Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Luke Derriman a prisoner at HMP Hewell on 23 January 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Luke Derriman died on 23 January 2018 at HMP Hewell from a brain haemorrhage as a result of a punch to the head. He was 39 years old. I offer my condolences to Mr Derriman's family and friends.

On 13 November 2018, Prisoner B was convicted of Mr Derriman's manslaughter. My investigation was suspended at the request of West Mercia police until the conclusion of Prisoner B's trial.

The reasons for Prisoner B's assault on Mr Derriman are unknown. Mr Derriman had only been at Hewell for two weeks when he died and I am satisfied that staff had no reason to consider that there were any links between Mr Derriman and Prisoner B, or that Mr Derriman was at risk from Prisoner B.

However, Prisoner B, had a history of violence and was judged to present a high risk to others in general. His risk to others was believed to increase when he used psychoactive substances (PS). On 18 January 2018 he admitted he was taking PS daily and asked a mental health nurse for help. He declined to see her later that day and a planned appointment had not taken place before Mr Derriman's death.

I am concerned that Prisoner B, was able to use PS so frequently and this was not communicated to healthcare staff and the substance misuse team each time, as it should have been. This might have led to earlier and more urgent assessment of Mr Prisoner A's, PS use and its effect on his mental health – although there is no way of knowing whether that might have prevented the assault on Mr Derriman.

Overall, I recognise that Hewell is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them. However, it is clear that more needs to be done and it is imperative that the prison uses the recently issued national guidance to ensure that the key drug issues at Hewell are being addressed.

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 **November 2019**

Contents

Summary

Events

1. Mr Luke Derriman was remanded to Hewell on 9 January 2018. He had a history of substance misuse, attempted suicide, self-harm, depression, anxiety, post-traumatic stress disorder, bi-polar disorder, schizophrenia and violent tendency disorder.

2. Prisoner B had been a prisoner at Hewell since September 2017. He had a history of mental illness, substance misuse, self-harm and violence. Prisoner B was identified as a risk to others and an entry in his medical record on 16 October 2017, noted that his risk of harm to others increased when he was under the influence of psychoactive substances (PS). On 18 January 2018, he admitted he was using PS daily and asked for help. He declined to speak to a mental health nurse later that day and a planned appointment had not taken place before Mr Derriman died.

3. At 3.20pm on 23 January, prisoners alerted staff that Mr Derriman was not breathing. Officers and nurses started resuscitation promptly and paramedics gave Mr Derriman advanced life support, but he died shortly after arriving at hospital at 5.00pm.

4. A pathologist found that Mr Derriman died from a basal sub-arachnoid haemorrhage (a brain haemorrhage) as a result of a punch to his head.

5. CCTV showed Prisoner B had thrown a punch in Mr Derriman's direction at 3.03pm and he was subsequently charged with manslaughter. At his trial, Prisoner A said that he punched Mr Derriman in self-defence. He was found guilty of manslaughter and sentenced to seven years in prison.

Findings

6. There was no intelligence to link Prisoner B, or any other prisoner, with Mr Derriman before Mr Derriman's death and no one came forward with information after Mr Derriman died. Prisoner B was assessed as presenting a high risk to others, but we do not consider that the prison had any reason to have predicted this specific incident or that there was any reason to keep Prisoner B and Mr Derriman apart.

7. It appears that healthcare staff and substance misuse services were not told every time Prisoner B was found under the influence of PS, as they should have been.

8. Hewell is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them. It is imperative that the prison adapts the recently issued national guidance to ensure that they continue to address these issues.

Recommendations

- The Governor and Head of Healthcare should ensure that healthcare and substance misuse services are informed every time a prisoner is found under the influence of an illicit substance and this is recorded on his medical record.
- The Governor should ensure that the key drug issues at Hewell are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded. Our investigation was suspended at the request of West Mercia police until the conclusion of Prisoner B's trial.

10. The investigator obtained copies of relevant extracts from Mr Derriman's and Prisoner B's prison and medical records. She also obtained copies of interview statements gathered by police investigators. She wrote to Mr Derriman's former cellmate but later learned from the police that he had died. Further information was obtained from the head of drug strategy and the head of the substance misuse team at Hewell.

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

12. We informed HM Coroner for Worcestershire of the investigation. The coroner gave us the results of the post-mortem examination. The coroner decided not to hold an inquest into Mr Derriman's death. We have not sent the coroner a copy of this report.

13. We contacted Mr Derriman's mother in February 2018, to explain the investigation and to ask if she had any matters, she wanted the investigation to consider. We also wrote to her in January 2019, but she did not respond, and we have not sent her a copy of this report.

