Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edward Barnes a prisoner at HMP Chelmsford on 8 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.

Mr Edward Barnes died on 8 June 2018 at HMP Chelmsford as a result of inhalation of his own vomit and methadone toxicity. He was 44 years old. I offer my condolences to Mr Barnes' family and friends.

Mr Barnes had only been in Chelmsford for seven days when he was found dead. He had a long history of substance misuse and was being treated for drug addiction using a strictly controlled dosage of methadone (an opiate substitute). However, the post-mortem found that the level of methadone in his system when he died was higher than he had been prescribed. It therefore appears that had he obtained additional methadone from another source in prison. This is a cause for serious concern.

I am also concerned that when an officer found Mr Barnes unresponsive in his cell, they did not call an emergency code.

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 **September 2019**

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Summary

Events

1. On 2 June 2018, Mr Edward Barnes was recalled to prison after failing to comply with his licence conditions. He was sent to HMP Chelmsford.

2. Mr Barnes had a long history of substance misuse and said he had been using crack cocaine and heroin on a daily basis in the community. He was located in the prison's drug treatment wing and a prison GP prescribed methadone (an opiate substitute) to treat his drug addiction.

3. Around midday on 7 June, prison officers radioed a medical emergency code for Mr Barnes as he appeared to be under the influence of drugs or alcohol. A nurse reviewed Mr Barnes and noted he appeared drowsy and confused. She considered he may have taken a synthetic cannabinoid (a psychoactive substance, PS, such as 'Spice'). The nurse took his observations and noted his condition was improving. She advised prison officers to check on him and told them to contact healthcare staff if his condition deteriorated.

4. There were no further concerns and Mr Barnes collected his evening meal from the servery at about 4.45pm.

5. A night patrol officer carried out a roll check in the evening and said she got a response from all prisoners, including Mr Barnes. She carried out another roll check the following morning and said she was satisfied that she had observed movement from Mr Barnes.

6. A member of day staff carried out another roll check approximately two hours later. She could not get a response from Mr Barnes. She went to the wing office and asked a senior officer to accompany her so they could enter the cell and check on his well-being.

7. They entered the cell and found Mr Barnes unresponsive. The senior officer called a code blue emergency. Two members of healthcare staff arrived but it soon became apparent that Mr Barnes had been dead for some time.

8. The post-mortem report concluded that Mr Barnes died from aspiration of gastric contents (inhaling his own vomit) and methadone toxicity (an excess of methadone).

Findings

9. The clinical reviewer considers that Mr Barnes had a good level of input from healthcare, drug treatment services and the mental health in-reach team during his seven days at Chelmsford. There was good evidence of care planning aimed at helping him to overcome his substance misuse issues.

10. The clinical reviewer found that healthcare staff responded promptly and appropriately when they were called to see Mr Barnes on the day before he died when he appeared to be under the influence of an unknown substance.

11. We are satisfied that Mr Barnes' health care was equivalent to that he could have expected to receive in the community.

12. The post-mortem found a higher level of methadone in Mr Barnes' system than his prescribed level. It therefore appears that he had obtained additional methadone illicitly from another source in prison. We cannot say whether this was smuggled in to the prison or whether other prisoners were trading their prescribed methadone. It is a cause for significant concern that Mr Barnes was able to obtain illicit methadone at Chelmsford.

13. The officer who found Mr Barnes unresponsive did not immediately call an emergency code. Although this did not affect the outcome for Mr Barnes as he had been dead for some time, it could make a critical difference in future cases.

Recommendations

- The Governor should ensure that the key drug issues at Chelmsford are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed. This should include reviewing the systems in place to ensure prisoners are unable to divert medication.

- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

The Investigation Process

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

15. The investigator visited Chelmsford on 21 June 2018. He obtained copies of relevant extracts from Mr Barnes' prison and medical records. The investigator returned to Chelmsford on 20 July and interviewed three members of staff. Another member of staff, who was unavailable for interview, was asked questions by email.

16. NHS England commissioned a clinical reviewer to review Mr Barnes' clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.

17. We informed HM Coroner for Essex and Thurrock of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. We were unable to write to Mr Barnes' next of kin to explain the investigation as they had refused to give the prison details of their address.

19. Our investigation was suspended between 27 June 2018 and 17 January 2019, while we awaited the cause of death and toxicology reports. The completion of this report was delayed as a result.

