

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Scott Riley a prisoner at HMP Gartree on 18 June 2018

A report by the Prisons and Probation Ombudsman

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*



© Crown copyright 2018

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Scott Riley died on 18 June 2018, having been found hanging in his cell in HMP Gartree. He was 35 years old. I offer my condolences to Mr Riley's family and friends.

Mr Riley had a history of substance misuse and transferred to Gartree after getting into drug-related debt at his previous prison. He then accrued further drug debts at Gartree. He moved to the segregation unit for his own protection, where he initially said that he had stopped using drugs and wanted to address his problems. During a short spell at HMP Leicester, however, he began using drugs again before returning to the segregation unit at Gartree. He appeared settled in the unit and said he felt safe there, and I am satisfied that staff at Gartree had no reason to consider that he posed a risk to himself.

I am concerned at the length of time it took for the emergency response nurse to arrive when Mr Riley was found hanging. It did not affect the outcome for Mr Riley who had been dead for some time when he was found, but in future emergencies such a delay could have serious consequences.

The clinical reviewer also identified some concerns about the administration of the healthcare department, including the distribution of medication, which the new healthcare provider will need to address.

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

February 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	11

Summary

Events

1. Mr Scott Riley was sentenced to life imprisonment in 2009. He had a history of drug misuse, and on one occasion had been monitored under Prison Service procedures for those thought to be at risk of self-harm. He arrived at Gartree in March 2018, having fallen into debt in his previous prison. Reception staff noted that he was receiving medication for an anxiety disorder but that there were no indications that he was at risk of self-harm. He was referred to the substance misuse team.
2. In April, Mr Riley and another prisoner barricaded themselves into a cell and asked to move to the segregation unit. He was taken there and disclosed that he had accrued drug debts on the wing and felt under threat. He asked for a referral to the mental health team and was referred to a psychiatrist. Mr Riley also said he was suffering pain from an old injury and asked for his prescription for painkillers to be increased to reduce the pain.
3. Mr Riley started work with the substance misuse team and said he wanted to end his drug habit. He said that since moving to the segregation unit he had abstained from any illicit drug use.
4. In May, Mr Riley temporarily transferred to HMP Leicester. While there, he began using illicit drugs again.
5. He returned to Gartree on 30 May and was once again held in the segregation unit. He told his drug worker that he had been using drugs since returning from Leicester. She made arrangements for a withdrawal pack to be provided to help Mr Riley with any symptoms of drug withdrawal, but he did not receive it before his death. He said he was interested in moving to a therapeutic community to help him address his drug problems. He told segregation unit staff that he had significant debts and they agreed to consider transferring him to another prison.
6. On the evening of 17 June, there were few indications that Mr Riley had any problems. Another prisoner subsequently said that he had been upset about losing the telephone details of members of his family, and he had not received his withdrawal pack. Nevertheless, staff said they heard him chatting normally with other prisoners through his door at about 1.30am on 18 June.
7. When an officer made a roll check at about 5.15am on 18 June, Mr Riley was found hanged. Staff attempted to revive him but paramedics arrived and pronounced Mr Riley dead.

Findings

Risk assessment

8. Mr Riley had some risk factors for suicide and self-harm: a history of anxiety, drug misuse and being under threat because of drug debts. However, once he was in the segregation unit for his own protection, he said he felt safe and became less anxious. As a segregated prisoner Mr Riley was seen daily by staff,

including healthcare staff. He was working with the substance misuse team and the mental health team. He did not appear to be negatively affected by his segregation and none of the staff who had contact with him considered him to be a threat to himself. Although Mr Riley had started misusing drugs again following his period in Leicester, there do not appear to have been any signs that could have led staff to predict that he would take his life.

Healthcare

9. The clinical reviewer noted some concerns about the management of Mr Riley's medication. In particular, Mr Riley did not receive the withdrawal pack that was agreed on 11 June.
10. The clinical reviewer also noted some potentially serious problems around the administration and staffing of the healthcare department. Since Mr Riley's death, a new healthcare provider has taken over and, in interview, healthcare staff seemed to have some confidence that the situation had improved. Even so, the commissioners will want to ensure that the healthcare department in Gartree is operating as it should be.
11. The emergency response nurse had been on duty for over 20 hours when she was called to Mr Riley's cell.

