Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Daniel Raworth a prisoner at HMP Hull on 13 January 2018

**A report by the Prisons and Probation Ombudsman**

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## Our Vision

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

## Our Values

**We are:**

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

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 Daniel Raworth died on 13 January 2018 from the combined effects of three prescription-only drugs at HMP Hull. He was 33 years old. I offer my condolences to Mr Raworth's family and friends.

Mr Raworth had not been prescribed any of the drugs found in his system after his death, and he must therefore have obtained them illicitly. While Hull has a drug strategy, it is clear that Mr Raworth was still able to obtain a range of prescription-only drugs that had not been prescribed to him, and that the prison needs to continue to work to reduce prisoners' access to illicit substances.

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

**Sue McAllister CB**
**Prisons and Probation Ombudsman** **June 2019**

## Contents

# Summary

## Events

1. Mr Daniel Raworth arrived at HMP Hull on 16 November 2017. On 23 November, he was sentenced to three and a half years imprisonment for supplying Class A drugs.

2. Mr Raworth had a history of substance misuse but on arrival at Hull he denied any recent drug use and declined a referral to the Drug and Alcohol Recovery Team. During his time at Hull, there was no intelligence to suggest he took or was involved in drugs.

3. On the morning of 13 January 2018, Mr Raworth's cellmate realised something was wrong when he could not wake Mr Raworth. He fetched officers who came to the cell. They could not get a response from Mr Raworth and then noticed vomit on his bed. They called a medical emergency code. A nurse arrived who assessed that Mr Raworth had signs of rigor mortis, so he did not attempt to resuscitate him. Paramedics confirmed Mr Raworth's death at 9.53am.

4. The post-mortem examination showed no natural disease that could have caused Mr Raworth's sudden death. Buprenorphine, pregabalin and quetiapine, all prescription-only drugs, were found in Mr Raworth's system. None of these drugs had been prescribed to Mr Raworth. While the drugs were found at lower levels than those normally associated with toxicity, the pathologist concluded that the combination of drugs was likely to have caused respiratory depression resulting in Mr Raworth's death.

## Findings

5. The clinical reviewer concluded that the clinical care Mr Raworth received at HMP Hull was equivalent to that he could have expected to receive in the community. He was offered support with substance misuse issues but he declined it.

6. We have no concerns about the emergency response and are content that the nurse's decision not to attempt resuscitation was correct.

7. We are concerned about the easy availability of illicit prescription drugs at Hull. Although the prison has a substance misuse strategy, more needs to be done to reduce supply and demand.

## Recommendations

- The Governor should ensure that the key drug issues at Hull continue to be identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

9. The investigator obtained copies of relevant extracts from Mr Raworth's prison and medical records.

10. The investigator interviewed one member of staff and one prisoner.

11. NHS England commissioned a clinical reviewer to review Mr Raworth's clinical care at the prison.

12. We informed HM Coroner for East Riding and Kingston Upon Hull District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr Raworth's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any issues.

14. Mr Raworth's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

# Background Information

## HMP Hull

16. HMP Hull is a local prison which holds up to 1,056 men in ten wings. City Healthcare Partnership provides health services at the prison. The prison has a wellbeing unit to support and progress prisoners with complex needs, which are difficult to meet in the normal prison environment. The unit includes a specialist palliative care cell. GP surgeries are held four days a week, with an out of hours service at other times.

17. In August 2018, Hull was selected to be part of the "10 Prisons Project", which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Hull was in April 2018. Inspectors found that health provision was reasonable and governance was mostly effective, but some health services had deteriorated since the last inspection. Drugs remained a challenge – drug testing rates suggested a positive rate of 24% although this was half the rate of the preceding 12 months. Other evidence suggested that the prison's work to combat drugs was beginning to be effective.

## Independent Monitoring Board

19. 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 28 February 2018, the IMB noted that psychoactive substances were at the root of a substantial amount of disciplinary and disorder problems. Mandatory drug tests were being conducted at the rate of 50 a month. The highest monthly total of positive results was ten. In August 2017, the number of illicit mobile phones discovered peaked at 16. This coincided with the transfer of a high number of men from other establishments and the number settled down to 5 by the end of 2017.

## Previous deaths at HMP Hull

20. Mr Raworth's death was the tenth at HMP Hull since January 2016. Seven of the previous deaths were from natural causes and two were self-inflicted. There were no similarities with this case. There have been a further eight deaths since Mr Raworth's (five from natural causes, two self-inflicted and one is yet to be classified).

# Key Events

21. On 16 November 2017, Mr Daniel Raworth was remanded in prison custody, charged with supplying Class A drugs, and sent to HMP Hull.

22. A nurse conducted Mr Raworth's reception health screen. She recorded that he appeared fit and well and was not on any medication. Although Mr Raworth had a history of substance misuse, he denied using drugs in the last month and refused a referral to the Drug and Alcohol Recovery Team.

