

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Darren Johnson a prisoner at HMP Haverigg on 20 January 2018

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

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## Our Vision

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

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We are:

**Impartial:** *we do not take sides*

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**Fair:** *we are honest and act with integrity*



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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 Darren Johnson died on 20 January 2018. He was found hanged in his cell at HMP Haverigg. A post-mortem examination showed that he had taken a psychoactive substance (PS) in the hours before his death. Mr Johnson was 45 years old. I offer my condolences to his family and friends.

Mr Johnson had a history of depression and substance misuse. He received adequate healthcare in prison and was appropriately supported throughout his time at Haverigg. Although Mr Johnson had self-harmed in the past, he had not done so for several years. I am satisfied that he gave staff no indication that he was at an increased risk of suicide or self-harm before his death.

It is troubling that throughout his time in prison, Mr Johnson was able to access illicit drugs, including PS, which might have played a role in his death. I am concerned that Mr Johnson's use of PS was not always recorded in his medical record, as it should have been. We have recently made a recommendation to Haverigg that they tackle the use of PS, and I repeat my concerns in this report.

While this would have not changed the outcome for Mr Johnson, who had been dead for some time, I am concerned that the officer who first opened his cell on the morning of 20 January did not check on him.

I am increasingly concerned by the number of deaths that I investigate in which PS has played a part. Mr Johnson's death is another example of the dangers of PS and how even prisons with effective measures in place to reduce PS use, are struggling to tackle it. I intend to raise my concerns with Ministers. I also draw the attention of the Prison Group Director for Cumbria and Lancashire to my concerns that PS may have contributed to the death of a second prisoner at Haverigg within a very short period.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**October 2018**

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# Summary

## Events

1. On 7 May 2016, Mr Darren Johnson was remanded to HMP Preston, charged with intent to supply class A drugs. This was not his first time in prison. On 7 July, Mr Johnson was sentenced to five years and eight months in prison.
2. On 16 December, Mr Johnson was transferred to HMP Haverigg. He was a well-behaved prisoner but, on numerous occasions in 2017, staff found Mr Johnson under the influence of psychoactive substances (PS, also known as 'Spice'). From September 2017, staff noted that Mr Johnson's behaviour had improved, he appeared to have abstained from illicit drug use and had achieved enhanced prisoner status. There is no evidence that Mr Johnson displayed any signs that he wanted to take his life throughout his time at Haverigg.
3. On 20 January 2018, staff unlocked Mr Johnson's cell at about 9.00am but did not speak to him to check on his wellbeing. At approximately 10.30am, the officer who unlocked Mr Johnson's cell found him hanged from a ligature made from torn sheets. Staff attended and radioed a medical emergency code, and the control room called an ambulance immediately. Healthcare and prison staff tried to resuscitate Mr Johnson, despite the presence of rigor mortis. When the paramedics arrived they took over his care, but shortly afterwards pronounced that he had died.

## Findings

### Assessment of risk

4. We are satisfied that staff properly assessed Mr Johnson and there was nothing to indicate that he was at high risk of suicide or self-harm.

### Drug management

5. Haverigg has a local policy for tackling PS and on the whole, staff responded swiftly and proactively to reduce the supply and demand of PS in line with the provisions of that policy.
6. Mr Johnson was found unwell on many occasions at Haverigg before September 2017, due to the effects of PS. Haverigg used a number of intelligence led interventions, which included sobriety tests, cell searches and disciplinary action to challenge and disrupt Mr Johnson's drug use, but he continued to use PS. Mr Johnson received appropriate support and advice on the dangers of using PS, and the prison took reasonable measures to protect him. However, on some occasions, when prison staff found Mr Johnson under the influence of an illicit substance, it was not noted in his medical record.

### Unlock procedures

7. We are concerned that the officer who unlocked Mr Johnson's cell at 9.00am on the morning of 20 January did not check his welfare. While it does not appear that this would have changed the outcome for Mr Johnson, early intervention in other circumstances might save a life.

## **Resuscitation**

8. While we understand that staff wanted to save Mr Johnson's life, rigor mortis was present. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Staff should therefore not have tried to resuscitate Mr Johnson.