Emergency response

12. When prison officers found Mr Riley hanging, there was a long delay before the emergency response nurse arrived. She and prison officers then attempted to resuscitate Mr Riley, even though it appeared that he had been dead for some time. This was inappropriate.

Recommendations

- The Head of Healthcare should provide this office, by 31 March, with evidence of the actions she has taken to improve the following:
 - prescribing practices in relation to drugs that may be abused/traded in prison;
 - medication reviews;
 - mental health referrals;
 - drug testing in reception;
 - the recruitment and retention of healthcare staff;
 - support for healthcare managers; and
 - systems to prevent staff having to work excessively long hours.
- The Head of Healthcare should ensure that emergency response staff, including agency staff, understand the importance of providing timely assistance in the case of an emergency.
- The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

The Investigation Process

13. The investigator, issued notices to staff and prisoners at HMP Gartree informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator visited Gartree in June and September 2018. He obtained copies of relevant extracts from Mr Riley's prison and medical records. The investigator interviewed one prisoner and six members of staff at Gartree.
15. NHS England commissioned a clinical reviewer to review Mr Riley's clinical care at the prison. The clinical reviewer joined the investigator for interviews of healthcare staff.
16. We informed HM Coroner for Leicester City and South District of the investigation. She gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
17. One of the PPO family liaison officers, wrote to Mr Riley's next of kin, to explain the investigation and to ask whether they had any matters that Mr Riley's family wanted the investigation to consider. Mr Riley's family raised no specific issues.
18. Mr Riley's family received a copy of the initial report. They did not raise any further issues.

Background Information

HMP Gartree

19. HMP Gartree, which is near Market Harborough in Leicestershire, holds some 700 men sentenced to life imprisonment and other indeterminate sentences. MITIE Care and Custody (Health) Ltd provided healthcare until November 2018. The service is now provided by Nottinghamshire Healthcare Foundation Trust. Nursing staff are available 24 hours a day.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Gartree was conducted in November 2017. Inspectors reported that more prisoners than before reported feeling unsafe, and that incidents of self-harm had increased. Drugs and alcohol were too readily available. Health provision had deteriorated and was of particular concern, although inspectors noted that the health provider had recently changed and improvements were expected. The segregation unit held some very challenging prisoners and inspectors noted some excellent and skilful management of those prisoners by prison officers.

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 November 2017, the IMB reported that the Board had concerns about the physical condition of the segregation unit and about the care provided for segregated prisoners with mental health needs. The Board also reported that it was very concerned about the provision of healthcare services, particularly mental health services following the introduction of the new healthcare provider (MITIE) in April 2017. Low and frequently changing staffing levels in healthcare were having a serious effect on the level of care offered to prisoners.

Previous deaths at HMP Gartree

22. Mr Riley was the eleventh prisoner to die at Gartree since 2013, six of whom died from natural causes. Previous investigations identified concerns about the ready availability of drugs at Gartree.

Segregation units

23. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a

daily period in the open air. The unit at Gartree is known as the Separation and Progression Unit.

Assessment, Care in Custody and Teamwork (ACCT)

24. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.
25. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multi-disciplinary review meetings involving the prisoner. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed.
26. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive substances (PS)

27. Psychoactive substances, previously known as 'legal highs' are an increasing 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.
28. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

