Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Ashley Williams a prisoner at HMP Lincoln on 6 June 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 Ashley Williams died on 6 June 2018 from the effects of psychoactive substances (PS) at HMP Lincoln. He was 27 years old. I offer my condolences to Mr Williams' family and friends.

Mr Williams was at Lincoln for only five weeks before he died. Staff suspected that he was associating with prisoners known to use PS and that he was involved in the distribution of illicit substances, but there was no indication that he was using PS himself. I am satisfied that staff could not have foreseen his death.

However, I am concerned at the availability of PS at Lincoln. While the prison has taken measures to tackle the issue, more needs to be done. I am increasingly concerned by the number of deaths my office investigates in which PS has played at least some part.

There is an urgent need for national guidance on the best measures to combat this serious problem. We have made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service in a previous investigation. 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 CB**
**Prisons and Probation Ombudsman** **April 2019**

## Contents

# Summary

## Events

1. On 3 May 2018, Mr Ashley Williams was convicted of grievous bodily harm. He was remanded in prison custody to await sentencing and sent to HMP Lincoln.

2. Mr Williams was assessed as posing too high a risk to share a cell and was allocated a single cell on arrival. His risk was reviewed two weeks later and his risk reduced. He was moved to a double cell on 5 June.

3. On 6 June, at around 8am, an officer unlocked Mr Williams' cell. Twenty minutes later, a prisoner went to Mr Williams' cell and saw him lying face down on the top bunk. He noticed vomit on his mattress and when he looked closer, he saw that Mr Williams' arms and face were discoloured. He pressed the general alarm to alert staff.

4. An officer responded and found that Mr Williams did not have a pulse and was cold to touch. Healthcare staff arrived and decided not to attempt resuscitation as Mr Williams had signs of rigor mortis. At 8.32am, a prison paramedic confirmed that Mr Williams had died.

5. The post-mortem examination found no injuries or natural disease that would have caused or contributed to Mr Williams' death. Psychoactive substances (PS) were found in his blood and in the absence of an alternative, PS intoxication was given as the cause of death.

## Findings

6. There was intelligence suggesting that Mr Williams was involved in distributing drugs around the prison but no evidence that Mr Williams had ever been seen under the influence of PS, or any other illicit substance, at Lincoln. We are satisfied that staff could not have foreseen his death.

7. We are concerned at the availability of PS at Lincoln. We have previously recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Chief Executive told us in response 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), HMPPS has still not issued the strategy.

8. Pregabalin, a medication that Mr Williams had not been prescribed, was found in his blood, so he must have obtained it illicitly. Although this did not cause Mr Williams' death, we consider the prison's drug strategy needs to include measures to address the diversion of prescribed medication.

9. The clinical reviewer considered that most of the care Mr Williams received at Lincoln was equivalent to that which he could have expected to receive in the community. There were however, several areas that fell short of expectations, namely that healthcare staff did not request his community GP record, document a secondary health screen or check his mental health history.

10. The officer who unlocked Mr Williams' cell did not check that he was alive and well as he should have done. This made no difference in this case as Mr Williams was already dead, but it is important that any welfare concerns are identified immediately when prisoners are unlocked.

## Recommendations

- 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 Governor should ensure that the prison's drug and alcohol strategy is amended to include measures to address the diversion of prescribed medication.
- The Head of Healthcare should ensure that healthcare staff:
  - routinely request community medical records for newly arrived prisoners;
  - offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050; and
  - request previous mental health records when conducting a mental health triage assessment.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

# The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Williams' prison and medical records.

13. The investigator interviewed five members of staff at Lincoln on 29 October 2018 and one member of staff by telephone on 1 November.

14. NHS England commissioned a clinical reviewer to review Mr Williams' clinical care at the prison. The clinical reviewer attended joint interviews with the investigator on 29 October.

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

16. The investigator contacted Mr Williams' mother and girlfriend to explain the investigation and to ask if they had any matters they wanted the investigation to consider. His girlfriend wanted to know:

    - whether the prison knew Mr Williams' cellmate had a parcel of drugs;
    - the reason why he was moved to a shared cell; and
    - why his cellmate did not realise what had happened and alert staff.

