Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carlington Spencer a detainee at Morton Hall Immigration Removal Centre on 3 October 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*

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 Carlington Spencer died in hospital on 3 October 2017 after suffering a stroke four days earlier, while a detainee at Morton Hall Immigration Removal Centre. He was 38 years old. I offer my condolences to Mr Spencer's family and friends.

I am not satisfied that Mr Spencer's clinical care was equivalent to that which he could have expected to receive in the community. Although Mr Spencer was on medication for high blood pressure, healthcare staff did not monitor his blood pressure routinely. In addition, after Mr Spencer collapsed on 29 September, his blood pressure was not taken as part of his clinical observations, and there was an unnecessary delay before an ambulance was called.

Mr Spencer had a history of taking psychoactive substances (PS) and admitted to taking them on the morning he was found with symptoms of a stroke. Use of PS has been linked to strokes and it is possible that this is what caused Mr Spencer's stroke. I am satisfied he received good support to address his substance misuse issues. I am also satisfied that since Mr Spencer's death, Morton Hall has taken further steps to reduce the availability of illicit substances in the IRC.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman **October 2018**

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Summary

Events

1. Mr Carlington Spencer arrived at Morton Hall Immigration Removal Centre on 31 May 2017, pending deportation to Jamaica. He had been transferred to Morton Hall on completion of his prison sentence.

2. Mr Spencer was an insulin dependent diabetic. He also took medication for high blood pressure and high cholesterol. He was overweight and a smoker. He was known to have used psychoactive substances (PS) in prison.

3. On 9 August, Mr Spencer collapsed in his room. Officers suspected he had taken PS. He was checked by a nurse and observed regularly until he recovered. The nurse made a referral to the Substance Misuse Service, who created a substance misuse recovery care plan.

4. At 3.30pm on 28 September, officers suspected Mr Spencer had taken PS again. A nurse assessed him and officers observed him regularly. At 11.37pm, a nurse and a healthcare assistant went to Mr Spencer's room and found him sitting on the floor. He could not stand up without the assistance of staff but denied having taken illicit substances. An officer observed him every hour during the night.

5. At approximately 9.30am on 29 September, a detainee told an officer that Mr Spencer was unwell. Mr Spencer told a nurse he had taken PS. Officers observed him every 30 minutes and made a referral to the Substance Misuse Service. He agreed to discuss his use of PS with a substance misuse practitioner later that day.

6. At approximately 12.45pm, a detainee alerted a nurse that Mr Spencer was unwell. The nurse assessed Mr Spencer and noted that he had the symptoms of a stroke. She went to the healthcare unit where at 1.09pm, she telephoned for an emergency ambulance. Paramedics arrived at Mr Spencer's room at 2.25pm and took Mr Spencer to hospital.

7. On 30 September, Mr Spencer was moved to a specialist stroke unit. After a brain stem test on 3 October showed no brain activity, hospital doctors decided to withdraw Mr Spencer's clinical care. He was pronounced dead at 3.32pm on 3 October.

8. The post-mortem report shows that Mr Spencer died from a stroke. The pathologist found no vascular abnormality that might have explained the development of a stroke. She noted that PS use can cause strokes and it was possible this had caused Mr Spencer's stroke, although she could not be certain.

Findings

9. Mr Spencer had risk factors associated with cardiovascular disease, including high blood pressure. The clinical reviewer found that healthcare staff did not routinely monitor Mr Spencer's blood pressure as they should have done and on the morning of 29 September, after Mr Spencer's collapse, the nurse did not take blood pressure readings as part of the clinical observations.

10. When Mr Spencer was found sitting on the floor of his room on the evening of 28 September, healthcare staff considered that his condition was due to the use of PS. This is possible. However, it is also possible that had suffered a 'mini stroke', in which case it should have been treated as a medical emergency.

11. The clinical reviewer concluded that the standard of Mr Spencer's clinical care at Morton Hall was not equivalent to that which he could have expected to receive in the community.