Key Events

29. Mr Scott Riley was convicted of murder in 2009 and sentenced to life imprisonment. His records show that he had been involved in the drug culture in prison and had sometimes asked to move to the segregation unit for his own protection because he had accrued debts related to drugs. He had engaged with drug workers, and had completed several drug treatment programmes in prison. He had been treated for depression and an anxiety disorder, and had been under the care of a psychiatrist. In 2014, he had been monitored under Prison Service procedures to support those judged to be at risk of self-harm (Assessment, Care in Custody and Teamwork, or ACCT) but since then there had been no indication that he was a threat to himself.
30. Mr Riley arrived at Gartree on 15 March 2018. His files showed that he was known to have used psychoactive substances (PS), such as 'spice', in prison. He had incurred debts in HMP Garth in early 2018, which had led to him being under threat and needing to move prisons.
31. In his reception health screening, the nurse noted that he was receiving treatment for his mental health issues and was on a prescription of two doses of pregabalin per day. (Pregabalin is used to treat anxiety and nerve pain. It can be abused because it can produce feelings of euphoria and because it can enhance the euphoric effects of other drugs.) Mr Riley said that he had not used any illicit drugs recently. The nurse noted that his mental health appeared stable and that he said he had no thoughts of self-harm.
32. On 13 April, Mr Riley had a secondary health screening. He told the nurse that his current medication was ineffective so he had been using heroin on the wing to combat pain from an old injury. He denied using PS. The nurse referred him to the substance misuse service, as well as to the doctor to address his medication. On 23 April, he attended the induction for a drug misuse counselling course.
33. On 29 April, Mr Riley and another prisoner barricaded themselves into a cell. They said that they had accrued unsustainable levels of debt. They asked to move to the segregation unit and, when this was agreed, they came out of the cell and were escorted there. Mr Riley had an initial segregation health screening and the nurse recorded that there were no clinical reasons why he could not be segregated. At Mr Riley's request, the nurse also referred him to the mental health team for assessment.
34. On 1 May one of the prison's managers, chaired a meeting to authorise Mr Riley's continued segregation. Mr Riley admitted that his debts were drug debts. He said he had been using drugs to self-medicate. He said he felt under threat and was concerned as he had given his mother's telephone number to other prisoners as a means of arranging the payment of his debts. He also requested a mental health review, so a nurse arranged a review for 14 May.
35. On 4 May a mental health nurse assessed Mr Riley. He reported that he felt anxious, paranoid, and unsafe on the wings, which often led to tensions with other prisoners. He said that he had trouble sleeping and his prescribed medication was not working. He had therefore been buying drugs from other

prisoners to help him cope but this had led to debt. She referred Mr Riley to a psychiatrist for possible Attention Deficit Hyperactivity Disorder (ADHD) and said that she would arrange for regular mental health reviews.

36. Mr Riley then saw a prison GP. He told her he was suffering pain from an old hand injury as well as experiencing anxiety. He asked her to increase his prescription of pregabalin, which she agreed to do. She said that if tests showed that he had taken any illicit drugs, then his pregabalin would stop.
37. On 10 May, a member of the substance treatment and recovery team (START) assessed Mr Riley. He said he wanted to end his use of opiates. He said he was content in the segregation unit and had abstained from drug use there, something that was difficult on the wing as he felt that drugs were forced on him. He had a debt of £800 and did not know how he would clear this.
38. On 14 May one of the prison's managers chaired a meeting to assess Mr Riley's continued segregation. A nurse from the mental health team, a Supervising Officer (SO) from the segregation unit, and a representative from the Independent Monitoring Board attended. They agreed that although Mr Riley was in debt on the wing, he had no problems on the unit. He was engaging with the mental health team and with the START team. The nurse noted that he had no health issues and there was no clinical reason for him not to remain in segregation. Mr Riley expressed an interest in transferring to a therapeutic community to address his drug issues.

HMP Leicester

39. On 16 May, Mr Riley temporarily transferred to HMP Leicester to attend court in relation to an assault charge where he had been the victim. He had a reception health screening and, although his blood pressure was high, he had no other issues. He gave no indication that he was at risk of harming himself. A member of the mental health team assessed him but Mr Riley said that he had no issues around substance misuse and did not want any further input from the team. Mr Riley was housed on a general residential wing as the reason he was living in the segregation unit at Gartree (debt) did not apply at Leicester.
40. On 20 May, another nurse gave Mr Riley a secondary health screening. She noted on his record that his blood pressure had returned to normal. She also noted that he said he had been using illicit drugs for the last three months, and referred him to the substance misuse team.
41. Later that day, the result of a drug test was positive. Mr Riley said that he had been using buprenorphine, an opiate, daily and was now withdrawing badly and had resorted to sniffing buprenorphine and using PS every night. He said he was waiting to see a psychiatrist for anxiety and possible ADHD and that the drugs relieved his mental health issues. The nurse noted that there were no indications of any risk of self-harm.
42. On 29 May, Mr Riley gave a further positive drug test. He said that he was using heroin and buprenorphine to treat his withdrawal symptoms.