20. 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 Chelmsford

21. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men aged 18 years and older.

22. There is a 24-hour 12 bed inpatient unit at the prison and Essex Partnership University Trust provide healthcare services.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Chelmsford was in June 2018. Inspectors reported there was a significant issue with the availability of illicit drugs at the prison. Forty percent of prisoner's subject to mandatory drug testing produced positive results, among the highest levels in the prison estate. Inspectors noted that while there was a focus at Chelmsford to reduce the supply of illicit drugs into the prison, the challenges remained at a significant level.

24. Inspectors also expressed concern at the management of prescription medication at Chelmsford. They noted that a number of prisoners were allowed to have tradeable medication in possession, as opposed to having to take such medication in the presence of healthcare staff.

25. They also noted that approximately 17% of the prison population had been prescribed tradeable antidepressant medication.

Independent Monitoring Board

26. 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 most recently published annual report for the year ending 31 August 2018, the IMB noted the widespread availability of drugs continued at Chelmsford, despite the good efforts of prison staff to prevent their use.

Previous deaths at HMP Chelmsford

27. Mr Barnes was the eleventh prisoner to die at HMP Chelmsford since June 2015. Nine of the deaths were self-inflicted and two were from natural causes. There have been five deaths since, three self-inflicted, one from natural causes and a further death that is currently awaiting classification.

28. We made a recommendation about the use of emergency radio codes in one previous report in 2016. We also made a recommendation about the diversion of prescription medication in 2017.

Key Events

29. On 6 February 2018, Mr Edward Barnes (who was also known as Edward Turner) was released from HMP Winchester on licence after serving three and a half years in prison for burglary.

30. On 2 June, Mr Barnes was recalled to prison after being charged with three further counts of burglary. He was sent to HMP Chelmsford.

31. Mr Barnes arrived at Chelmsford with a number of pre-existing medical conditions, including epilepsy, Type 2 diabetes and high cholesterol. He had been diagnosed with paranoid schizophrenia, dissocial personality disorder, a low IQ and a chronic brain injury. He had a history of substance misuse, including heroin, cocaine, cannabis and ecstasy, and was dependent on diazepam (a tranquiliser). He had served several previous prison sentences and had also spent several periods in secure psychiatric hospitals. He had a history of self-harm as well as of aggression to others.

32. During previous prison sentences he had been under the care of the drug treatment services throughout and had been prescribed methadone for his addictions. There had been incidents when he was suspected of, or admitted to, taking psychoactive substances (PS) and also of him hiding his prescribed medications and of having illicit substances in his possession in prison.

33. During Mr Barnes' reception health screen at Chelmsford, a nurse noted he had been prescribed atorvastatin (for high cholesterol), metformin (for diabetes), olanzapine (for schizophrenia) and omeprazole (for excess stomach acid). Mr Barnes told the nurse that before he was recalled to prison, he had been homeless and was a daily user of heroin and crack cocaine.

34. Following her review, the nurse referred Mr Barnes to the prison's mental health in-reach team (MHIRT) and the substance misuse team (IDTS). Mr Barnes was then located on E wing, the prison's drug treatment wing.

35. A prison GP reviewed Mr Barnes later that day. He noted his previous prescriptions and updated them. He prescribed 695ml of methadone to be issued over a period of 19 days to treat Mr Barnes' drug dependency. Day one the dosage would be 10mls, day two consisted of two doses of 10mls, the third day two doses of 30mls, the fourth day two doses of 17.5mls, day five, two doses of 20mls and day six a single dose of 40mls. The remainder of the dosage was to be issued at 40mls per day until the course of treatment was complete.

36. On 3 June, a healthcare support worker reviewed Mr Barnes as part of his drug treatment programme. She took his observations (the measurement of temperature, respiratory rate, pulse, blood pressure and blood oxygen saturation, an indicator of a patient's state of health) but found nothing remarkable. She noted that Mr Barnes was displaying mild symptoms of withdrawal but that he did not report any significant health concerns.

37. The following day, an IDTS Nurse Manager carried out a thorough and lengthy review of Mr Barnes as part of his IDTS treatment programme. She noted that his history of substance and alcohol misuse started at the age of 11 and had

continued into adulthood. Following her review, she ensured Mr Barnes knew how to contact MHIRT and IDTS if he felt the need to do so. She also noted he should be subject to both random and routine drug testing as part of his drug treatment programme. She planned to review Mr Barnes on a weekly basis.