12. We are concerned that the nurse did not radio an emergency code when she suspected that Mr Spencer had suffered a stroke on 29 September. Instead, she returned to the healthcare unit and called for an ambulance 24 minutes after she first saw Mr Spencer. This caused an unnecessary delay.

13. Mr Spencer had a history of using PS in prison and at the IRC and this may have caused his stroke. The standard of substance misuse support Mr Spencer received at Morton Hall was good. Since Mr Spencer's death, Morton Hall has taken steps to reduce the availability of PS in the IRC.

Recommendations

- The Head of Healthcare should ensure that detainees with risk factors for cardiovascular disease are offered routine monitoring.
- The Head of Healthcare should ensure that healthcare staff record a patient's blood pressure in routine clinical observations.
- The Centre Manager and Head of Healthcare should ensure that all staff are reminded of the procedures they must follow in a medical emergency, as set out in DSO 09/2014.

The Investigation Process

14. The investigator issued notices to staff and detainees at Morton Hall IRC informing them of the investigation and asking anyone with relevant information to contact her. Six detainees provided written statements about events leading to Mr Spencer's death.

15. The investigator obtained copies of relevant extracts from Mr Spencer's custodial, detention and medical records from the IRC. She also spoke to Mr Spencer's case owner at the Home Office's Criminal Casework Team and obtained copies of relevant paperwork relating to Mr Spencer's detention. Our investigation was suspended between 13 October 2017 and 8 February 2018 while we awaited the cause of death.

16. The investigator and an Assistant Ombudsman interviewed six members of staff at Morton Hall on 24 April.

17. NHS England commissioned a clinical reviewer to review Mr Spencer's clinical care at the IRC. She conducted joint interviews with the investigator and Assistant Ombudsman.

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

19. The investigator wrote to Mr Spencer's ex-wife, his nominated next of kin, to explain the investigation and to ask if she had matters she wanted the investigation to consider. She did not respond to our letter.

20. On 24 January, the solicitor acting on behalf of Mr Spencer's sister and partner wrote to the investigator and raised the following:

    - The family expressed concern that Mr Spencer's clinical care fell below an acceptable standard.
    - They were concerned that healthcare staff focused on Mr Spencer's use of PS and did not properly consider his clinical symptoms.
    - They were concerned about the delay in calling an ambulance when Mr Spencer showed signs of a stroke.

21. The solicitor representing Mr Spencer's family received a copy of the initial report. They did not make any comments.

22. The initial report was shared with the Home Office. The Home office pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

Morton Hall Immigration Removal Centre

23. Morton Hall IRC is located near Lincoln. It is the only IRC managed by HM Prisons and Probation Service (HMPPS) on behalf of the Home Office. It holds up to 392 men. The residential accommodation comprises six units with single rooms. Two of the units, Windsor and Fry, are regarded as more secure and detainees who are seen as higher risk are housed there. A small team of Home Office staff provide liaison between detainees, case workers in other Home Office locations and the wider operational network of immigration enforcement. Healthcare services are run by Nottinghamshire NHS Foundation Trust on a 24-hour basis. There is no healthcare inpatient unit at Morton Hall.

HM Inspectorate of Prisons

24. The most recent inspection of Morton Hall was in November 2016. Inspectors reported that detainees were mostly negative about access to and the quality of health services. However, waiting times for primary care clinics were short overall and primary health services remained good.

25. An emergency code system was used to ensure healthcare staff and ambulances were called promptly for medical emergencies, although this was not the standard colour coding, which could have caused confusion for staff transferred in from other establishments.

26. Inspectors commented that Morton Hall's drug strategy was reviewed annually and now included more emphasis on treatment, but there was still insufficient focus on strategies to reduce demand, and it did not explicitly address psychoactive substances (PS). In practice, there was a focus on the increasing PS problems, including medical emergencies, although there were no PS awareness sessions for detainees or staff. Well-attended monthly substance misuse meetings discussed all key areas and created actions, although some were repeatedly carried over and not all were sufficiently strategic. Links with security were good.