## **Post-mortem examination**

9. A toxicology report concluded that Mr Johnson had taken PS at some point before his death.

## **Recommendations**

- The Governor and Head of Healthcare should ensure that staff consistently implement Haverigg's policy for managing prisoners suspected of using PS and other illegal substances and ensure that members of staff appropriately record and share information, particularly about potential risk.
- The Governor should ensure that all prison staff are aware of the correct roll check procedures and that when a cell door is unlocked staff satisfy themselves of prisoners' wellbeing and that there are no immediate issues that need attention.
- The Governor and Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare and discipline staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Haverigg informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
11. The investigator obtained copies of relevant extracts from Mr Johnson's prison and medical records.
12. NHS England commissioned a clinical reviewer to review Mr Johnson's clinical care at the prison.
13. The investigator interviewed 13 members of staff and one prisoner at Haverigg In March 2018, some jointly with the clinical reviewer. Two prisoners refused to be interviewed.
14. We informed HM Coroner for North and West Cumbria of the investigation who gave us the toxicology results. The post-mortem report results were not available at the time of writing. We have sent the Coroner a copy of this report.
15. One of the Ombudsman's family liaison officers contacted Mr Johnson's sister to explain the investigation and to ask if she had any matters that she wanted the investigation to consider. Mr Johnson's sister wanted to know as much as possible about the circumstances leading to Mr Johnson's death.
16. Mr Johnson's sister received a copy of the initial report. She raised a number of issues that do not impact on the factual accuracy of this report.

## Background Information

### HMP Haverigg

17. HMP Haverigg holds 286 sentenced men. Cumbria Partnership Trust provides physical health services. A GP works at the prison full-time and an out of hours service is provided by a local practice. Greater Manchester Mental Health Trust provides mental health and substance misuse services, with two psychiatrists subcontracted to work one day a week at the prison.

### HM Inspectorate of Prisons

18. The most recent inspection of HMP Haverigg was in March and April 2017. Inspectors found that 40% of prisoners said that they had felt unsafe at some point at Haverigg. The integrated mental health team provided a reasonably good and responsive service, despite some staff shortages, and worked closely with the substance misuse team. There was a good range of education and work placements and a focus on making sure that prisoners spent time out of their cells.

### Independent Monitoring Board

19. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to November 2017, the IMB reported that it was concerned about the widespread use of psychoactive substances (PS) and the impact of this on the health of prisoners and staff. They also noted its contribution to violence, debt and bullying, and that a violence reduction strategy had been developed to deal with these issues. They noted that the geographical position of the prison and its large perimeter fence meant that it was difficult to prevent illicit items getting into the prison. They concluded that the use of ACCT procedures to support prisoners at risk of suicide and self-harm was good and the standard of care was high.

### Previous deaths at HMP Haverigg

20. Since 2014, there have been seven deaths at Haverigg, three of which were self-inflicted, including Mr Johnson's. We have made previous recommendations about recording information about a prisoner's risk to themselves, the management of PS use, the importance of checking on prisoners' well-being during roll checks, and unlocking cells immediately when there is a life-threatening situation. We are concerned that we have had to repeat our concerns in this report.

### Psychoactive Substances (PS)

21. PS (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.

22. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time 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.
23. HM Prisons and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled PS as part of established mandatory drugs testing arrangements.

## Key Events

24. In May 2016, Mr Darren Johnson was arrested and charged with intent to supply class A drugs. He was remanded to HMP Preston. He had spent a considerable amount of his adult life in custody.
25. Mr Johnson had a significant and long history of substance misuse. A prison GP at Preston prescribed Mr Johnson mirtazapine (an antidepressant) which he took daily. He was allowed to keep his medication in his cell and administer it himself.
26. On 7 July, Mr Johnson attended court and was sentenced to five years and eight months in prison. He was due to be released on 23 February 2019.