38. Around midday on 7 June, prison officers noted Mr Barnes appeared drowsy, confused and short of breath. They were concerned that he might be under the influence of an illicit substance. The officers radioed a code blue medical emergency (which is used to indicate a prisoner is unconscious or having difficulty breathing) to summon the help of healthcare staff.

39. A nurse responded and reviewed Mr Barnes. She initially considered he might be under the influence of 'Spice' (a highly potent form of PS). However, when she took his observations she noted there was nothing significant about the results. She also noted his condition was improving while she was reviewing him.

40. The nurse submitted an intelligence report about the incident and advised prison officers to check on Mr Barnes during the day, which they did. She told Mr Barnes to contact healthcare staff if he needed assistance. Mr Barnes' condition continued to improve.

41. At approximately 4.45pm, Mr Barnes went to the servery to collect his evening meal and returned to his cell.

42. At 8.10pm, an Operational Support Grade (OSG) arrived on E wing to start her duties. She noted in the wing observation book (used to record any significant events that have occurred during the day) that Mr Barnes had been suspected of being under the influence of an unknown substance. She carried out a roll check and said that she gained a response from all the prisoners on the wing, including Mr Barnes.

Events of 8 June

43. At 5.40am, the OSG started the morning roll check. She said that when she arrived at Mr Barnes' cell, she opened the observation hatch and noticed he was lying on his bed on his left side. She told the investigator that she noted nothing out of the ordinary with the cell or Mr Barnes, and that while she was looking into the cell, she noticed he moved his right foot, which was hanging off the side of the bed. She said she had no concerns for his well-being and she continued with the roll check.

44. At approximately 7.20am, an officer carried out another roll check. When she arrived at Mr Barnes' cell, she opened the observation hatch and noticed he was lying in his bed and that his bedding appeared neat, but she thought he had a grey complexion. She stayed at the cell door for a few seconds to see if she could see any signs that he was breathing. She was unable to see clearly as Mr Barnes was under his bedclothes and she was unsure if he was asleep or not. She knocked on the cell door to get a response from Mr Barnes, but he did not respond. She was still unsure if he was in a deep sleep.

45. She left the cell and went to the wing office to tell a Supervising Officer (SO) that she could not get a response from Mr Barnes. They returned to the cell at

approximately 7.23am. The SO also attempted to get a response from Mr Barnes, but Mr Barnes did not respond.

46. The SO then entered the cell to check on Mr Barnes' well-being. He noted that Mr Barnes was lying in his bed and he appeared asleep. There were no apparent signs that Mr Barnes had been in distress at any point. He checked his wrist for signs of a pulse and checked for any signs of breathing, but there were none.

47. At 7.24am, the SO called a code blue medical emergency over his radio. Control room staff immediately telephoned for an emergency ambulance.

48. The OSG left the cell to get the emergency grab bag (a bag containing the equipment required to deal with a medical emergency) and while doing so she used her radio to ask IDTS Charge Nurse to attend. The nurse had already responded to the code blue call and was making his way to Mr Barnes' cell.

49. When the nurse arrived, he saw the SO kneeling on the bed. Mr Barnes was lying on his left side and there was a plate of partially eaten food next to him. He also noted there was saliva on Mr Barnes' chin and undigested food in his mouth. He checked Mr Barnes' wrist for signs of a pulse but there was none and, as he did so, he noted a stiffness in Mr Barnes' hand indicating rigor mortis had begun to set in. The nurse decided cardiopulmonary resuscitation (CPR) was not appropriate as it was likely that Mr Barnes had died at least an hour earlier. Paramedics arrived at the cell and took control of Mr Barnes' care.

50. At approximately 7.35am, the Charge Nurse arrived at the cell. Both she and the paramedics who attended the incident confirmed the nurse's decision not to attempt CPR.

51. At 7.50am, paramedics confirmed that Mr Barnes had died.

Contact with Mr Barnes family

52. At 8.30am, a Supervising Officer (SO) was appointed to act as the prison's family liaison officer (FLO). Mr Barnes did not have a next of kin listed in his prison records. The FLO examined Mr Barnes' list of telephone contacts and found telephone numbers for family members.

53. The FLO telephoned the number listed for Mr Barnes' mother and asked if he could visit her. However, she refused to give her address details and said she did not want anyone from the prison in her home. The FLO had no option but to break the news of her son's death to her over the telephone.