Background Information

HMP Hewell

14. HMP Hewell holds remand and sentenced adult male prisoners across two sites, one open and one local prison taking prisoners from the courts. House blocks 1-6 form the closed part of the prison and have a total operational capacity of 1,278. Care UK provides health services, including on-site paramedics, and there is an 18-bed inpatient unit.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hewell was in September 2016. Inspectors reported that their main concerns were with safety and respect. Violence was very high and almost a quarter of prisoners said they felt unsafe. One of HMIP's main recommendations was that managers should take a rigorous approach to identifying, investigating and dealing with violence. Inspectors found that although drugs were widely available, supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee.

Independent Monitoring Board

16. 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 30 September 2018, the IMB reported that members thought the prison had become a safer place. Violent incidents in the prison were less unpredictable and indiscriminate and related more to conflicts between individuals. The Board continued to believe that staffing levels were insufficient to meet the needs of the prison.

Previous deaths at HMP Hewell

17. Ten prisoners died at Hewell in the two years before Mr Derriman's death and five prisoners died in 2018, after Mr Derriman died. Nine of these fifteen deaths were from natural causes, two were self-inflicted and four were drug related.

18. Although we recognised in our investigations that the prison is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them, we were concerned about the easy availability of drugs at Hewell. In particular, we noted that prisoners were able to access drugs very quickly after arriving at Hewell.

Psychoactive substances (PS)

19. 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.

20. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

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

Key Events

Mr Luke Derriman

22. Mr Luke Derriman had a history of substance misuse, attempted suicide, self-harm, depression, anxiety, post-traumatic stress disorder, bi-polar disorder, schizophrenia and violent tendency disorder. He had been in prison before.

23. On 8 January, Mr Derriman was remanded into police custody charged with burglary and assaulting the police officers that arrested him. A court detention officer completed a suicide and self-harm warning form because Mr Derriman said he felt like hanging himself.

24. On 9 January, Mr Derriman arrived at HMP Hewell. He told a nurse that he was prescribed buprenorphine (an opiate substitute used to treat opiate addiction), mirtazapine (an antidepressant), diazepam (a tranquiliser), gabapentin (a pain killer), lymecycline (an antibiotic) and omeprazole (for gastric ulcers). Mr Derriman also gave a history of depression but denied any thoughts or history of attempted suicide and self-harm. Mr Derriman arrived with his buprenorphine prescription.

25. Mr Derriman was allocated cell 14 on B1 landing on Houseblock 4, the unit for prisoners with substance misuse issues. He shared a cell with Prisoner C who he said he had known for a long time.

26. The next day, a nurse from the Integrated Substance Misuse Team (ISMS) assessed Mr Derriman using an opiate withdrawal scale. He did not show any signs of suffering opiate withdrawal. A prison GP continued his prescriptions for diazepam, gabapentin and mirtazapine. Mr Derriman's urine tested positive for buprenorphine, methadone (an opiate substitute), opiates and benzodiazepines (tranquilisers).

27. On 12 January, Mr Derriman was prescribed methadone instead of buprenorphine because of his positive urine test for methadone and opiates. Mr Derriman's withdrawal was monitored daily until 17 January, when he reported no symptoms. He was referred to the psychosocial team and placed on the waiting list.

28. On 17 January, a resettlement officer completed Mr Derriman's resettlement interview. The resettlement officer said that Mr Derriman was polite and appeared motivated to engage with resettlement and support services. On 18 January, Mr Derriman's gabapentin prescription was increased from 1200mg daily to 2700mg daily, the dose he was on in the community.

29. Mr Derriman was not the subject of any intelligence reports during his time at Hewell.

Prisoner B

30. Prisoner B had a history of mental illness, substance misuse, self-harm and violence. He had been in prison before and moved to Hewell in September 2017. He was identified as a risk to others and an entry on his medical record on 16 October 2017, noted that his risk of harm to others increased when he was under

the influence of PS. The same month, he was discussed by a multi-disciplinary mental health team. They decided to offer him a range of psychological therapies and one to one nursing support, however he declined to attend the appointments offered.

31. On 8 November 2017, a work-place assessment identified Prisoner B as an elevated risk to others in the workplace.

32. On 14 November 2017, Prisoner B was found under the influence of an illicit substance. His medical record does not indicate that healthcare staff or the substance misuse team were informed, as they should have been.

33. On 22 November 2017, Prisoner B threatened an officer and said he would set fire to his cell. On 9 December, he bit another prisoner during a fight and verbally abused nurses. On 22 December, he moved to B2 landing on Houseblock 4 as a cleaner.