### HMP Haverigg

27. On 16 December 2016, Mr Johnson was transferred to HMP Haverigg. An officer completed Mr Johnson's first night interview. She noted no specific concerns. Mr Johnson listed his sister as his next of kin.
28. A mental health nurse and an assistant practitioner completed Mr Johnson's initial health screen. All newly arrived prisoners at Haverigg receive a separate screen for mental health, substance misuse and physical healthcare, and details are recorded on SystmOne, the prison's electronic medical database.
29. Mr Johnson said that he had no thoughts of suicide or self-harm and had not been monitored under prison suicide and self-harm prevention procedures, known as ACCT, since 2004. The mental health nurse noted that Mr Johnson had a history of low mood and anxiety, but he did not want to be referred to the mental health team for support. Mr Johnson had been prescribed mirtazapine daily for several years. He had a history of using cannabis, cocaine, heroin, amphetamine, Spice (a PS) and alcohol. Mr Johnson did not test positive for illicit drugs at his reception screen. Mr Johnson said that he did not want to be referred to Unity, the substance misuse service at Haverigg.
30. On 20 December, a prison GP reviewed Mr Johnson's medical history. He noted that he would continue to review Mr Johnson's prescription of mirtazapine, particularly if there was evidence that he was continuing to use illicit drugs.
31. On 21 December, a substance misuse worker assessed Mr Johnson, who asked to be referred for acupuncture as a complimentary therapy to support his abstinence from illicit drugs. He was placed on a waiting list.
32. Prison records indicated that by the end of December, Mr Johnson had settled well at Haverigg and was employed.

### 2017

33. On 6 January 2017, a prison GP reviewed Mr Johnson and explained that illicit drugs could enhance the sedative effect of mirtazapine and he would stop prescribing it, if Mr Johnson displayed evidence of taking illicit substances.
34. On 18 January, staff submitted an intelligence report which noted that they had found a homemade drug pipe during a routine check of Mr Johnson's cell.

Despite this, Mr Johnson tested negative for illicit substances, including PS, in January and February 2017.

35. On 14 February, the substance misuse worker saw Mr Johnson, who asked to be referred to Unity again. He attended his first SMART recovery programme group session on 28 March, and it was noted that he participated well. The group focussed on providing life skills as part of a substance misuse recovery programme.
36. On 31 March, staff found Mr Johnson under the influence of PS. They called healthcare staff, who responded and said that prison staff should continue to observe him and to contact them again if his condition deteriorated. Under local Incentives and Earned Privileges (IEP) procedures (which are designed to encourage good behaviour and challenge misbehaviour), staff reduced Mr Johnson to the basic IEP level and submitted an intelligence report. At the time, Mr Johnson was sharing a cell with another prisoner.
37. Aware of Mr Johnson's recent use of illicit substances, a prison GP emailed the mental health team on 2 April to ask if they had any concerns about stopping Mr Johnson's mirtazapine due to his use of PS. He noted that Mr Johnson would no longer be allowed to keep his medication in his cell and administer it himself.
38. On 6 April, staff found hooch (an illicit homemade alcohol) in Mr Johnson's cell and, on 10 and 15 April, found Mr Johnson and his cellmate under the influence of PS. They submitted intelligence reports and Mr Johnson remained on basic IEP level. (Healthcare staff recorded no information about these two incidents, and we therefore do not know whether they were informed or attended.) On 21 April, staff reinstated Mr Johnson's IEP level to standard after a period of good behaviour.
39. On 22 April, an officer spoke to Mr Johnson, who said that he was upset that he was no longer allowed to keep his medication in his cell. He had taken mirtazapine for over 20 years and said that he could not cope without it. The officer referred Mr Johnson to the mental health team. A nurse recorded that she referred Mr Johnson to the Primary Care Mental Health Team (PCMHT).
40. On 24 April, staff found Mr Johnson and his cellmate sitting on the cell floor, unable to talk coherently or stand up. Staff suspected that they were under the influence of PS and submitted an intelligence report. This incident is not recorded in Mr Johnson's medical record. Two days later, Mr Johnson started work in the prison laundry.
41. On 27 April, a prison GP reviewed Mr Johnson, who said that he had not intentionally taken illicit drugs on 31 March but had been spiked (given the drug without his knowledge) by another prisoner. The GP noted that he would check Mr Johnson's allegation with wing staff. He noted that if it was found to be untrue, he would start to reduce Mr Johnson's mirtazapine and possibly prescribe an alternative antidepressant.
42. On 5 May, a prison GP reviewed Mr Johnson's records and noted that it was unsafe to prescribe him mirtazapine because of his reported illicit drug use on the

