat but that this could have been due to the effects of substances. He was subsequently discussed at mental health allocations meetings and regularly followed up by the nurse.
88. The clinical reviewer spoke to the nurse. He said he had not seen Mr McNair under the influence of non-prescribed drugs during the latter part of his time at Lewes, and, at the time of his death, he considered Mr McNair to be at low risk of self-harm and that he seemed to be improving both physically and psychologically.
89. The clinical reviewer agrees that this view was consistent with Mr McNair's medical record. She is satisfied that the care Mr McNair received in respect of his mental health was equivalent to that which he could have expected to receive in the community.

Emergency response

90. Prison Service Instruction (PSI) 24/2011, which sets out the procedures for management and security in prisons at night, says that under normal circumstances prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two staff present. However, it goes on to say that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over the usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff can enter the cell on their own. The prison's local policy reflects these provisions.
91. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in local policies at Lewes.
92. We are concerned that when an officer could not get a response from Mr McNair (on 16 June), he did not call an emergency code over his radio or enter Mr McNair's cell, instead he went to get help from the wing office which was approximately 30 metres away.
93. The investigator asked the officer to describe his decision making at the point he decided to fetch assistance rather than radio for it or go into the cell alone. The officer said that, at the time, he had only recently been trained and this had been his first set of night shifts. He was able to demonstrate he understood the emergency code system. He said that he had a radio with which to summon assistance but issues with the airwaves meant it was much quicker for him to go and fetch a colleague.
94. The officer said that during training he had been told categorically he could never go into an unlocked cell alone because of safety and security issues. The

investigator presented the officer with different scenarios where a prisoner may have obviously come to harm and needed immediate assistance. The officer said that his training was clear that whatever the circumstance he should not enter a locked cell alone. This is not correct. We make the following recommendation:

The Governor should ensure that staff are reminded of the national and local policies on entering cells during medical emergencies.

The Executive Director of Performance in HMPPS should ensure that POELT training accurately reflects national policies on entering cells during medical emergencies.

95. The investigator also spoke to the officer who had locked Mr McNair up the evening of 16 June. He said that Mr McNair had seemed chatty and well when he last saw him and that his death had shocked him. He was aware that it was Mr McNair's birthday the following day and recalled that Mr McNair told him he had recently been sentenced. The investigator checked with the prison but they only have a record of Mr McNair going to court to and receiving a fine for one of his convictions and said that he was, in fact, still due to be sentenced for the rest of them. An officer was surprised by this but said there was nothing about Mr McNair's presentation to suggest he might have been under the influence of substances.
96. The officer also said that he had called the code blue and although he had to give control room staff more information about Mr McNair's condition, he was under the impression they had called the ambulance immediately. South East Coast Ambulance Service records show that, in fact, the call was made at 7.45pm which is six minutes after the officer broadcast the code blue. The ambulance service records also show that they arrived at the prison at 7.55pm but were not allowed to access it until 8.03pm.
97. The managers with responsibility for the control room and the gate on 16 June (two CM's) were unable to explain any of the apparent delays.
98. We are concerned that control room staff did not act in line with national policy, and we make the following recommendation:

The Governor should ensure that:

- **control room staff call an ambulance immediately when a medical emergency is called; and**
- **arrangements are in place to escort ambulance personnel to medical emergencies as quickly as possible.**

Substance Misuse

99. Mr McNair was suspected of diverting medication from the medication hatch on a number of occasions. The first instance occurred on 3 April and an intelligence report was submitted. There were three further instances of suspected non-compliance on 4 April, 6 April and 9 April. Although there is no evidence of any further intelligence reports being completed, the pharmacy worker did ask a GP to review the situation and Mr McNair's morphine prescription was stopped as a result.
100. The investigator asked the head of health care whether healthcare staff have access to the necessary system to file intelligence reports and, if not, what mechanisms exist to share information about a prisoner's suspected substance misuse with discipline staff. He said that most healthcare staff did have access to the system and he would have expected them to file intelligence reports when they suspected a prisoner is under the influence of drugs or secreting medication. He said that any staff who do not have access can ask prison staff to log onto the security system for them and take them through the report template. Healthcare staff also attend monthly security meetings to ensure that substance misuse information is shared between all staff in the prison.
101. As there is no evidence that intelligence reports were completed on all the occasions where Mr McNair appeared to be either under the influence of drugs or diverting medication, we make the following recommendation:

The Head of Healthcare should ensure healthcare staff file intelligence reports where they suspect a prisoner is engaging in behaviour relating to substance misuse and/or the diversion of medication.

102. On 11 April, Mr McNair told a GP that staff were mistaken about him diverting medication, but on 17 April, he told a member of staff that he had been pressured into selling his medication and wanted to move wings. He was moved to a different wing on 21 April, and entries on his record suggest that he reported being much happier. We are satisfied that in this instance, the prison took action to protect Mr McNair's well-being.
103. The prison has a substance misuse strategy which focuses on supply reduction and building recovery. The Head of Reducing Reoffending leads on the development and implementation of the strategy and reports progress and failures to the senior management team. Nevertheless, the recent HMIP inspection found that drugs were easily accessible to prisoners at Lewes. It is clear, therefore, that more needs to be done to reduce both the supply and the demand for drugs.
104. Lewes is not alone in facing this problem – 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. However, in the PPO's view there is an urgent need for national guidance to prisons from HM Prison and Probation Service (HMPPS) providing evidence-based advice on what works.

105. 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 (February 2019), this strategy has still not been issued. We therefore make 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.

**Prisons &
Probation**

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