17. Mr Williams' mother and girlfriend received a copy of the initial report. They did not make any comments.

18. 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 Lincoln

19. HMP Lincoln houses up to 729 remanded and convicted men. It serves the courts of Lincolnshire, Nottinghamshire and Humberside. It has four residential wings, which include a vulnerable prisoners' unit. Nottingham Healthcare NHS Trust provides health services and there is 24-hour nursing cover. There is no inpatient unit at Lincoln.

### HM Inspectorate of Prisons

20. The most recent inspection of HMP Lincoln was in January and February 2017. Inspectors reported that the prison remained overcrowded, which, along with the age of the prison, meant there were significant challenges in keeping conditions decent for those held. They reported that healthcare staff vacancies had an impact on service delivery but, overall, a dedicated team provided prisoners a reasonably good service. Inspectors reported that the prison had an excellent relationship with local police and that there had been some impressive work to manage the challenges around PS.

### Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 January 2018, the IMB reported that throughout the year, there had been an ongoing number of nurse vacancies in general healthcare which had some impact on delivery of services although the service provider was proactive in recruiting to vacant posts. They noted that the prison had implemented a robust drug strategy, but the availability and use of PS, continued to cause additional pressure on prison and healthcare staff.

### Previous deaths at HMP Lincoln

22. Mr Williams was the 12th prisoner to die at Lincoln since June 2015. Of the previous deaths, six were from natural causes, four prisoners took their own lives and one died as the result of homicide. There has been one death since, which was self-inflicted. We have previously made recommendations about requesting community medical records and unlock procedures.

### Psychoactive Substances (PS)

23. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

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

25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

# Key Events

26. On 3 May 2018, Mr Ashley Williams was convicted of grievous bodily harm. He was remanded in prison custody to await sentencing and sent to HMP Lincoln.

27. At reception, prison staff conducted a cell sharing risk assessment (CSRA) and noted that Mr Williams had assaulted a cellmate while serving a sentence in 2011. He was assessed as high risk and allocated a single cell.

28. A nurse saw Mr Williams for an initial health screen. He recorded that Mr Williams said he had no health problems and no substance misuse issues, but was prescribed citalopram (an antidepressant). The nurse obtained Mr Williams' consent to request his community medical record and tasked pharmacy staff to check his prescription with his GP. However, there is no record that this took place.

29. On 4 May, a prison GP prescribed citalopram but did not see Mr Williams in person. The same day, an offender supervisor, referred Mr Williams to the prison's mental health team after he reported having antisocial personality disorder, anxiety, depression and previous involvement with a mental health inpatient unit in Derbyshire.

30. On 9 May, a mental health nurse screened Mr Williams' referral and referred him for a triage assessment to determine whether he still had community mental health involvement. Later that day, prison staff submitted an intelligence report saying that Mr Williams was associating with a group of around five prisoners known to use psychoactive substances (PS). While there is no indication that Mr Williams used PS, the report says he was acting as a 'runner', taking illicit drugs from one part of the prison to another.

31. On 11 May, Mr Williams failed to attend an initial mental health assessment and a mental health nurse spoke to him through his cell observation hatch. Mr Williams told her that he did not feel he needed support and declined to engage. The nurse noted that he did not report any thoughts of suicide or self-harm. She told him how to self-refer to mental health services in the future.

32. On 18 May, a prison manager chaired a CSRA review and noted that Mr Williams' level of risk was reduced to standard as he had shared a cell during sentences after 2011 without issue. On 25 May, an officer introduced himself as Mr Williams' keyworker and recorded that he did not report any issues or concerns. On 5 June, staff moved Mr Williams to a double cell.

### Events on Wednesday 6 June

33. At around 5am on 6 June, an operational support grade (OSG), started the morning roll check. In his prison statement, he says that when he arrived at Mr Williams' cell, he looked through the cell observation hatch and saw two prisoners, one on each bunk, who appeared asleep.

34. At around 8am, an officer looked through the observation hatch on Mr Williams' cell and unlocked the door. He told the investigator that the name card outside the cell showed that the cell was only occupied by one prisoner, Mr Williams'

cellmate, as it had not been updated. He said he opened the door, shouted "hello", and saw one prisoner on the bottom bunk, and what looked like belongings on the top bunk.