- wing. He prescribed a reducing dose of mirtazapine starting on 11 May from 30mg to 15mg daily for two weeks, after which the medication would be stopped.
43. On 11 May, a wellbeing practitioner assessed Mr Johnson. Although she was a substance misuse practitioner, she was seconded to the PCMHT and had had previous contact with Mr Johnson through Unity. She recorded that Mr Johnson said that he had had anxiety and depression for 20 years. At the review, Mr Johnson was focussed on continuing his mirtazapine and was unwilling to discuss any other issues.
  44. Medical records show that although Mr Johnson had agreed in February 2017 to participate in the weekly Safe Management and Recovery Training (SMART) group programme (lasting a period of 24 weeks), his attendance was intermittent. As a result, on 23 May, the wellbeing practitioner (in her role as the Substance Misuse Recovery Co-ordinator) removed Mr Johnson from the group. However, Mr Johnson reapplied to return to the SMART group in June and his application was approved. She noted that Mr Johnson then attended regularly.
  45. An officer recorded that he had a conversation with Mr Johnson on 4 June. Mr Johnson was frustrated that the doctor had not re-prescribed mirtazapine. The officer noted that other than this, Mr Johnson had appeared okay, was employed and remained a compliant prisoner.
  46. On 6 June, a prison GP saw Mr Johnson and prescribed a daily dose of sertraline (a non-sedating antidepressant). Mr Johnson took this medication for one week but stopped because he said that it made him have suicidal thoughts. He stopped prescribing the medication on 27 June. He suggested that Mr Johnson should try an alternative antidepressant but he declined.
  47. On 3 July, the wellbeing practitioner saw Mr Johnson, who discussed being prescribed methadone nearer to his release date. He admitted to using PS once a month and said he had taken heroin three weeks earlier but was not opiate dependant. He said that he had no thoughts of suicide or self-harm but had low mood and anxiety. She discussed Mr Johnson's situation with the prison GP the next day. She asked Unity to refer him to the mental health team.
  48. On 6 July, staff found Mr Johnson and his cellmate incoherent and staggering about in their cell. Both prisoners appeared under the influence of PS again. Staff downgraded Mr Johnson's IEP level to basic and submitted an intelligence report. The next week, staff again found Mr Johnson under the influence of PS several times. (Healthcare staff recorded no information about these incidents, and we do not know whether they attended Mr Johnson's cell or were told about the incidents.) During a search of his cell, staff found that Mr Johnson had a television, which he should not have had as a prisoner subject to the basic IEP level. Staff reminded Mr Johnson of the standards of behaviour that he was expected to adhere to which included attending work and his sessions with Unity. On the same day, the mental health team made an appointment to review Mr Johnson. Due to a prison lockdown, this was rescheduled to 13 July. Mr Johnson failed to attend this appointment.
  49. Mr Johnson regularly attended the SMART group session but on 15 July, staff again found him under the influence of an illicit substance. They called

- healthcare staff, who responded and said that prison staff should continue to observe him and to contact healthcare staff again if his condition deteriorated.
50. On 20 July, the wellbeing practitioner completed a mental health review with Mr Johnson who again said that he wanted mirtazapine. He refused to be referred for any form of psychological therapy, despite his low mood. He believed that his mental health was deteriorating because he was not taking mirtazapine. During their conversation, Mr Johnson admitted that his cellmate regularly used PS. She suggested that Mr Johnson should consider moving to a single cell to reduce his exposure to illicit substances. Afterwards, she spoke to an officer, who agreed to keep an eye on Mr Johnson and to encourage him to relocate to a different cell.
  51. By 25 July, staff recorded that Mr Johnson's behaviour had much improved. His work in the prison laundry was of a high standard, he was always punctual and polite. Mr Johnson appeared to have stopped using PS. On 27 July, staff upgraded Mr Johnson's IEP level to standard, and moved him to a single cell.
  52. On 3 August, staff found Mr Johnson under the influence of PS. They called healthcare staff who responded and said that prison staff should continue to observe him and to contact healthcare staff again if his condition deteriorated. Staff once again downgraded Mr Johnson's IEP level to basic and submitted an intelligence report. Staff reviewed Mr Johnson's employment in the prison workshop and noted that he could continue to be employed in the laundry but restrictions applied to some tasks because he was on basic IEP.
  53. On 14 August, a Supervising Officer (SO) recorded that Mr Johnson was adhering to the prison regime, attending his group sessions with Unity and regularly working in the prison workshop. The SO reinstated Mr Johnson's IEP to standard and told him that any further use of illicit substances would result in a return to basic IEP. Staff considered that Mr Johnson was a polite prisoner whose frequent use of PS negatively affected his character.
  54. On 16 August, Mr Johnson failed to attend work. An officer noted that Mr Johnson was found under the influence of PS. Mr Johnson was apologetic and said that he could not stay away from using illicit drugs. Staff submitted an intelligence report, downgraded Mr Johnson's IEP level to basic. Healthcare staff referred Mr Johnson to Unity to speak to the wellbeing practitioner.
  55. On 17 August, the wellbeing practitioner completed a mental health review and introduced to Mr Johnson his new wellbeing practitioner. Mr Johnson said that he felt unhappy and frustrated as he believed that he had been given PS the previous day without his knowledge and that this had affected his wellbeing. She encouraged him to look at the positives in that he was discussing the issue. This improved Mr Johnson's mood, who said that he would participate in auricular acupuncture and do sudoku puzzles to keep himself busy while he waited for his IEP review. On 26 August, Mr Johnson was again found under the influence of PS. Staff submitted an intelligence report.
  56. Staff made positive comments about Mr Johnson's behaviour over the next few days and reinstated his standard IEP level on 30 August. An officer noted on 2