23. On 23 November, Mr Raworth was sentenced to three and a half years imprisonment.

### Events of 12/13 January 2018

24. Mr Raworth's cellmate told the investigator that Mr Raworth went to sleep at about 10.30pm on 12 January, and he went to sleep at about 11.00pm.

25. At 6.00am on 13 January, an officer did the morning roll check and around the same time, Mr Raworth's cellmate woke up to use the toilet. He said Mr Raworth had his back to him, but one leg was slightly dangling off the bed. He pushed it back on the bed but did not notice anything unusual. He went back to sleep after using the toilet.

26. An officer unlocked Mr Raworth's cell at approximately 8.00am. He did not recall any interaction with Mr Raworth but told the investigator that it was his usual practice to get a response from prisoners at unlock.

27. Mr Raworth's cellmate woke up again at approximately 9.30am when another prisoner came to their cell to borrow some hair clippers. He told the other prisoner to wake Mr Raworth for the clippers and the other prisoner said he was cold. He looked more closely at Mr Raworth and, realising something was wrong, went to get a prison officer for help.

28. At approximately 9.40am, Mr Raworth's cellmate told an officer that he wanted him to come and look at his cellmate. Two officers went to Mr Raworth's cell where he was lying on the bed. One of the officers shook Mr Raworth but did not get a response. When he tried to move him, he saw vomit and at 9.43am, called a medical emergency code blue (used when a prisoner is unconscious or having breathing difficulties) on his radio. One of the officers asked the other to go to the wing office in case the ambulance service needed to speak to them directly.

29. A nurse heard the code blue and responded immediately. He found that Mr Raworth was cold to touch and his limbs were rigid. He concluded that Mr Raworth was showing signs of rigor mortis and therefore did not attempt to resuscitate him.

30. At 9.48am, paramedics arrived and at 9.53am, they confirmed Mr Raworth's death.

## Contact with Mr Raworth's family

31. The prison appointed a family liaison officer (FLO) for Mr Raworth's family. On 13 January, she was on a bedwatch and was relieved at 11.20am. When she arrived at the prison, she was briefed by prison managers and after completing the necessary checks she travelled to Mr Raworth's mother's house to break the news with another officer. Mr Raworth's mother was not home but the FLO telephoned her and she said she would be home in ten minutes. When she returned home, the FLO broke the news to her and helped her tell Mr Raworth's partner who lived nearby.

32. The FLO continued to support Mr Raworth's family. His funeral was held on 20 February 2018 and the FLO and a custodial manager attended. The prison contributed to the funeral costs in line with national policy.

## Support for prisoners and staff

33. After Mr Raworth's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

34. The prison posted notices informing other prisoners of Mr Raworth'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 Raworth's death.

## Post-mortem report

35. The post-mortem examination found no evidence of natural disease that could have caused or contributed significantly to Mr Raworth's death.

36. Toxicology tests showed that Mr Raworth had the following prescription-only drugs in his blood: buprenorphine (a synthetic opiate, also known as subutex, used to treat opiate addiction but also widely abused), pregabalin (used to treat epilepsy and nerve pain but also widely abused as it can be used to enhance the euphoric effects of other drugs) and quetiapine (an antipsychotic, which is also abused). None had been prescribed to Mr Raworth.

37. None of the drugs found in Mr Raworth's system were at levels associated with toxicity. However, the pathologist concluded that the combination of buprenorphine, pregabalin and quetiapine was likely to have caused fatal respiratory depression, and that Mr Raworth died from the effects of these three drugs.

# Findings

## Clinical care

38. The clinical reviewer was satisfied that the care Mr Raworth received at HMP Hull was equivalent to that he could have expected to receive in the community. During his reception screen he was offered a referral to the Drug and Alcohol Recovery Team which he declined.

39. The clinical reviewer agreed with the nurse's assessment on 13 January that Mr Raworth showed signs of rigor mortis and that attempting cardiopulmonary resuscitation would not, therefore, have been appropriate.

## Hull's drug strategy

40. The drug strategy in place at the time of Mr Raworth's death was issued in June 2017 (and reissued in March 2018). It aims to reduce the supply of illegal substances, identify any prisoners with substance misuse problems at the earliest opportunity, reduce demand, provide interventions and use intelligence to take action against those who bring substances into the prison.

41. There are no records indicating that Mr Raworth ever presented as under the influence of drugs at Hull, or any intelligence to suggest he was involved trading drugs. It is unclear how Mr Raworth obtained the prescription drugs that were found in his system and which were not prescribed to him. They could have been smuggled into the prison, or prisoners who had been prescribed that medication could have diverted and traded it. Hull's strategy covers diverted medication and says there must be careful selection and management of prescribed medication and proactive observation and supervision.

42. Hull is not alone in facing the problem of drugs – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies, but we welcome the fact that HMPPS has now produced national guidance to prisons from HMPPS providing evidence-based advice on what works, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

43. The new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

44. As part of the 10 Prisons Project, much of this work has already started at Hull but more needs to be done to address issues of drug supply and demand. We recommend that:

**The Governor should ensure that the key drug issues at Hull continue to be identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.**

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