Independent Monitoring Board

27. Each IRC has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that detainees are treated fairly and decently. In its most recent annual report for the year ending 31 December 2016 the IMB noted that Morton Hall is a very well-run establishment and provides a safe and secure environment for the detainees being held there. However, they observed that there had been increasing levels of verbal abuse, aggression and violence directed to staff, often as a consequence of drug abuse.

Previous deaths at Morton Hall IRC

28. Mr Spencer was the third detainee at Morton Hall to die since October 2014. One detainee died from natural causes and one took his own life. One detainee has taken his own life since. We have made a recommendation before to Morton Hall about the importance of staff using an emergency medical code.

Psychoactive Substances (PS)

29. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) 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. People 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.

30. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) in prisons 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.

Key Events

31. On 4 December 2015, Mr Carlington Spencer was remanded to custody at HMP Nottingham charged with drugs related offences. On 28 April 2016, he was sentenced to two years and 10 months in prison. On 18 May 2016, he was moved to HMP Moorland. On 8 May 2017, he completed his prison sentence but remained detained at Moorland under immigration powers pending his deportation to Jamaica. On 31 May, he was moved to Morton Hall Immigration Removal Centre.

32. On arrival at Morton Hall, a nurse completed Mr Spencer's initial health assessment. She noted he had type 1 diabetes, high blood pressure, high cholesterol, anxiety and was prescribed sertraline (an antidepressant). He was a smoker and declined help to stop. She also noted Mr Spencer's history of using psychoactive substances (PS) in prison and made a referral to the substance misuse service. She recorded Mr Spencer's blood pressure as slightly high and his body mass index as 27 (overweight). Nurses created a care plan to manage Mr Spencer's diabetes. IRC GPs prescribed medication for high blood pressure and high cholesterol.

33. On 5 June, a mental health nurse assessed Mr Spencer's mental health and noted he was relaxed and calm. She created a mental health care plan to monitor Mr Spencer's mood, mental state and medication for depression.

34. On 14 June, Mr Spencer did not attend an appointment with the substance misuse service. A substance misuse practitioner made another appointment for 26 July. However, this appointment was cancelled because she was unwell.

35. On 27 June, Mr Spencer did not attend the diabetes clinic for a routine assessment. On 8 July, a nurse saw Mr Spencer, who complained of feeling unwell. Mr Spencer said he was unable to test his blood sugar because his monitor had run out of batteries. She recorded Mr Spencer's blood sugar as low and gave him glucose tablets to increase his sugar levels. She took Mr Spencer's blood sugar later that day and recorded his blood sugar levels within the normal range for a diabetic.

36. On 28 June, an IRC GP saw Mr Spencer, who asked to stop taking sertraline because it was not helping. The GP reduced the dose and stopped prescribing sertraline on 20 July.

37. On 24 July, a nurse assessed Mr Spencer's mental health and noted that Mr Spencer was no longer prescribed sertraline. Mr Spencer said he felt fine during the day but suffered from disturbed sleep. She noted that Mr Spencer no longer required support from the IRC's mental health service and gave him advice about how to access support if he needed it.

38. On 8 August, Mr Spencer did not attend the diabetes clinic for a routine assessment.

39. On 9 August, an officer found Mr Spencer collapsed in his room. Mr Spencer had his eyes closed and was unresponsive. The officer called an emergency code two (used to indicate a serious loss of blood, severe burns or scalds or

suspected fracture) and a nurse attended. She told the control room Mr Spencer did not need an ambulance. She noted that Mr Spencer had vomited, his pulse was high, his blood pressure was low and his oxygen saturation level was low. She noted that she believed Mr Spencer was under the influence of PS and observed Mr Spencer for the next 30 minutes until he recovered. She told IRC officers to observe Mr Spencer every 15 minutes over the next two hours. Officers opened an illicit substance monitoring document to record their observations. The nurse made a referral to the substance misuse service. No evidence of PS use was found in Mr Spencer's room. Officers submitted an intelligence report.