September that Mr Johnson's behaviour was good, he appeared to have stopped taking PS (for four days) and he complied with the prison regime.

57. The new wellbeing practitioner had started seeing Mr Johnson regularly. He told the investigator that they had built up a good rapport and their sessions focused on intervention and distraction techniques to relieve boredom and help him avoid PS. Mr Johnson maintained that he did not want to engage in psychological therapy but wanted to be prescribed mirtazapine again. Mr Johnson did not express thoughts of suicide or self-harm in his sessions with him.
58. Throughout September and October, staff reported that Mr Johnson had excelled in his attitude and commitment and was considered to be the best worker in the prison laundry. Consequently, staff upgraded Mr Johnson's IEP level to enhanced.
59. On 25 October, the wellbeing practitioner saw Mr Johnson who complained of hearing voices during the night. He was unable to describe them clearly. He disclosed that he had been sexually assaulted at a previous prison and found this distressing. He was unwilling to provide further details about the incident. The practitioner referred Mr Johnson to the secondary care mental health team for an assessment as he was concerned that this might indicate a more severe mental health problem.
60. On 14 November, a mental health nurse assessed Mr Johnson. He noted Mr Johnson's family history, his involvement with the criminal justice system and his lengthy history of substance misuse. Mr Johnson had complained of hearing male voices in his head, which were worse at night, telling him that he would be better off dead. He noted that he explored this further with Mr Johnson and assessed that the voices were ruminating, recurrent thoughts rather than auditory hallucinations as a symptom of a psychotic episode.
61. Mr Johnson told the mental health nurse that he had previously tried to hang himself in 2014 but had no current thoughts of suicide. The nurse assessed that Mr Johnson had low mood and situational unhappiness. He agreed with Mr Johnson that he should continue to see Mr Riley. He said that he would also discuss with a prison GP whether he should be prescribed a different antidepressant.
62. On 15 November, a prison GP saw Mr Johnson after his discussion with the mental health nurse. He prescribed a daily dose of duloxetine daily (an antidepressant). The GP told the investigator that when he prescribed a new antidepressant, he would see the patient after approximately three weeks to review any side effects and then again after approximately eight weeks to assess the effectiveness of the drug. This was because most antidepressants take six to eight weeks to bring about any noticeable improvement in mood.
63. Mr Johnson continued to attend the SMART group sessions. On 29 November, his former wellbeing practitioner noted that he contributed well to the group's discussion.

64. On 4 December, wing staff noted that Mr Johnson had continued to demonstrate good and polite behaviour and a high level of commitment to his job. He had lived in Residential Unit 1 for over a year.
65. On the same day, a prison GP reviewed Mr Johnson, who said that his mood had improved but was concerned that the application that he had submitted for a transfer to a Category D open prison had recently been declined. (The prison had refused Mr Johnson's application as they remained concerned about his previous PS use.)
66. Because of Mr Johnson's continued hard work and good attitude, he was offered a job in the prison's call centre, which was considered a key job. This meant that from 12 December, Mr Johnson was unable attend the SMART group sessions as he was working in the call centre.
67. On 20 December, the wellbeing practitioner saw Mr Johnson, who said that he continued to hear voices in his head. He had no thoughts of suicide or self-harm and communicated well throughout the assessment.