Return to Gartree

43. On 30 May Mr Riley returned to Gartree. At his health screening Mr Riley told a nurse that he had no problems with drug misuse and had not used any illicit substances in the last month. She noted that he was calm and co-operative, with no apparent physical or mental health problems, and that he denied any thoughts of harming himself. She noted that his urine had not been tested for drugs but she did not explain why not.
44. Mr Riley was assessed for fitness for continued segregation, and this was agreed. He reported no issues, caused no problems, and was polite to staff. He was seen daily by healthcare staff and there were no concerns over his health or his continued segregation.
45. On 8 June, Mr Riley told a prison GP that he was experiencing increased pain in his hand. He requested a higher dosage of pregabalin. She found a good range of movement in the hand, so rather than increase his medication she referred him to a physiotherapist.
46. On 11 June, a member of START saw Mr Riley. He told her that he had been using drugs since returning from Leicester. He asked for a withdrawal pack, and Ms Hyland agreed to arrange this. Mr Riley again said that he would like to be transferred to a therapeutic community where he could address his drug issues.
47. A note on Mr Riley's medical record shows that a withdrawal pack was prescribed that afternoon. This should have been sent to the pharmacy to be administered.
48. The following day, Mr Riley again asked the prison GP to increase his prescription of pregabalin but she said she would bring forward his physiotherapy appointment. That afternoon a nurse assessed Mr Riley's health in view of his continued segregation. He noted that there were no health or wellbeing concerns.
49. On 15 June, unit staff reviewed Mr Riley's ongoing segregation. Mr Riley said that he had debts of £800. Staff suggested beginning arrangements for transferring him to another prison and Mr Riley agreed to this. The nurse noted that there were no clinical reasons to advise against his ongoing segregation. It was agreed that Mr Riley did not require overnight checks.
50. A member of START saw Mr Riley in passing on the segregation unit on 16 June. She said that he did not seem to be his usual self, did not give her his usual greeting smile and appeared preoccupied. He told her that he had still not received his withdrawal pack so she said she would check what had happened.

Events on 17/18 June

51. On the morning of Sunday 17 June, a nurse saw Mr Riley. In interview she said that this was for a wellbeing check and that she had no concerns about him. She saw him again that evening when giving him his medication and said she remembered him being relaxed and talkative.
52. The prisoners in the cell next to Mr Riley's said that he had not known Mr Riley before but that they had spoken to each other out of their windows since he arrived in the unit on 5 June. He also said that Mr Riley was anxious about

receiving his property from C wing, and that when the property arrived on the evening of 17 June, Mr Riley was very upset because a card which contained the telephone numbers of his family was missing. Mr Riley was worried that another prisoner had taken the card and could now contact his family using an illicit phone. Mr Riley told an officer who said he would make enquiries about the missing card.

53. At approximately 8.30pm, the officer was conducting a roll check on the unit. Mr Riley asked him if he would pass some CDs to another prisoner. He did so, and a short time later the other prisoner asked the officer to hand the CD case back to Mr Riley. Having checked that there was nothing in the case, he did so and Mr Riley thanked him.
54. During the night another prisoner in the segregation unit asked to speak to Listeners (prisoners trained by the Samaritans to provide peer support). At about 11.00pm, three officers escorted him to the adjudication room immediately opposite Mr Riley's cell and sat outside while he spoke to the Listeners. The prisoners in the cell next to Mr Riley's also saw the Listeners in the adjudication room from about 00.45am to 1.30am. Prison officers said that while they were escorting the Listeners around the unit they could hear Mr Riley talking normally with other prisoners through his cell door.
55. According to unit records, Mr Riley did not raise any issues during the night.
56. At approximately 5.16am, an officer was conducting a roll check on the unit. When he arrived at Mr Riley's door, he was unable to see inside the cell as the observation panel had been blocked. As Mr Riley's cell was on the ground floor, the officer went outside the unit to look through the window. Again, he was unable to see anything through as the window was obscured. He went back inside and kicked Mr Riley's door but got no response. He then went into the office and contacted one of the prison's managers who was the night orderly officer (in charge of the prison overnight). The officer told him that he was unable to see into Mr Riley's cell. Approximately two minutes later, one of the prison managers and a second officer arrived on the unit and the officer unlocked the cell door.
57. Mr Riley was hanging by a ligature attached to the light fitting. The prison manager stepped away from the cell and used his radio to call a code blue emergency. This signifies a prisoner unable to breathe or having difficulty breathing and triggers all emergency response staff to attend, and the communications room to request an ambulance automatically. The incident log shows that the code blue call was made at 5.21am and an ambulance was requested at 5.22am.
58. The two officers went into Mr Riley's cell, cut the ligature and lowered his body to the floor. One of the officers began cardiopulmonary resuscitation (CPR). They came out of the cell, then he went back in, but after two minutes came back out again. Some five minutes after the prison manager had called the code blue emergency, CCTV footage showed the emergency response nurse, a nurse arrived on the wing. She went to the medical cabinet on the unit, then back past the cell, apparently to get a pen. She looked into the cell, and after a short delay went in.

59. The nurse's note on the medical record showed that when she went into the cell Mr Riley was lying on his back. He was unresponsive. His body was cold and rigid and she could not detect any signs of life. She began to perform CPR, assisted by the prison officers, and applied a defibrillator. The defibrillator did not detect any shockable rhythm, so the nurse and the officers continued to try to resuscitate Mr Riley until the ambulance crew arrived and took over. At 5.43am paramedics declared Mr Riley dead.

Contact with Mr Riley's family

60. Gartree appointed a family liaison officer, and she and the prison Governor, travelled to see Mr Riley's mother to inform her of her son's death. In line with Prison Service policy, Gartree offered a contribution towards the costs of Mr Riley's funeral.

Support for prisoners and staff

61. After Mr Riley's death, the Governor 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.
62. Prisoners were notified of Mr Riley's death by notices posted on the wings, which indicated where they could get support if they felt it necessary. All prisoners subject to ACCT monitoring had their circumstances reviewed in case they had been affected by Mr Riley's death, as were all prisoners in the segregation unit.
63. The prisoner in the cell next to Mr Riley's, said that no staff had asked him if he was alright, although he had been able to hear everything that happened.

Post-mortem report

64. The post-mortem report showed that Mr Riley died as a result of hanging. Toxicology tests showed therapeutic quantities of his prescribed medication, as well as traces of drugs that had not been prescribed to him. Tests did not show any traces of psychoactive substances.
65. A brown powder was found in the cell which the pathologist said was presumed to be a psychoactive substance, but we have not seen any test results.

Findings

Risk assessment

66. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others* (Safer Custody), and PSI 7/2015, *Early Days in Custody – Reception in, first night in custody, and induction to custody*, both list a number of risk factors for suicide and self-harm. All staff who come into contact with prisoners are expected to be aware of these risk factors.
67. Although Mr Riley had a number of these risk factors – a history of depression, drug abuse and being bullied – the staff who came into contact with Mr Riley, including unit staff, healthcare staff and drug workers, said that they did not consider that he was at risk of self-harm at any stage. Once he was housed in the segregation unit he said he felt safe and appeared more upbeat. Nurse Harris saw Mr Riley during the evening of 17 June when she gave him his medication. She said that he was talkative and did not give her any reason to believe he might harm himself.
68. We are satisfied that Mr Riley did not give staff any reason to consider he might pose a risk to himself and that staff could not have anticipated that he would take his life.

Segregation

69. When Mr Riley moved to the segregation unit he immediately seemed to become less anxious. He did not present any problems to staff and told his substance misuse worker that he was detoxifying from drug use. (This broke down during the time he spent in HMP Leicester, and post-mortem toxicology tests found drugs in his system that he had not been prescribed.) Although the Independent Monitoring Board have raised some concerns about the physical environment of the segregation unit in Gartree, we are satisfied that Mr Riley had proper reviews of his segregation status, and was visited regularly by healthcare staff. There is no evidence that he was being negatively affected by his ongoing segregation. During consideration of his continuing segregation, staff and Mr Riley discussed his debts. Together they agreed to begin procedures that would allow him to transfer to another prison.

Healthcare

70. The clinical reviewer found a number of deficiencies in the healthcare Mr Riley received and concluded that, overall, the care he received was not equivalent to that he could have expected to receive in the community.

Physical healthcare

71. The clinical reviewer said that good prescribing practices were not being followed at Gartree at the time of Mr Riley's death, especially in relation to pregabalin. Mr Riley had initially been prescribed pregabalin for anxiety but it was then also used for the treatment of pain in his hand without further full assessment. Although pregabalin can be used for both anxiety and pain, it tends not to be used in a custodial setting because of the potential for abuse. While Mr Riley

reported pain due to various old injuries, this was not sufficiently well substantiated to allow the medication he wanted (pregabalin) to be prescribed, and it is possible that this was drug-seeking behaviour by Mr Riley.

72. The clinical reviewer was satisfied that better practice has been established around medication reviews since July 2018.

Mental healthcare

73. The clinical reviewer was concerned that Mr Riley had been diagnosed with anxiety and prescribed pregabalin, but did not appear to have been reviewed. As he had been in prison for 12 years, she was surprised that he was only referred to a psychiatrist for an assessment for ADHD shortly before he died. However, she was satisfied that the changes made by the new Head of Mental Health at Gartree now reflect mental health provision in the community.

Substance misuse

74. Mr Riley had longstanding drug issues. He attempted to address these frequently while in custody, but always fell back into misuse. Since arriving at Gartree he had again engaged with the drug misuse team and, once housed in the segregation unit, he managed to detoxify.
75. When he moved temporarily to Leicester, however, he began to use drugs again. When he returned to Gartree he told the nurse at reception that he had no problems with drug misuse and had not used any illicit substances in the last month, despite having told a nurse at Leicester the previous day that he was using heroin and buprenorphine.
76. We share the clinical reviewer's concern that Mr Riley's drug use was not identified when he returned to Gartree and that he was not tested for drugs. Post-mortem tests revealed traces of diazepam (a tranquiliser) and zopiclone (a sleeping pill), drugs that Mr Riley had not been prescribed. There is no intelligence to suggest where he obtained these, whether he brought them back from Leicester where he had not been in segregation, or whether he had sourced them on his return to Gartree. A quantity of brown powder was found in Mr Riley's cell, but what this is has not yet been identified. Toxicology reports indicate that he had no PS in his system.
77. A week before he died, Mr Riley told a member of START he had been using drugs and she ordered a withdrawal pack. We share the clinical reviewer's concern that he did not receive this before his death. However, the clinical reviewer was told that withdrawal packs are now readily available from the pharmacy under the new healthcare providers.

Staffing issues

78. The clinical review identified serious problems in the healthcare department at Gartree at the time of Mr Riley's death, particularly in relation to the recruitment and retention of staff and a lack of support for managers. We note that MITIE, who were the healthcare providers at the time of Mr Riley's death, were replaced by new providers in November 2018.

79. When the nurse responded to the emergency call at 5.21am, she had been on duty since 7.45am the previous day. When her scheduled shift had finished, the nurse due to take over did not arrive so she remained on duty for a further shift. While it appears that she volunteered to do so, the clinical reviewer noted that her duty of care may have left her feeling that she had no choice. She is an agency nurse and we have been unable to contact her to clarify this. Nevertheless, the Royal College of Nursing advises that a nurse should not work longer than a single twelve-hour shift, for the wellbeing of both the nurse and his or her patients.

80. We make the following recommendation:

The Head of Healthcare should provide this office, by 31 March, with evidence of the actions she has taken to improve the following:

- **prescribing practices in relation to drugs that may be abused/traded in prison;**
- **medication reviews;**
- **mental health referrals;**
- **drug testing in reception;**
- **the recruitment and retention of healthcare staff;**
- **support for healthcare managers; and**
- **systems to prevent staff having to work excessively long hours.**

Emergency response

81. When the officer was unable to see into Mr Riley's cell because of the blocked observation panel, he went out of the building to look through the window. He was unable to do so as this was also obscured. He returned to the door and kicked it, while calling to Mr Riley but without response. He then contacted the night orderly officer to report that he was unable to confirm Mr Riley's presence.

82. Prisoners block their observation panels for many reasons, including a simple wish for privacy. The officer had no reason to believe that Mr Riley was at risk that night and we are satisfied that his actions were reasonable.

83. Once other staff had arrived and entered the cell and found Mr Riley hanging, there was a delay of several minutes before the nurse arrived on the unit in response to the emergency medical code. There was then a further delay before she entered the cell. She was an agency nurse and the clinical reviewer has been unable to contact her to ask her to explain the delays. We note the excessive length of time she had been on duty. However, we agree with the clinical reviewer that the delay was unacceptable. While it will not have affected the outcome for Mr Riley, who had been dead for some while when he was found, it could make the difference between life and death in future emergencies.

84. We make the following recommendation:

The Head of Healthcare should ensure that emergency response staff understand the importance of providing timely assistance in the case of an emergency.

85. We also share the clinical reviewer's concern that it was inappropriate to attempt to resuscitate Mr Riley. The record made by the nurse shows that he was clearly dead when he was found, and she told the police that the ambulance paramedic said he had been dead for some hours.

86. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, say that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples evidence of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual's situation. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

87. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

**Prisons &
Probation**

Ombudsman
Independent Investigations