35. At around 8.20am, a prisoner went to Mr Williams' cell to see his new stereo and to meet his cellmate. In his prison statement, he says he saw Mr Williams on the top bunk, lying on his front, with his head resting on one arm. Mr Wilkinson says he spoke to Mr Williams' cellmate and suggested they wake him up, to which he replied, "He ain't moved from that spot since last night." Mr Wilkinson then noticed vomit on Mr Williams' mattress, moved his head and saw that his arms and face were discoloured. He says he called out to another prisoner, who entered the cell, before pressing the general alarm to alert prison staff.

36. At around 8.24am, a prisoner alerted an officer of Mr Williams' condition and he made his way to the cell, followed by an officer. An officer saw Mr Williams lying face down on the top bunk and found that he had stopped breathing, did not have a pulse and was cold to touch. The officer told the investigator that he requested healthcare attend via a radio, but there is no record of this.

37. In the meantime, a custodial manager (CM), arrived in response to the general alarm and, at 8.27am, used a radio to request that the emergency response nurse to attend. The nurse responded immediately and asked another nurse to attend, as she was already dealing with an emergency.

38. A short time later, two healthcare support workers, arrived at Mr Williams' cell with an emergency medical bag. At 8.30am, a nurse arrived and noticed that Mr Williams' body was cold and stiff. She was unsure whether she should start cardiopulmonary resuscitation (CPR) and requested that another nurse attend. The other nurse attended and decided not to start CPR as rigor mortis was present and Mr Williams was clearly dead. At 8.32am, a prison paramedic confirmed that Mr Williams had died.

### Contact with Mr Williams' family

39. That morning, the prison appointed Senior Officer (SO) as family liaison officer (FLO). The FLO checked Mr Williams' prison record and found that although he had not named a next of kin, he had received several visits from his girlfriend.

40. At 12.05pm, the FLO arrived at Mr Williams' girlfriend's address with a prison manager and a prison chaplain. The FLO introduced herself and Mr Williams' girlfriend said, "Please tell me it's not what I've just heard." The prison manager broke the news of Mr Williams' death and offered support. Intelligence suggests another prisoner had already told her using a mobile phone or a prison phone. Mr Williams' girlfriend said that Mr Williams had recently re-established contact with his mother and that she would inform her of his death.

41. On 8 June, the FLO contacted Mr Williams' mother to introduce herself and she said she was happy for his girlfriend to continue as the prison's main point of contact. The FLO provided ongoing support to Mr Williams' family until his funeral, which she attended with the prison chaplain, on 12 July. The prison contributed toward the cost, in line with national policy.

### Support for prisoners and staff

42. After Mr Williams' 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.

43. The prison posted notices informing other prisoners of Mr Williams' 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 Williams' death.

### Post-mortem report

44. The post-mortem report found no injuries or natural disease that would have caused or contributed to Mr Williams' death. Toxicology analysis of Mr Williams' blood found citalopram and pregabalin (a medication used to treat epilepsy and nerve pain) present at therapeutic levels, and 5f-ADB (a type of PS). The report noted that PS can cause chest pain and an irregular heartbeat as well as respiratory depression. It concluded that this was potentially lethal and in the absence of an alternative, PS intoxication was the cause of death.

### Events after Mr Williams' death

45. On 6 June, shortly after Mr Williams died, prison staff submitted an intelligence report saying that his cellmate had a history of illicit substance misuse and supply. They also listened to Mr Williams' telephone records and submitted a report saying he told his girlfriend he wants to "chill with keem" and that he will be a "coke head" (someone who uses cocaine). The same day, prison staff searched Mr Williams' cell and found a quantity of drugs, vapes (electronic cigarettes) and a mobile phone.

46. Over the next five days, prison staff submitted several intelligence reports containing information from other prisoners. These included reports that Mr Williams' did not smoke drugs and must have been influenced by his cellmate's smoke and that his cellmate gave him a cigarette which he said contained cannabis but actually contained PS.

# Findings

## Psychoactive substances

47. The post-mortem report gave Mr Williams' cause of death as PS intoxication. There was no record of Mr Williams being seen under the influence of PS, or any other illicit substances, while he was at Lincoln.

48. Records show one strand of intelligence indicating that Mr Williams was possibly involved in the distribution of PS. At interview, the acting head of security, told the investigator that staff would only act on a credible amount of intelligence, as acting on a single strand could be counterproductive.