### January 2018

68. On 15 January 2018, staff recorded that Mr Johnson had progressed exceptionally well in his new role at the call centre.
69. On 17 January 2018, a prison GP saw Mr Johnson and reviewed his antidepressant. He recorded that Mr Johnson had a history of low mood and his current mood was low because he had not had electricity in his cell overnight. Mr Johnson told the GP that he felt he had nothing to live for and was just waiting for his life to end. He said that he was still hearing voices. The GP told the investigator that he considered starting ACCT procedures but Mr Johnson was adamant that he was not suicidal. He said that he had felt the same way for the past 20 years. Mr Johnson had also told the GP that the power in his cell had been restored and he was now okay. The GP agreed to discuss Mr Johnson's situation at the next mental health team meeting (the next day) and emailed the wellbeing practitioner to ask him to review Mr Johnson.
70. The wellbeing practitioner reviewed Mr Johnson that day. Mr Johnson complained that having no electricity in his cell had lowered his mood. However, wing staff had moved Mr Johnson to another cell until the electricity had been restored. He noted that Mr Johnson did not exhibit any immediate risk concerns.
71. On 18 January, the wellbeing practitioner again reviewed Mr Johnson who continued to say that mirtazapine was a better drug for him. He had no concerns about Mr Johnson's mental health at this review. When the wellbeing practitioner probed him about his comment to the GP that he had "nothing to live for" and was "waiting for his life to end", Mr Johnson dismissed having thoughts of suicide or self-harm.
72. That day, the wellbeing practitioner, the GP and their colleagues discussed Mr Johnson at the mental health team meeting. All attendees noted that no additional action was needed to support Mr Johnson, and PCMHT would continue to support him.

73. A prisoner who worked with Mr Johnson in the call centre, told the investigator that he spoke to Mr Johnson after he had returned from his healthcare appointment. He said that Mr Johnson told him that he was disappointed that the prison doctor had refused to “put him back on his medication” and he said that he may as well kill himself. Staff were not aware of this at the time.
74. At 4.50pm on 19 January, a SO spoke to Mr Johnson while he collected his evening meal. He said that Mr Johnson appeared in good spirits and was laughing and joking.
75. The night duty officer checked all prisoners in Residential Unit 1 at around 8.30pm that night. She raised no concerns.

### **Saturday 20 January 2018**

76. At 6.25am on 20 January, the night duty officer completed her morning roll check on Residential Unit 1. She reported no concerns.
77. An officer started his duty at 7.15am and received a handover from the night duty officer. He then conducted a roll check of the unit. He said that Mr Johnson was in bed when he opened the cell observation hatch for Mr Johnson’s cell. He moved on to check the next cell. More staff started duty on the wing from around 8.30am.
78. At 9.00am, staff started to unlock cell doors in Residential Unit 1 for the morning association period. Officer A told the investigator that when he got to Mr Johnson’s cell, he looked through his observation panel and unlocked the cell door. He could not recall where Mr Johnson was in the cell but said that if he had seen something abnormal, he would have raised the alarm. There was no clear CCTV coverage of the wing landing near Mr Johnson’s cell, and the investigator was unable to confirm whether staff completed the roll check and unlock procedures correctly.
79. Officer A described the wing as very busy after prisoners were unlocked as it was the association period (when prisoners mixed with each other) and those who needed methadone were arriving at the wing’s medication hatch. No one recalled seeing Mr Johnson leave his cell that morning.
80. At the end of the association period at 10.30am, Officer A started checking and locking prisoners back in their cells. When he arrived at Mr Johnson’s cell, he looked through the observation panel. He described the cell as dark and said that the television was off. He saw Mr Johnson sitting on the floor, with his back against his bed and legs outstretched. He said that Mr Johnson’s facial expression looked strange, his lips looked swollen as if he had been in a fight or had taken drugs. He pulled the cell door shut and shouted for staff assistance.

### **Emergency response**

81. Officer B responded and arrived at the cell in seconds. He said that the cell was dark and Mr Johnson was sitting on the floor, unresponsive. He too thought that from the way Mr Johnson looked, it appeared as if he had been assaulted or was under the influence of an illicit substance. As the officers went into the cell, they saw that Mr Johnson was suspended by a partially hidden ligature, tied to the

window bars. Some prisoners had gathered outside the cell and were shouting, “why has he not cut him down”. Officer A said the ligature was out of sight and tied so tightly that they had not initially seen it. Officer B cut the ligature and was assisted by Officer C, who had joined the officers in the cell. Officer C radioed a medical emergency code blue (to indicate that a prisoner is unconscious or having problems breathing) at 10.33am. The control room called an ambulance immediately.