40. On 15 August, the substance misuse practitioner went to Mr Spencer's unit to offer him support and harm reduction advice but was unable to find him. On 16 August, a substance misuse support worker saw Mr Spencer on the unit. Mr Spencer said he was angry that he had used PS and felt that his mental health had deteriorated. She discussed the risks of using PS and encouraged Mr Spencer to engage with the Substance Misuse Service.

41. On 18 August, Mr Spencer went to see the substance misuse practitioner in the healthcare unit. Mr Spencer said he was not currently using illicit substances. She created a substance misuse recovery care plan to provide Mr Spencer with ongoing support to reduce his risk of using PS.

42. On 27 August, a nurse saw Mr Spencer, who complained of feeling anxious and waking frequently during the night. The nurse made a referral to a GP.

43. A IRC GP saw Mr Spencer on 5 September. Mr Spencer said healthcare staff were not looking after him and he had not seen the diabetic nurse since his arrival in June. The GP arranged a full set of blood tests and made a referral to the diabetes nurse.

44. On 13 September, a nurse saw Mr Spencer to discuss the management of his diabetes. She noted that Mr Spencer had failed to attend the diabetes clinic on two occasions. The same day, Mr Spencer was taken to hospital for a blood test because healthcare staff were unable to obtain a sample. The results were received on 21 September and showed that Mr Spencer's hormone levels were abnormal. A IRC GP arranged a repeat set of blood tests, which were taken the same day.

45. On 14 September, a IRC GP saw Mr Spencer to discuss his concerns about his healthcare. Mr Spencer asked to start taking antidepressants again and the GP prescribed fluoxetine. The next day, Mr Spencer told a nurse he felt happier because staff had listened to his complaints.

46. On 19 September, the substance misuse practitioner completed a substance misuse assessment. Mr Spencer said he had used PS once recently and was currently drug free.

47. On 27 September, the substance misuse practitioner saw Mr Spencer in accordance with his substance misuse care plan. Mr Spencer said he was drug free. She noted that Mr Spencer understood the reasons for his negative behaviour and the need for a positive lifestyle.

Events of 28 September 2017

48. At approximately 3.30pm, an officer reported that Mr Spencer appeared to be under the influence of PS. He called an emergency code two and the control room called an ambulance. A nurse responded immediately. She was unable to enter Mr Spencer's room because he was standing in front of the door. She noted that Mr Spencer was fully conscious and alert and there was a strong, sweet smell outside his room. She told IRC staff that Mr Spencer did not need an ambulance and to observe him every 30 minutes. Officers opened an illicit substance monitoring document to record their observations.

49. At 4.31pm, the nurse checked on Mr Spencer in his room. He appeared sleepy but denied using illicit substances. She recorded Mr Spencer's pulse, blood pressure, blood glucose and blood pressure were within normal limits. She made a referral to the Substance Misuse Service.

50. At 7.34pm, the nurse assessed Mr Spencer again. She recorded that his clinical observations were within the normal range. Mr Spencer said he felt sleepy and hot. She arranged a welfare check by the nurse on night duty.

51. At approximately 8.45pm, an officer checked on Mr Spencer in his room. Mr Spencer was fully responsive and did not complain of feeling unwell. The officer asked a nurse if he could close the illicit substance misuse document. The nurse told him to close the document and confirmed she would check on Mr Spencer when she gave Mr Spencer his prescribed medications.

52. At 11.37pm, the nurse and a healthcare assistant went to Mr Spencer's room for a welfare check. The officer accompanied them. Their accounts differed. The nurse said that Mr Spencer was sitting on the floor, that he was sleepy but coherent and that once he had been helped to his feet he was able to walk unsteadily around his bed. The officer told the investigator that Mr Spencer was found sitting on the floor with toilet paper hanging from his mouth, that he was unable to move one of his legs and had to be lifted onto his bed. The healthcare assistant told the investigator that Mr Spencer was on his bed the entire time.