34. On 9 January 2018, Prisoner B was found under the influence of PS and lost his cleaning job. He was also found under the influence of PS on 10, 11 and 12 January. On 10 January, he was put on the basic level of the Incentives and Earned Privileges (IEP) Scheme (the IEP scheme aims to encourage and reward responsible behaviour). It appears that healthcare staff and the substance misuse team were not informed about the incidents on 9 and 10 January, as they should have been.

35. A drug support worker tried to visit Prisoner B on 11 January, but he had gone to the library. Houseblock 4 staff asked the prison paramedic, to assess Prisoner B on 12 January. Prisoner B denied using PS and refused the assessment. She also attempted to assess Prisoner B on 12 January, but was not able to because he was under the influence of PS.

36. Prisoner B was again found under the influence of PS on 15 January and had to be escorted back to his cell. An officer said he was concerned by Prisoner B's recent deterioration in behaviour. He said that each time he was found under the influence, his behaviour became more unpredictable. On 17 January, Prisoner B was under the influence again and was described as walking strangely and slurring his words. There is no evidence that either healthcare staff or substance misuse services were informed of an officer's concerns or that Prisoner B was under the influence on these two occasions.

37. On 18 January, Prisoner B told a mental health nurse that he needed support because he was using PS daily. She said that she would come to see him on Houseblock 4 later the same afternoon. When a nurse visited Prisoner B, he told her he did not want to see her after all. The nurse booked an appointment to see Prisoner B, but this did not take place before Mr Derriman died.

Events of 23 January 2018

38. The investigator watched CCTV from B1 landing Houseblock 4. At 3.02pm, Prisoner B walked down the stairs, approached Mr Derriman's cell door and waited outside. At 3.03pm Mr Derriman appeared briefly in the cell doorway. Prisoner B faced him and then threw a punch into the doorway. A prisoner

playing table tennis nearby gestured to Prisoner B to move away and closed the cell door.

39. In a separate incident at about 3.09pm on C2 landing Houseblock 4, two officers said that they stopped a fight between two prisoners. One of the prisoners was knocked unconscious. A SO said he saw a prisoner on the floor, apparently unconscious, and radioed a code blue emergency. The control room officer called an ambulance in line with national and local instructions. Records from West Midlands Ambulance Service showed the emergency services were contacted at 3.09pm.

40. A nurse and Healthcare Assistant responded to the emergency. The prisoner regained consciousness but had a large swelling on the side of his head, so the nurse decided not to cancel the ambulance.

41. CCTV from B1 landing between 3.05pm and 3.20pm showed several different prisoners, including Prisoner B go in and out of Mr Derriman's cell. At 3.20pm, a prisoner appears to raise the alarm by calling upstairs.

42. An officer said he heard a prisoner on level one call out, "Boss there's a lad not breathing." The officer went straight to Mr Derriman's cell and found three prisoners standing over him. CCTV showed the officer entered Mr Derriman's cell at 3.21pm. He said Mr Derriman was lying on his bed facing the TV with his eyes open and was unresponsive. The officer radioed a code blue emergency and began cardio-pulmonary resuscitation (CPR). A SO responded and went straight to Mr Derriman's cell. He helped the officer move Mr Derriman to the floor and continued CPR. He said Mr Derriman's throat was "deformed" and he was making a gurgling sound. He was unable to find any obstruction in Mr Derriman's throat.

43. A nurse and a Healthcare Assistant arrived at Mr Derriman's cell at 3.22pm. They brought the emergency bag and defibrillator and found the officer doing chest compressions. Several staff from the substance misuse team also responded quickly because they were based on Houseblock 4.

44. A nurse examined Mr Derriman's throat and said she felt a loose section similar in shape to a lower set of dentures underneath his skin but could not locate an obstruction. She tried to insert an i-gel airway without success so tried a smaller one. She said this improved ventilation but Mr Derriman's airway was "not right". She asked for the ambulance crew called for the fight on C2 landing to be directed to Mr Derriman's cell first.

45. The nurse and the other staff present completed four cycles of cardio-pulmonary resuscitation and rhythm analysis by the defibrillator before ambulance paramedics arrived at 3.35pm and took over. The defibrillator did not advise an electric shock.

46. Paramedics changed the airway and gave Mr Derriman adrenaline and naloxone (used to block the effects of opioids). They also examined Mr Derriman's throat but could find no obstruction. Mr Derriman's heart began beating again but he was not breathing on his own. The ambulance left the prison at 4.29pm. Mr Derriman received further treatment at hospital but died at 5.04pm.