49. Mr Williams was moved to a double cell the day before he was found dead. His cellmate had a history of illicit drug use. However, we would not expect officers to conduct a security review before moving a prisoner from a single to a double cell. We are satisfied that staff acted appropriately and could not reasonably have foreseen Mr Williams' death.

50. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs, including PS, at Lincoln. Lincoln is not alone in facing this problem – the ready availability of drugs 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 now an urgent need for national guidance to prisons from HM Prison and Probation Service (HMPPS) providing evidence-based advice on what works.

51. In a previous investigation, we recommended that the Chief Executive of HMPPS should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive told us in response 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.**

## Diverted medication

52. The drugs citalopram and pregabalin, both at therapeutic levels, were found in Mr Williams' blood after his death, although neither was listed as a cause of death. Mr Williams was not prescribed pregabalin, so he must have obtained it illicitly. (Pregabalin is used to treat epilepsy and nerve pain but can also be taken to increase the euphoric effects of other drugs, such as opiates. It is a highly tradeable medication in prisons.)

53. While we recognise that the prison has a drug strategy, we are concerned that it does not cover diversion of prescribed medication. While the pregabalin in Mr William's blood did not cause his death, we consider that work is required to reduce the availability of diverted medication.

**The Governor should ensure that the prison's drug and alcohol strategy is amended to include measures to address the diversion of prescribed medication.**

### Clinical care

54. The clinical reviewer considered that most of the care Mr Williams received at Lincoln was equivalent to that which he could have expected to receive in the community. He continued to receive medication he said he was taking in the community and was appropriately seen by a mental health nurse.

55. There were however, aspects of Mr Williams' care that fell short of expectations, namely that healthcare staff did not check his prescription with his community GP, request his previous mental health record or complete a secondary health screen.

56. Prison Service Order (PSO) 3050 – Continuity of Healthcare for Prisoners - requires that, when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with. Given that Mr Williams said he took antidepressants and had previous involvement with a mental health hospital, it was particularly important that healthcare staff should have obtained his community GP and mental health record. However, there is no record that staff obtained this information. The clinical reviewer considered that staff should have checked Mr Williams' prescription and requested his mental health record.

57. PSO 3050 also requires that newly arrived prisoners should be offered a general health assessment in the week after first reception. This assessment is expected to be equivalent to a primary care assessment when registering with a new GP in the community. At interview, a nurse told the investigator that the prison healthcare team had decided to complete first and second health screens at the same time, as prisoners did not always turn up for a secondary screen. However, we are concerned that a nurse did not record that he had completed a secondary health screen.

58. We are satisfied that, overall, Mr Williams received a satisfactory standard of clinical care at HMP Lincoln. However, we make the following recommendation:

**The Head of Healthcare should ensure that healthcare staff:**

- **routinely request community medical records for newly arrived prisoners;**
- **offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050; and**
- **request previous mental health records when conducting a mental health triage assessment.**

## Unlock procedures

59. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual says, "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

60. Additionally, Prison Service Instruction 75/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock… Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process".

61. When interviewed, an officer told the investigator that he shouted "hello" when he opened Mr Williams' cell. He did not specifically say whether he got a response, but said this is something he would normally do. He said the cell card identifying who should be in the cell had not been updated to include Mr Williams and that he thought he saw what looked like belongings on the top bunk. Despite the incorrect door card, we consider that an officer should have satisfied himself that what he saw was belongings, and not another prisoner, particularly as the officer who had conducted the earlier roll check had counted two prisoners.

62. While the failure to follow the correct unlock procedure did not affect the outcome for Mr Williams as it appears he had been dead for some time, it is important that staff identify if a prisoner's life is at risk at the earliest opportunity. We make the following recommendation:

    **The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.**

## Emergency response

63. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Lincoln's local policy instructs staff to call the control room and to outline the medical issue if the incident is not life threatening. In more serious cases, a code blue should be used to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. The calling of a medical emergency code instructs the control room to call an ambulance immediately.

64. The officer who found Mr Williams told the investigator that he decided to request medical assistance instead of calling a medical emergency code blue, as it was clear that Mr Williams had died. He said he did not want to cause staff to panic and to call an ambulance, if there was nothing they could do. While there is no specific record showing that an officer asked healthcare staff to attend, we are satisfied that staff requested medical assistance swiftly. We consider that prison staff acted appropriately in the circumstances.

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