    Mr Spencer denied using any illicit substances. The nurse recorded his pulse as normal, oxygen saturation level as slightly low, and blood pressure as high. She asked IRC staff to open an illicit substance monitoring document with three observations every 30 minutes, followed by hourly observations during the night. The officer observed Mr Spencer throughout the night and on each occasion noted he was asleep.

Events of 29 September 2017

53. At approximately 9.30am, a detainee approached an officer and said Mr Spencer was unwell. The officer went to Mr Spencer's room and saw him on the floor. Mr Spencer was conscious and speaking to other detainees, who helped him onto his bed. The officer called an emergency code two at 9.36am and the control room called an ambulance. A nurse attended immediately. She recorded Mr Spencer's oxygen saturation and pulse as within the normal range and his blood sugar level as high. There is no evidence that she recorded Mr Spencer's blood pressure. She told IRC staff that Mr Spencer did not need an ambulance.

54. Mr Spencer told the nurse he had taken PS. She advised Mr Spencer to drink water and to take his insulin when he felt better. She told officers to observe Mr Spencer every 30 minutes and made a referral to the Substance Misuse Service. Officers opened a substance misuse monitoring document.

55. At 10.34am, a substance misuse support worker checked on Mr Spencer, who was asleep on his bed. Mr Spencer's blood sugar level had reduced but was still high.

56. At 11.59am, the substance misuse practitioner saw Mr Spencer in his room to discuss his use of PS. Mr Spencer said he felt fine and agreed to attend healthcare later that day.

57. At approximately 12.45pm, a detainee alerted a nurse that Mr Spencer was unwell. She went to his room immediately and found him lying on his bed. She noted that the left-side of Mr Spencer's face was drooped and he had slurred speech. Mr Spencer's blood sugar level was high so she encouraged him to administer his insulin, which he did with difficulty. She went to the healthcare unit where, at 1.09pm, she telephoned for an emergency ambulance. She returned to Mr Spencer's room and continued to monitor him. At 1.50pm, the Clinical Matron chased up the ambulance, but was told that no specific time of arrival could be given. The ambulance arrived at Morton Hall at 2.15pm and paramedics arrived at Mr Spencer's room at 2.25pm.

58. At 2.50pm, the ambulance took Mr Spencer to hospital. He was accompanied by two officers but was not restrained. He arrived at the hospital at 3.33pm.

Mr Spencer's time in hospital

59. At 5.28pm, the hospital contacted Morton Hall to discuss Mr Spencer's condition. A clinical matron told them that Mr Spencer's symptoms had started at 12.45pm. The hospital told her that investigations had revealed that Mr Spencer had suffered a large stroke.

60. On 30 September, Mr Spencer was moved to the stroke unit at another hospital for specialist care. On 1 October, The Home Office released Mr Spencer from immigration custody. Hospital doctors placed Mr Spencer in a medically induced coma. After a brain stem test on 3 October showed no brain activity, hospital doctors decided to withdraw Mr Spencer's clinical care. He was pronounced dead at 3.32pm on 3 October.

Contact with Mr Spencer's family

61. A family liaison officer was appointed upon Mr Spencer's admission to hospital. Mr Spencer's ex-wife was listed as his next of kin.

62. The family liaison officer called Mr Spencer's ex-wife at 9.30pm on 29 September, to inform her of his condition. He arranged for Mr Spencer's ex-wife to visit Mr Spencer in hospital.

63. Mr Spencer's ex-wife was present when he died on 3 October. Mr Spencer's body was repatriated to Jamaica on 30 November, with all the costs being covered by the Home Office. It also paid for the funeral costs.

Support for detainees and staff

64. After Mr Spencer's death, a 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.

65. The IRC posted notices informing other detainees of Mr Spencer's death and offered support. Staff reviewed all detainees assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Spencer's death.