47. Officers watched CCTV from the landing after Mr Derriman was taken to hospital. As a result, they moved Prisoner B to the segregation unit, and he was later arrested by the police and charged with manslaughter. Prisoner B refused to comment in his police interview. Of the prisoners on B1 landing when Mr Derriman was assaulted, only Prisoner C agreed to give a police statement. He confirmed that he was present in his cell when Mr Derriman was assaulted and that he was not the assailant but he did not name anyone else.

48. The next day, the officer said one of the prisoners playing table tennis when the assault took place, told him that he had witnessed Prisoner B assault Mr Derriman. The prisoner said Prisoner C was with Mr Derriman in their cell and Mr Derriman was breathing. He said he closed the cell door and told Prisoner B to walk away. He checked Mr Derriman a few minutes later and said he was still breathing.

Contact with Mr Derriman's family

49. On 23 January, the Deputy Governor and the prison chaplain, drove to Mr Derriman's mother's house and broke the news of Mr Derriman's death.

50. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

51. After Mr Derriman's death, a senior 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.

52. The prison posted notices informing other prisoners of Mr Derriman's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Derriman's death. Prisoner C was moved to a different cell and offered support.

Post-mortem report

53. The pathologist found that Mr Derriman had suffered a traumatic injury to the left side of his neck which caused bleeding in his brain that in turn led to cardiac arrest. He concluded that the impact was likely to have occurred very close in time to Mr Derriman collapsing into an unresponsive state.

54. The toxicology report showed Mr Derriman was not under the influence of illicit substances at the time of his death. The pathologist concluded that Mr Derriman died from:

1a. Traumatic basal subarachnoid haemorrhage (TBSAH)

1b. Blunt force injury to the left side of the neck

Prisoner B's trial

55. Prisoner B said at his trial that he hit Mr Derriman in self-defence as a "pre-emptive strike." Prisoner C, who had been released from prison gave evidence at Prisoner B's trial. He again said he was present when Mr Derriman was assaulted but did not give the name of the person who assaulted him. Prisoner B was found guilty and the judge sentenced him to seven years in prison. Prisoner C has since died.

Findings

Substance Misuse Management and Prisoner B's risk

56. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was becoming a source of increasing concern in prisons. Not only does PS use have a profoundly negative impact on physical and mental health, but trading these substances can lead to debt, violence and intimidation. We cannot say for certain whether Prisoner B was under the influence of PS when he punched Mr Derriman but, given that he admitted to taking PS daily in January 2018, it is very possible.

57. There was no intelligence to link Prisoner B, or any other prisoner, with Mr Derriman before Mr Derriman's death and no one came forward after Mr Derriman died to provide any information linking them or to suggest a motive for the assault. There is also no evidence that Mr Derriman posed a threat to Prisoner B. Although Prisoner B and Mr Derriman were located in the same houseblock, their cells were on different floors and staff had not noticed them associating with each other.

58. Prisoner B was assessed as presenting a high risk to others and his risk was believed to increase under the influence of PS. He was involved in a fight with another prisoner in December 2017, although there are no other violent incidents in his record during his time at Hewell (between 30 September 2017 and 22 January 2018), including during the period between 9 and 17 January when he said he was using PS daily.

59. Nevertheless, we are concerned that healthcare staff or substance misuse services were not informed every time Prisoner B was found under the influence of PS, as they should have been. Prisoner B clearly had some awareness that his increased use of PS was having a detrimental effect on his mental health because he asked for help five days before Mr Derriman's death. A mental health appointment was made but had not taken place before Mr Derriman died. If healthcare and substance misuse services had had a clearer picture of the extent of his PS use and the concerns of wing staff, this might have led to more urgent intervention. We recommend:

    The Governor and Head of Healthcare ensure that healthcare and substance misuse services are informed every time a prisoner is found under the influence of an illicit substance and this is recorded on his medical record.

60. Our investigations into Mr Derriman's death and those of four other prisoners at Hewell whose death involved some link to PS, found that the prison is taking a number of measures to tackle the problem of PS. Hewell holds a monthly drug strategy meeting and has implemented a number of strategies to reduce the availability of illicit substances in the prison. These strategies include mandatory drug testing, the use of drug detection dogs and taking action to prevent drones from being able to access certain areas of the prison. The prison is also trialling a swab machine to check mail, an x-ray machine to scan parcels and a body scanner for all visitors.

61. We are satisfied that the prison is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them. However, more clearly needs to be done to reduce supply and demand.

62. Hewell is not alone in facing this problem – PS 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, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

63. In relation to reducing the supply of drugs, 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."

We therefore recommend:

The Governor should ensure that the key drug issues at Hewell are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141