54. Despite repeated efforts over the days that followed, the family refused to allow prison staff to visit them to discuss Mr Barnes' death. The FLO telephoned Mr Barnes' family on a number of occasions offering them support.

55. Mr Barnes' funeral was held on 5 July. The prison offered a financial contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

56. After Mr Barnes' death, a prison manager debriefed the staff who were involved in the incident giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

57. The prison posted notices informing other prisoners of Mr Barnes' 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 Barnes' death.

Post-mortem report

58. The post-mortem report gave the cause of death as aspiration of gastric contents (inhaling vomit from the stomach into the windpipe and lungs) and methadone toxicity (a high level of methadone in the blood).

Findings

Clinical care

59. Mr Barnes arrived at Chelmsford with a long history of substance misuse. The clinical reviewer considers that he received a good level of input from healthcare, drug treatment services and the mental health in-reach team during the seven days he spent at Chelmsford. There was good evidence of care planning aimed at helping him to overcome his substance misuse issues.

60. The clinical reviewer also said that healthcare staff responded promptly and appropriately when Mr Barnes appeared to be under the influence of an unknown substance on the day before he died.

61. The clinical reviewer concluded that the clinical care Mr Barnes received while at Chelmsford was equivalent to that which he could have expected to receive in the community. We agree.

62. The clinical reviewer has made a number of recommendations in her review, which we do not repeat in this report but which the Head of Healthcare will wish to address.

Substance misuse

63. When he arrived at Chelmsford, Mr Barnes told healthcare staff he was a daily user of heroin and crack cocaine. He had a urine test and the results indicated the presence of opiates, meaning Mr Barnes already had a tolerance for methadone treatment.

64. The clinical reviewer found that healthcare staff prescribed methadone appropriately and at a dose commonly used in maintenance regimes. Healthcare staff took his tolerance into consideration and prescribed him 695mg of methadone to be taken over a 19-day period, a dosage in line with recommendations in *Drug Misuse and Dependence: UK guidelines on clinical management* (known as 'the Orange Book') which provides guidance for those involved in treating of prisoners with drug addiction issues.

65. All methadone dispensed at Chelmsford is in liquid form. The prison has a system in place to ensure that when prisoners attend the medication hatch on E wing to collect their methadone, pharmacy staff, supervised by IDTS officers, observe the prisoner swallowing the methadone. They are also required to drink 200mls of water to ensure the methadone is swallowed and not retained by the prisoner.

66. The post-mortem found that Mr Barnes had a substantial level of methadone in his blood at the time of his death, above his prescribed level. It therefore appears that Mr Barnes had obtained additional methadone illicitly in prison and taken it before he died.

67. Mr Barnes had only been at Chelmsford for seven days. There was no intelligence to suggest that he was involved in diverting medication (retaining it for later use or to sell to other prisoners) and his medical records noted that he was fully compliant with his methadone plan.

68. In a previous investigation at Chelmsford in March 2017, we made a recommendation to the Governor and the Head of Healthcare, that an effective strategy should put in place to reduce the trading of prescribed medications. The prison accepted the recommendation and said that it would review the circumstances around the trading of prescribed medication and consider whether it was appropriate to stop a prisoner's medication if he was suspected of trading it or continue with the prisoner taking the medication under supervision.

69. We cannot say whether Mr Barnes used additional methadone that had been smuggled in to the prison or whether he obtained it from other prisoners who were trading their prescription methadone. Either way, it is a cause for significant concern that Mr Barnes was able to obtain methadone (and possibly also PS) so soon after arriving at Chelmsford.

70. Drug-taking 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.

71. In relation to reducing the supply of drugs, the 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 Chelmsford are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed. This should include reviewing the systems in place to ensure prisoners are unable to divert medication.

Emergency response

72. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two-code medical emergency response system. Chelmsford's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

73. When an officer failed to gain a response from Mr Barnes while carrying out the morning roll check, and could not be sure he was breathing, she did not call an emergency code. Instead, she went to the wing office to ask the SO for assistance. We consider that the officer should have use her radio to call a code blue which would have ensured immediate assistance and an ambulance being called immediately.

74. Although in this particular case the delay had no impact on the outcome for Mr Barnes as he had been dead for some time, in other circumstances, any such delay could be crucial. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code to effectively communicate the nature of an emergency.

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