Post-mortem report

66. The post-mortem report found that Mr Spencer died from a right middle cerebral artery infarction (stroke). Toxicology tests did not identify the presence of PS but the toxicologist noted that these drugs would have been excreted over the four days between Mr Spencer taking them and him dying in hospital. The pathologist did not identify any vascular abnormality that might explain the development of a stroke. She noted that PS use had been linked to the development of stroke and considered that PS use was a possible cause of stroke in Mr Spencer's case.

Findings

Clinical care

67. Mr Spencer was an insulin dependent diabetic. Healthcare staff put in place a comprehensive care plan and monitored his blood sugar levels regularly.

68. Mr Spencer had several risk factors for cardiovascular disease including high blood pressure, high cholesterol, being a smoker and being overweight. When he arrived at Morton Hall on 31 May, the lead nurse for coronary heart disease was asked to add Mr Spencer to the waiting list for a review, but an appointment was not made before he died. That appointment would have covered many of the same tests and the same lifestyle advice given to Mr Spencer in his diabetes reviews, but it would have also taken his blood pressure, which was not taken during the diabetes reviews. The clinical reviewer expressed concern that Mr Spencer's blood pressure was not monitored regularly at Morton Hall given his cardiovascular disease risk factors.

69. The clinical reviewer also noted that when Mr Spencer's clinical observations were taken on the morning of 29 September in response to the code two call, the nurse did not take his blood pressure. She also failed to take his blood pressure when taking his clinical observations later the same morning. The nurse could not explain why she had not recorded Mr Spencer's blood pressure as part of her clinical observations. She said she was confident that he was showing the signs of a stroke. The clinical reviewer commented that blood pressure is recognised as a key indicator of a patient's physical health and should form part of a patient's overall assessment.

70. The clinical reviewer considers it possible that Mr Spencer had suffered a transient ischemic attack (TIA - a mini stroke caused by a temporary disruption in the blood supply to part of the brain) on the evening of 28 September, when he was found sitting on the floor of his room. A TIA is a clear warning of the potential for further TIAs or a stroke. Mr Spencer had several of the risk factors associated with a TIA, specifically smoking, high blood pressure and cholesterol. While a TIA is not a full stroke, it should still be considered as a medical emergency.

71. Healthcare staff considered that Mr Spencer's condition on that evening was due to PS use. The clinical reviewer said that because of the different ways in which people react to PS, it is possible that this was the case and she could not say for sure whether Mr Spencer had suffered a TIA.

72. The clinical reviewer concluded that Mr Spencer's clinical care was not equivalent to that which he could have expected to receive in the community and we agree. We make the following recommendations:

    The Head of Healthcare should ensure that detainees with risk factors for cardiovascular disease are offered routine monitoring.

    The Head of Healthcare should ensure that healthcare staff record a patient's blood pressure in routine clinical observations.

Emergency response

73. DSO 09/2014, *Emergency Medical Response Codes,* requires IRCs to have a medical emergency response code protocol, which ensures an ambulance is called immediately in a life-threatening emergency. It states that all IRC staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The DSO makes it clear that there should be no delay in admitting and discharging an ambulance in a medical emergency.

74. Morton Hall had a Centre Manager's Order (*Emergency response No. 023.16*) in place at the time of Mr Spencer's death. This contained mandatory instructions for detention staff to use in the event of an emergency response and stated they must:

> "Call the Comms room by radio or telephone immediately. The term 'Code One' should be used for chest pain, difficulty in breathing, being unconscious, fitting or concussed, severe allergic reaction or suspected stroke. The term 'Code Two' should be used for serious loss of blood, severe burns or scalds or suspected fracture."

75. The instruction added that Comms staff must call for an ambulance immediately on receiving a code one or code two call, and request healthcare staff to attend immediately to deal with the patient. It also stated that the Comms room should inform gate staff to ensure they facilitate the swift entry and exit of emergency vehicles. The instruction also stated that if staff had concerns about the medical welfare of residents, but did not think it was serious enough to be life threatening, healthcare staff and Oscar 1 (the senior officer on duty) should be contacted immediately. However, if the situation developed into an emergency situation, the emergency procedure should be implemented immediately.