82. Officer C and Officer A laid Mr Johnson on the floor. Officer C assessed Mr Johnson but found no signs of life. Officer A said that when the officers placed Mr Johnson flat on the floor, his legs stayed elevated. His body was cold and stiff. Officer D joined the officers in Mr Johnson’s cell, closely followed by a nurse. A healthcare assistant collected the medical emergency bag and defibrillator (a device that monitors heart rhythms and administers an electric shock if required) from the wing and joined the other staff in the cell.
83. The nurse said that at first assessment there were no signs of life from Mr Johnson and his legs were elevated off the ground while his torso was on the ground. Another nurse started cardiopulmonary resuscitation (CPR) by doing chest compressions, assisted by Officer C and the healthcare assistant. Mr Johnson’s tongue was swollen, blocking his throat; his jaw was stiff, which prevented an airway being inserted, and so a nasal airway was inserted. Mr Johnson’s face was pale in colour. The defibrillator pads were applied but advised no shock.
84. The paramedics arrived at the cell at 10.50am, and took over the care of Mr Johnson. After assessing him, they pronounced him dead at 10.58am. An air ambulance had been called but was stood down at 11.02am.

### **Contact with Mr Johnson’s family**

85. A governor and a member of the chaplaincy team visited Mr Johnson’s sister, who was his next of kin at around 2.30pm. They broke the news of Mr Johnson’s death to her and offered their condolences and support. The Head of Safer Custody was appointed as the prison’s family liaison officer and liaised with Mr Johnson’s next of kin.
86. Mr Johnson’s funeral was held on 6 February and, in line with Prison Service policy, Haverigg contributed to its cost.

### **Support for staff and prisoners**

87. A governor debriefed the staff involved in the emergency response and offered his support and that of the staff care team. Staff checked and reviewed prisoners assessed as at risk of suicide or self-harm, in case they had been affected by Mr Johnson’s death.

### **Post-mortem report**

88. The post-mortem examination concluded that Mr Johnson died as a result of compression of the neck due to low hanging. The toxicology results indicated that Mr Johnson had taken synthetic cannabinoids (a form of PS) at some point before his death. The toxicology report noted that most drugs remain in the

bloodstream for up to 12 to 24 hours after last use. The report also noted that, although the use of PS may have a negative effect on a person's state of mind, it was not possible to say how it might have affected Mr Johnson at the time of his death.

# Findings

## Assessment of risk

89. When Mr Johnson arrived at Haverigg on 16 December 2016, staff raised no concerns about his risk of suicide or self-harm and he was not subject to ACCT procedures during his stay at Haverigg. Discipline staff, substance misuse staff and healthcare staff addressed Mr Johnson's mental health and substance misuse problems throughout his stay, which appeared fairly well documented. On 17 and 18 December, a prison GP and the wellbeing practitioner acted promptly to assess Mr Johnson's mental health after he reported that his mood was low. Neither was concerned about his risk to himself. Mr Johnson said that his mood had been generally low for the past 20 years and he denied that he intended to take his own life.
90. Based on the available evidence, we are satisfied that staff could not reasonably have known that Mr Johnson was at an increased risk of suicide before his death.

## Drug management

91. Mr Johnson regularly used PS, and admitted it at times. We consider that staff at Haverigg offered Mr Johnson appropriate support and advice about the dangers of using PS and that the prison took reasonable measures to keep him safe. The clinical reviewer noted that the prison GP, mental health and substance misuse teams offered Mr Johnson support throughout his time at Haverigg but this did not prevent him from using PS frequently.
92. However, from September 2017 until his death, Mr Johnson appeared to staff to have stopped taking drugs. Mr Johnson had a good prison job because of his commitment, good work, attitude and enhanced IEP status.
93. Haverigg's local policy, Approach and Strategy for Tackling PS, acknowledges that PS is currently the biggest single threat to the good order and discipline of the prison and the safety of prisoners and staff. It says that Haverigg takes a "zero tolerance" approach to PS. It says that staff must test those suspected of taking PS, and that the IEP policy should be used to address a prisoner's use of PS. Prisoners should also be referred to the healthcare team for a review of their prescribed medication and to Unity for support. Information should be logged in the observation book and a prisoner's electronic record, staff should complete an intelligence report and an incident report should be given to their manager.
94. The previous death in custody at Haverigg occurred just 37 days before Mr Johnson's. In that case, we made a recommendation about the use of psychoactive substances (PS) and how this had not been effectively identified, challenged, treated and recorded.
95. In this case, Haverigg generally followed the principles of their policy. However, there were a few occasions when there is no evidence in SystmOne, the electronic medical record, that healthcare staff attended Mr Johnson's cell to examine him after prison staff had allegedly found him under the influence of an illicit substance. Haverigg does not operate a 24-hour healthcare service and, in some instances, incidents might have occurred during the out-of-hours period,