76. On 15 October 2017, Morton Hall issued a Centre Manager's Order (*Emergency response No.025.17)* which changed the coded call procedure and stated that:

> "The term 'Code Blue' must be used for chest pain, difficulty in breathing, being unconscious, choking, fitting or concussed, severe allergic reaction or suspected stroke'.
>
> "The term 'Code Red' must be used for serious loss of blood, severe burns or scalds or suspected fracture'.

77. When the nurse saw Mr Spencer at 12.45pm on 29 September after residents raised the alarm about his health, she recognised that Mr Spencer was showing the signs of a stroke. We would have expected her to have used her radio to call an emergency code, but instead she returned to the healthcare unit and telephoned for an ambulance. She did not make this telephone call until 1.09pm, 24 minutes after she first attended to Mr Spencer. In a medical emergency it is imperative that the correct procedures are followed and that an ambulance is called immediately. We make the following recommendation:

The Centre Manager and Head of Healthcare should ensure that all staff are reminded of the procedures that should be followed in a medical emergency, as set out in DSO 09/2014.

78. We note that the ambulance did not arrive at Morton Hall for over one hour after it was requested. The clinical reviewer noted that this was outside the standards expected for emergency ambulance response times. However, decisions taken by East Midlands Ambulance Service are outside our remit.

79. We found there had been some confusion among IRC staff about the correct medical emergency code to use when the system was code one and code two. On 9 August and 28 September, the wrong code was used when Mr Spencer was found unresponsive. We note that the code system has now changed to code blue and code red, which is clearer, so we make no recommendation.

Illicit substances

80. Mr Spencer had a history of taking illicit substances. When he arrived at Morton Hall, he was offered an appointment with the substance misuse service but chose not to attend. The substance misuse team contacted Mr Spencer after he took PS on 9 August. They put in place a substance misuse recovery care plan which provided ongoing support to reduce his risk of taking illicit substances. The clinical reviewer considered that Mr Spencer received a good standard of substance misuse care at Morton Hall.

81. Morton Hall has a Substance Misuse Strategy, issued in September 2017. It states the IRC will not tolerate the presence of illicit drugs and is committed to eliminating the supply of, and demand for, drugs. It also states that it has systems in place to identify, assess and support detainees with a drug misuse problem.

82. Healthcare has a PS policy in place to respond, observe and escalate incidents of PS use. Healthcare staff can refer detainees to either a clinical or psychological pathway. The nurses told us at interview that they did not receive any formal training on the effects of taking PS and the risks to a patient's physical health.

83. The manager responsible for drug strategy told us that Morton Hall had a comprehensive system in place to reduce the presence of PS on the units. This included methods to reduce staff corruption, monitoring of detainees' mail, analysis of security intelligence and searching of detainees and their rooms.

84. The PPO's Learning Lessons Bulletin on New Psychoactive Substances (as then called), issued in July 2015, sets out why these substances were a source of increasing concern in prisons. There was emerging evidence that NPS posed dangers to both physical and mental health. In addition, trading these substances could lead to debt, violence and intimidation. In our Annual Report for 2016/2017 we noted that the number of deaths where the use of NPS may have played a part continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies including better monitoring by drug treatment services and effective violence reduction strategies.

85. The manager responsible for drug strategy told us that since Mr Spencer's death, Morton Hall has introduced measures to reduce the risk of illicit substances entering the IRC. This included increasing the number of security patrols around the perimeter fence. Additional fencing around the 5-a-side football pitch has

also been proposed subject to funding. She also told us that Morton Hall is in the process of employing their own active drugs dog.

86. We are satisfied that these measures indicate a more robust implementation of the local drugs strategy. We do not therefore make a recommendation.

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