and the healthcare team might not have been told about incidents of PS. Regardless of the reason, every incident of this nature should be reported to healthcare staff as soon as possible to ensure that treatment and medical interventions are appropriately recorded and acted on. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that staff consistently implement Haverigg’s policy for managing prisoners suspected of using PS and other illegal substances, and ensure that members of staff appropriately record and share information, particularly about potential risk.**

### PS in the prison estate

96. The PPO’s Learning Lessons Bulletin on PS, issued in July 2015, sets out why PS have become a source of increasing concern in prisons. There is evidence that PS poses dangers to both physical and mental health. In addition, trading these substances can lead to debt, violence and intimidation. In our Annual Report for 2016-2017, we noted that the number of deaths, where the use of PS might have played a part, continued to rise and that there was a greater need than ever for more effective drug supply and demand reduction strategies, including better monitoring by drug treatment services and effective violence reduction strategies.
97. We have now investigated a significant number of deaths where PS have been a factor and we are very concerned that even prisons with effective measures in place to reduce the use of PS, are struggling. We have therefore made a national recommendation to the Chief Executive Officer of HMPPS on the need for a well communicated national strategy. The Acting Ombudsman also intends to raise her concerns with Ministers.

### Unlock procedure

98. PSI 75/2011 on residential services requires clearly understood systems in place for staff to assure themselves of the wellbeing of prisoners during or shortly after unlock. The PSI states:

“...if a prisoner is expected to leave their cell for an activity shortly after being unlocked, then it will be sufficient for there to be a check on any prisoner who does not do so. Where prisoners are not necessarily expected to leave their cell, staff will need to check on their wellbeing, for example by obtaining a response during the unlock process...”
99. On 20 January, prison staff told us that they checked Mr Johnson at 6.25am and did not notice anything unusual. At around 7.30am, an officer said that he checked on Mr Johnson during the morning roll count and thought that he saw Mr Johnson in bed. At 9.00am, Officer A unlocked Mr Johnson’s cell, but did not get a verbal response from him when he tried to check on his welfare during the unlock procedures. His body was not found until 10.30am, three hours after the morning roll check and one and half hours after his cell was unlocked. We cannot know how long Mr Johnson had been dead when he was found, but the presence of rigor mortis indicated that he had been dead for some time.

100. While we understand that staff will not necessarily want to wake prisoners early in the morning, it is essential that staff satisfy themselves that a prisoner is alive and well, and take some action if there is no sign that the prisoner is breathing. We make the following recommendation:

**The Governor should ensure that all prison staff are aware of the correct roll check procedures and that, when a cell door is unlocked, staff satisfy themselves of prisoners' wellbeing and that there are no immediate issues that need attention.**

### Resuscitation

101. Prison and healthcare staff responded quickly to the medical emergency code blue on 20 January and called an ambulance for Mr Johnson. Staff conducted CPR but told the investigator that Mr Johnson was cold and stiff, which indicated that rigor mortis was present.
102. In September 2016, the National Medical Director at NHS England wrote to the Heads of Healthcare for prisons in England and Wales to introduce new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation after a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines give examples of futility as including the presence of rigor mortis.
103. We understand the wish to continue resuscitation until death has been formally recognised, but trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. Staff should understand that they are not required to carry out CPR in these circumstances. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that, in accordance with European Resuscitation Council Guidelines, healthcare and discipline staff fully understand the circumstances in which resuscitation is inappropriate and are confident about applying the guidance on resuscitation appropriately.**

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations