

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Goodwin, a prisoner at HMP Lindholme, on 16 December 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*



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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 Andrew Goodwin died on 16 December 2018 of mixed drug toxicity, which included psychoactive substances and methadone, at HMP Lindholme. He was 38 years old. I offer my condolences to Mr Goodwin's family and friends.

Mr Goodwin had a significant history of substance misuse in the community and continued to take illegal drugs at Lindholme. Although he had engaged with substance misuse services, and the prison took some action to limit his access to drugs, I am concerned that he was clearly able to obtain and use illicit drugs without difficulty. Staff were largely unaware that he was taking drugs on the wing.

In a previous PPO investigation on the death of a prisoner in September 2018 we found that, despite the prison's comprehensive drug strategy, drugs were readily available at Lindholme and the prison was failing to tackle the problem effectively. I am concerned that this still appeared to be the case at the time of Mr Goodwin's death.

I am also concerned that there was a delay before a medical emergency code was called. We cannot say if this affected the outcome for Mr Goodwin, but it could be critical in other emergencies.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

April 2020

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Summary

Events

1. On 18 May 2017, Mr Goodwin was sentenced to nine years in prison for the supply of drugs. He was sent to HMP Nottingham. Mr Goodwin had a significant history of substance misuse in the community.
2. While at Lindholme, Mr Goodwin was placed on a methadone maintenance programme. He took his methadone every day and did not raise any concerns. Mr Goodwin also engaged with the substance misuse team and had regular one-to-one sessions with a caseworker.
3. On 29 December 2017, Mr Goodwin tested positive for amphetamines, cannabis and psychoactive substances (PS). Mr Goodwin continued taking drugs, including PS, and staff submitted many intelligence reports about his substance misuse.
4. On 25 October 2018, staff made a major finding of 'hooch' (illicit home-made alcohol) in Mr Goodwin's cell.
5. On 16 December, at around 7.30pm, Mr Goodwin told a prisoner that he was going to "have a smoke" of PS and went to his cell. At around 8.30pm, the prisoner went to check on him. Mr Goodwin had locked himself into his cell and the prisoner saw through the observation panel that Mr Goodwin was sitting in his chair. About 15 minutes later, he saw that Mr Goodwin had fallen to the floor. He tried unsuccessfully to get a response from Mr Goodwin and shouted to raise the alarm. At around 9.10pm, another prisoner pressed a cell bell to alert staff to Mr Goodwin's condition.
6. Around two minutes later, an Operational Support Grade (OSG) responded and radioed for staff assistance. The OSG went to fetch the key of Mr Goodwin's cell which was in the staff office. When she returned, she stayed behind a locked gate and passed the cell key to a prisoner through the gate. The prisoner entered Mr Goodwin's cell and saw that Mr Goodwin had turned blue and was "slumped over the chair". The prisoner started cardiopulmonary resuscitation procedures (CPR). The OSG called a medical emergency code and an ambulance was called at around 9.20pm.
7. An ambulance arrived at the prison's gate at around 9.34pm. Paramedics arrived at Mr Goodwin's cell and continued with CPR. They pronounced Mr Goodwin dead at 10.23pm.
8. The post-mortem examination found that Mr Goodwin died from mixed drug toxicity. This was a combination of PS and methadone.

Findings

Clinical Care and substance misuse services

9. The clinical reviewer concluded that the healthcare provided to Mr Goodwin was at least equivalent to that he would have received in the community. Mr Goodwin was regularly reviewed by a substance misuse keyworker who offered substance

misuse advice. The clinical reviewer concluded that Mr Goodwin received appropriate input from the substance misuse, mental and physical healthcare teams. She commended the joint and interdisciplinary approach to Mr Goodwin's healthcare.

Drug strategy

10. Staff were largely unaware of Mr Goodwin's consumption of PS on the days leading up to his death. It appears that Mr Goodwin was able to obtain and use drugs at Lindholme without difficulty.
11. Although we recognise that staff had taken some actions in line with local policy to deal with Mr Goodwin's drug abuse, these actions were clearly insufficient. Mr Goodwin did not receive any intelligence-led drug testing in 2018 despite relevant drug-related intelligence being available, and he was never subject to any targeted or intelligence-led searches. The lack of regular search and drug testing was a missed opportunity to encourage Mr Goodwin to address his drug abuse.
12. Mr Goodwin appears to have been producing 'hooch' at Lindholme. We are not satisfied that staff investigated this matter fully or took sufficient action. The prison must raise its awareness of hooch and should specifically address it in its drugs strategy.

Emergency response

13. We do not criticise the OSG for not going onto the spur alone when prisoners told her that Mr Goodwin was unresponsive.
14. We are, however, concerned that there was a delay of around four minutes in calling an emergency code and in calling an ambulance.
15. We consider that night staff in particular need clear guidance on how to respond to potential emergencies on the prison's spurred wings.

Contact with family

16. It took the prison 12 hours to deliver the news of Mr Goodwin's death in person to his family. We consider that the news should have been delivered earlier.

Recommendations

- The Governor should ensure that:
 - effective supply and demand reduction actions, including regular intelligence-led MDTs are properly implemented to help reduce the availability and abuse of drugs, including the trafficking of prescription medications;
 - staff are vigilant to signs of drug and alcohol abuse and take appropriate action; and
 - the drug strategy includes clear actions to tackle the abuse of alcohol, including hooch.

- The Governor should issue clear guidance to staff working on the spurred wings at night on:
 - the circumstances in which they should call a medical emergency code if they are not able to see the prisoner themselves; and
 - the circumstances in which it might be appropriate to give cell keys to prisoners.
- The Governor should ensure that, whenever possible, prison staff deliver the news of a prisoner's death without delay.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
18. The investigator obtained copies of relevant extracts from Mr Goodwin's prison and medical records.
19. The investigator interviewed eight members of staff and two prisoners at Lindholm in March 2019. NHS England commissioned a clinical reviewer to review Mr Goodwin's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.
20. We informed HM Coroner for South Yorkshire East District of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
21. The investigator contacted Mr Goodwin's next of kin to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. Mr Goodwin's next of kin did not raise any questions.
22. The investigator sent a copy of the initial report to Mr Goodwin's next of kin. She did not make any accuracy comments.
23. The prison service also received a copy of the initial report. They did not make any accuracy comments. Their response to our recommendations and action plan is annexed to this report.

Background Information

HMP Lindholme

24. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Care UK provides healthcare services and healthcare staff are on duty between 7.30am and 7.30pm every day.
25. At the time of his death, Mr Goodwin was living on A wing, a small residential wing which holds around 64 prisoners (in double and single cells) across eight spurs. All prisoners on the wing have access to their own rooms, which they can open and lock with a personal room key, and to a communal landing on the spur. At the end of each spur there is a locked gate giving access to a corridor. At night prisoners are not locked in their cells (although they may choose to lock themselves in if they wish) and are free to access the landing on their spur.
26. In August 2018, Lindholme was selected to be part of the '10 Prisons Project' which seeks to improve safety, security and decency in the prisons involved. The project is focusing on reducing violence, improving living conditions, preventing drugs from entering prisons and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Lindholme was carried out in October 2017. Inspectors found that there had been some improvement in safety at Lindholme. The Inspectorate was able to lift its previous assessment from 'poor' to 'not sufficiently good'. This improvement was because of changes in reception and first night arrangements, however, and was not a reflection of any decrease in the amount of violence or of the threat posed to the prison by illicit drugs. These remained severe.
28. Over two-thirds of prisoners said that it was very easy or quite easy to get illicit drugs, and almost half said this of alcohol. Over a quarter of prisoners said that they had developed a drug problem while at Lindholme, which was worse than at similar establishments. The availability and use of psychoactive substances (PS) remained a serious problem.
29. Inspectors noted the substance misuse meeting was only held once every two months and attendance was poor. There was no representation from the security department. There was no detailed supply reduction action plan and a lack of a coordinated approach between all key stakeholders. Although inspectors accepted that the lengthy perimeter of the prison was difficult to defend, they found there was a need for a comprehensive, coordinated drug supply reduction plan.

Independent Monitoring Board

30. 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 January 2019, the IMB reported that substance misuse continued to be a problem at the prison although

the prison had introduced several measures to tackle drugs. It also reported an increase in hooch-related incidents.

Previous deaths at HMP Lindholme

31. Mr Goodwin was the eleventh prisoner to die at Lindholme since February 2017. Of those deaths, four were self-inflicted, one was from natural causes and the other six were drug-related. Mr Goodwin's death was the fourth PS-related death in 2018.
32. In our investigation into the death of a prisoner in September 2018, we expressed concern at the ready availability of drugs at Lindholme and that the prisoner concerned was able to access PS without difficulty. In the same investigation, we expressed significant concern about the lack of urgency displayed by a member of staff in responding to a medical emergency. We made a recommendation to the governor to ensure that staff enter cells as quickly as possible in life-threatening situations.
33. In response to our recommendations of June 2019, the prison said that all staff have received training on the actions that must be taken when discovering an unresponsive prisoner. Staff were also made aware of local instructions about entering a cell during night state in life-threatening situations.

Psychoactive Substances (PS)

34. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a significant problem across the prison estate. They are difficult to detect and can affect people in several 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.
35. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
36. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Incentives and Earned Privileges (IEP) Scheme

37. Each prison has an Incentives and Earned Privileges scheme which aims to encourage and reward responsible behaviour, encourage sentenced prisoners to engage in activities designed to reduce the risk of re-offending and to help create a disciplined and safer environment for prisoners and staff. Under the scheme, prisoners can earn additional privileges such as extra visits, more time out of cell,

and the ability to earn more money in prison jobs and to wear their own clothes. There are three levels, basic, standard and enhanced.

Key Events

Background

38. On 18 May 2017, Mr Goodwin was sentenced to nine years in prison for the supply of drugs. He was sent to HMP Nottingham.
39. On 14 August, Mr Goodwin was transferred to HMP Lindholme.
40. During his initial health screening Mr Goodwin told a nurse that he did not drink alcohol and said that he did not want to be involved in alcohol treatment. Mr Goodwin said that he did not have any thoughts of suicide and self-harm and declined any referral to mental health services. Mr Goodwin said he had started to misuse drugs when he was 14 years old and was taking heroin daily in the community. He was on a methadone maintenance programme and was prescribed 30mls of methadone daily. On 10 October, this was increased to 40ml daily.
41. Mr Goodwin had had a severe infection of his appendix in 2013 and as a result, he had a colostomy bag (a pouch to collect his faeces). Healthcare staff regularly reviewed this.
42. In November, healthcare staff tested Mr Goodwin for drugs as part of his substance misuse programme. The test showed positive results for methadone and opiates.
43. In December, Mr Goodwin missed a substance misuse session with his substance misuse caseworker. Two days later, an officer noted that Mr Goodwin was under the influence of drugs during association on the wing. The officer recorded that this was not the first time that Mr Goodwin appeared to have taken drugs. She noted that staff were aware of the situation and intended to monitor Mr Goodwin over the weekend. Six days later, the same officer noted that Mr Goodwin again appeared to be under the influence of drugs.
44. Later that month, staff carried out an intelligence-led mandatory drug test (MDT) on Mr Goodwin. The MDT showed positive results for amphetamines, cannabis and PS. Mr Goodwin was found guilty of breaking Prison Rules at a disciplinary hearing a month later and an extra 18 days' imprisonment was added to his sentence. Staff also downgraded his IEP level to standard. This was the only MDT that Mr Goodwin was given at Lindholme.

2018

45. On 2 January 2018, Mr Goodwin met with the substance misuse officer and asked when he was to start his recovery program. The substance misuse officer asked Mr Goodwin to complete the programme's application form, which he had failed to provide. Two days later, Mr Goodwin's mental health was reviewed. Mr Goodwin had been asked to complete a sleep diary but had not done so. He reported however, that he was improving. Mr Goodwin agreed to complete the diary for the next session.
46. On 18 January, an officer reviewed Mr Goodwin who had completed his sleep diary. The officer found that Mr Goodwin had good sleeping habits and was well.

She agreed Mr Goodwin's discharge from mental health services after he had had a follow-up meeting a month later.

47. On 29 January, staff moved Mr Goodwin to J wing, a residential location. On 12 February, an officer recorded that Mr Goodwin was found to be under the influence of PS while at work. The officer issued him with a negative IEP warning. On 21 March, staff moved Mr Goodwin to A wing, the drug recovery wing.
48. On 14 April, a nurse reviewed Mr Goodwin's medication and agreed to increase his methadone dose to 50ml per day. Mr Goodwin remained on 50ml until he died.
49. On 11 August, an officer noted that Mr Goodwin and two other prisoners appeared under the influence of drugs. The officer submitted a security intelligence report. Eight days later, the same officer noted that Mr Goodwin appeared to be under the influence of PS at tea time. The officer also submitted a security intelligence report.
50. On 22 August 2018, another officer found one litre of hooch in Mr Goodwin's cell. She placed Mr Goodwin on a disciplinary charge and submitted an intelligence report.
51. On 30 August 2018, yet another officer found Mr Goodwin under the influence of drugs while at work. She made a note in Mr Goodwin's NOMIS record.
52. On 9 September, another officer noted that Mr Goodwin appeared to be under the influence of drugs. The officer also found a smoking device in his cell and submitted a security intelligence report. The next day Mr Goodwin had a disciplinary hearing and was found guilty of being in possession of unauthorised articles. He was punished with 14 days forfeiture of privileges and stoppage of earnings.
53. On 13 September, an officer submitted a security intelligence report after a prisoner said that PS was available on A wing. The prisoner said that he did not feel safe on the wing. He also said that officers were aware that PS was available but were not doing anything about it. The intelligence assessment noted that Mr Goodwin was one of the prisoners who had an extensive record suggesting that he was taking illicit drugs on the wing.
54. On 27 September, Mr Goodwin had a disciplinary hearing and was found guilty of being in possession of an unauthorised item. Mr Goodwin was punished with 14 days stoppage of earnings.
55. On 25 October, an officer found 20 litres of hooch in Mr Goodwin's cell. The officer downgraded Mr Goodwin's IEP level to basic. Staff recorded that this was not the first-time that staff had found hooch in Mr Goodwin's cell. They placed Mr Goodwin on a disciplinary charge but it does not appear that he was referred to the substance misuse team.
56. Two days later, Mr Goodwin had a disciplinary hearing and was found guilty. He was punished with 28 days forfeiture of privileges and stoppage of earnings. The

same day, staff moved Mr Goodwin to J wing. This was because the discovery of alcohol in his cell meant that he could not remain on the drug recovery wing.

57. On 13 November, a doctor reviewed Mr Goodwin. The doctor left Mr Goodwin's methadone dose at its existing level and planned for him to continue with substance misuse therapy.
58. On 23 November, staff upgraded Mr Goodwin's IEP level to standard and recorded that Mr Goodwin was behaving well. Staff did not submit any intelligence reports during this period.
59. From 28 November until his death, records show that healthcare staff dispensed 50 ml of methadone to Mr Goodwin every morning. He raised no concerns. On 6 December, Mr Goodwin was moved back to A wing. Staff did not make any relevant records in his NOMIS or raise any concerns over the following ten days.

Events of 16 December

60. On 16 December, at 10.34am, healthcare staff administered Mr Goodwin's dose of methadone.
61. At around 7.30pm, a fellow prisoner asked Mr Goodwin whether he wanted food as he had prepared a meal. Mr Goodwin told the prisoner that "he was going to have a smoke" then come back to eat. The prisoner told the investigator that he thought Mr Goodwin was going to smoke PS as he was a regular user. When Mr Goodwin did not return, the prisoner went to Mr Goodwin's cell to check on him. Mr Goodwin had locked himself in his cell. The prisoner opened the observation panel and saw that Mr Goodwin was sitting in his chair. The prisoner thought Mr Goodwin was sleeping. He tried to wake him but obtained no response and went away.
62. At around 8.30pm, the prisoner returned to Mr Goodwin's cell. He looked through the observation panel and saw that Mr Goodwin had fallen to the floor. The prisoner told the investigator that Mr Goodwin was "on his hands and knees". He started to bang on the door, which was locked, shouting Mr Goodwin's name but obtained no response. Other prisoners arrived.
63. At around 9.10pm, one of the prisoners who went to Mr Goodwin's door pressed his cell bell to alert staff and two minutes later an Operational Support Grade (OSG) officer went to Mr Goodwin's spur. She did not enter the spur but spoke to prisoners through the locked gate at the end of the spur. Two prisoners told OSG officer that Mr Goodwin was not responding and might not be breathing. The OSG officer said that she immediately radioed for staff assistance and went to the main office to get the key for Mr Goodwin's cell.
64. At around 9.16pm, she returned and passed Mr Goodwin's cell key through the locked gate to a prisoner. The prisoner opened Mr Goodwin's door, together with another prisoner, and they saw that Mr Goodwin had turned blue and was "slumped over the chair". They informed the OSG officer. The OSG officer radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing). One of the prisoners said that he checked for a pulse and started to do cardiopulmonary resuscitation (CPR).

65. Shortly afterwards, a Custodial Manager (CM), who is the Night Orderly Officer, arrived in response to the code blue. He entered the spur and went into Mr Goodwin's cell. The custodial manager said that he saw that Mr Goodwin was on the floor with his head "sort of half under the bed". He said that Mr Goodwin's legs were towards the door. The custodial manager said that he noticed Mr Goodwin was not lying on his back but on his side.
66. The custodial manager moved Mr Goodwin's legs and pulled him out from under the bed. Together with other staff, he turned him onto his back. The custodial manager said that Mr Goodwin's ears and fingers were blue but his face was red. He also said that he was warm to the touch. The custodial manager checked for a pulse but could not find one and started CPR. He also instructed an officer to fetch the defibrillator, which was brought immediately. The custodial manager thought that if Mr Goodwin was dead, he could not have been dead for long. While he was trying to resuscitate Mr Goodwin, the custodial manager noticed a vape and a smoking implement in the cell.
67. At 9.20pm, service records show that an ambulance was called. An ambulance arrived at the prison gate at around 9.34pm. When they arrived at Mr Goodwin's cell, paramedics continued with CPR but at 10.23pm, Mr Goodwin was pronounced dead.

Post-mortem report

68. The post-mortem examination found that Mr Goodwin died from mixed drug (PS and methadone) toxicity.
69. The toxicology analysis revealed no alcohol in his system. The methadone levels found were within the toxic range (although the toxicologist noted that this overlapped to some extent with the therapeutic range. Some codeine and loperamide (medicine to treat diarrhoea) were also found, together with gabapentin (an anticonvulsant which is often abused because of its euphoric effects) and thebaine (a stimulant). Apart from methadone, none of these drugs were prescribed to Mr Goodwin.
70. PS was also detected in Mr Goodwin's system, but not formally quantified. The pathologist noted that neurological and cardiac side-effects can readily occur when using PS.

Contact with Mr Goodwin's family

71. On 17 December, at 10.24am, an officer and the Governor went to Mr Goodwin's next of kin's house and broke the news of the death to her. They offered support.
72. Mr Goodwin's funeral took place on 16 January 2019. The prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

73. After Mr Goodwin's death, an officer in the prison 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.

74. The prison posted notices informing other prisoners of Goodwin's 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 Goodwin's death.

Findings

Clinical care and substance misuse services

75. The clinical reviewer concluded that the healthcare provided to Mr Goodwin was of a reasonable standard and was at least equivalent to that he would have received in the community.
76. At HMP Nottingham, Mr Goodwin was given methadone maintenance therapy which continued at Lindholme. In April 2018, healthcare staff agreed to increase his methadone dose from 30ml to 50ml. Mr Goodwin continued taking methadone daily until he died and did not raise any significant concerns. The clinical reviewer found that healthcare staff appropriately reviewed Mr Goodwin's medication, including his methadone, and made adequate referrals to the substance misuse team.
77. The substance misuse keyworker, regularly reviewed Mr Goodwin and engaged well with him. The substance misuse caseworker frequently discussed drug tolerances with Mr Goodwin, and the risks of overdose from taking illicit drugs. He also spoke to him about harm minimisation and the risks of poly-substance use.
78. The clinical reviewer concluded that Mr Goodwin continued to have appropriate input from the substance misuse, mental and physical healthcare teams. She commended the joint and interdisciplinary approach to Mr Goodwin's healthcare.

Drug strategy

79. Lindholme operates a 'zero-tolerance policy' on substance misuse and has a comprehensive drug strategy to tackle drug supply and demand. The strategy sets out measures to target drug trafficking using prisoner and visitor searches, the IEP scheme and the disciplinary process, including punitive sanctions such as adding days to prisoner's sentences.
80. One of the key objectives of the strategy is to reduce the availability of substances in the establishment. It acknowledges ongoing concerns about the inappropriate use of prescribed medication by prisoners and sets out interventions such as random checks on prisoners and their in-possession medication, paying particular attention to "tradable" medication. The drug strategy also recognises the significant risk that PS presents to the safety and security of the prison and sets out actions to combat this risk.
81. We recognise that Lindholme is actively trying to address the issue of drugs. The head of drugs strategy at the time of Mr Goodwin's death told the investigator that the prison is photocopying all incoming mail to ensure that PS-impregnated letters are not able to reach prisoners. She said that this has helped to reduce the number of PS incidents each month. The prison has also bought new scanning machines to test all mail and property entering the prison for illicit substances. It is also working to tackle staff corruption. Other measures taken include the introduction of zonal fencing in the prison's industrial area to reduce opportunities for those throwing drugs over the wall, and a more robust search process during visits.

PS and drug abuse

82. Mr Goodwin nevertheless managed to take drugs at Lindholme. In December 2017 Mr Goodwin tested positive for amphetamines, cannabis and PS. There was intelligence in September 2018 that Mr Goodwin was a regular user of drugs. Two prisoners told the investigator that Mr Goodwin frequently took PS on A wing in the days before his death.
83. Hours before Mr Goodwin was found dead, he told other prisoners that he was going to “have a smoke” of PS. Prisoners said this was a frequent occurrence.
84. We are concerned that, despite this, staff were unaware of Mr Goodwin’s PS use in the days leading up to his death. We are also concerned that Mr Goodwin was able to obtain and use drugs at Lindholme without difficulty. A prisoner told the investigator that PS was widely available on the wing. Another prisoner said that drugs are “all over the prison” and that it was easy to acquire vapes, PS and “whatever you want” on the spurs.
85. Although we recognise that staff had taken some actions in line with local policy to deal with Mr Goodwin’s drug abuse, these were clearly insufficient. In particular, we are concerned that Mr Goodwin was not given any intelligence-led MDTs in 2018 despite relevant drug-related intelligence being available. MDTs are key in reducing and deterring the demand for drugs and this is acknowledged by the prison’s drug strategy. In addition, Mr Goodwin was never subject to any targeted or intelligence-led searches. The lack of regular search and drug-testing was a missed opportunity to address Mr Goodwin’s continuing drug abuse.

Methadone

86. The toxicology analysis found levels of methadone within the toxic range in Mr Goodwin’s body and the post-mortem examination concluded that this contributed to his death. This suggests that Mr Goodwin had obtained additional methadone, over and above his prescription.
87. We are also concerned that Mr Goodwin continued to be prescribed methadone even though he was suspected to be using PS (which can be a lethal combination).

Hooch

88. On 25 October, staff found 20 litres of hooch in Mr Goodwin’s cell. It appears he was producing this for other prisoners. This was the second such find. We are astonished that Mr Goodwin was able to store such a large amount in his cell on the recovery wing and are very concerned that staff did not take the required actions to deal with this major finding.
89. A staff member told the investigator that staff should have referred the matter to the wing’s manager and to the substance misuse team. This was not done. Mr Goodwin had rejected alcohol treatment on his arrival at Lindholme. Staff therefore missed an opportunity on this occasion to review any alcohol interventions with Mr Goodwin. Crucially, there is no evidence that staff investigated this matter further in order to understand the scope of the hooch problem on the wing, or undertook a further search of Mr Goodwin’s cell.

90. The IMB reports that there has been an increase in hooch-related incidents at the prison as a result of a reduction in drug-trafficking routes, and that the number of hooch-related incidents increased from six in February 2018 to 36 in January 2019. We consider that the prison needs to raise its awareness of the potential risks of alcohol/hooch abuse and take robust action to tackle it.
91. In the light of Mr Goodwin's death, we continue to be concerned about the apparent ease with which prisoners are able to obtain and use illicit substances, including PS, at Lindholme. We make the following recommendation:

The Governor should ensure that:

- **effective supply and demand reduction actions, including regular intelligence-led MDTs, are properly implemented to help reduce the availability and abuse of drugs, including the trafficking of prescription medications;**
- **staff are vigilant to signs of drug and alcohol abuse and take appropriate action; and,**
- **the drug strategy includes clear actions to tackle the abuse of alcohol, including hooch.**

Emergency response

92. Prisoners on A wing are not locked in their cells at night and are free to access the communal landing on their eight-bed spur.
93. At night, the member of staff on duty in A wing remains on the corridor linking the eight spurs. They have a key in a sealed pouch to open the gate at the end of each spur to allow them to access the spurs in an emergency. Keys to the individual cells are kept in the staff office.
94. PSI 24/2011, which covers management and security at night, requires that all prisoners are locked in their cells during night state. Under normal circumstances, the night orderly officer must authorise the unlocking of a cell during night state, and no cell should be opened unless at least two or three members of staff are present. One of these should be the night orderly officer. However, the PSI also states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may go into the cell on his or her own. Night staff should not, however, take any actions that they feel would put themselves or others in unnecessary danger.
95. The PSI also says that before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of staff observes through the panel and any pre-existing knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation. This should form the basis of a decision as to whether to enter immediately or wait for assistance.

96. In line with the PSI, Lindholme's local security strategy says that the preservation of life overrides security concerns in the case of a life-threatening emergency. It says that a member of staff may enter a cell with caution, ensuring his or her own safety under these circumstances.
97. We have some concerns about the emergency response in this case. When a fellow prisoner saw Mr Goodwin unresponsive in his cell and pressed the cell bell, an OSG officer went to the locked gate at end of Mr Goodwin's spur and spoke to two prisoners through the gate. They told her that Mr Goodwin was unresponsive in his locked cell. The OSG officer did not open the gate and enter the spur to check on Mr Goodwin herself, but instead radioed for staff assistance and went to the staff office to get the key to Mr Goodwin's cell which she passed to a prisoner.
98. We do not criticise the OSG officer for not entering the spur on her own. There were potentially eight unlocked prisoners on the spur and this could have been a ploy to lure her onto the spur or to enable them to rush past her onto the corridor.
99. However, we are concerned that the OSG officer did not call a medical emergency code blue when she was told that Mr Goodwin was unresponsive. Although we appreciate that she had no way of knowing if Mr Goodwin was genuinely unresponsive, PSI 3/2013, *Medical Emergency Response Codes*, says that if staff are in any doubt about the nature of an injury, they must call an emergency code since "it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required". The calling of the code should trigger healthcare staff to attend with the appropriate equipment and the control room staff to call an ambulance immediately.
100. In this case, the OSG officer did not call a code blue until after she had fetched the cell key and given it to the prisoner and after the prisoner had entered the cell and confirmed that Mr Goodwin was unresponsive. This was four minutes after another prisoner first told her that Mr Goodwin was unresponsive and meant that there was a four-minute delay in calling an ambulance. We cannot say whether this affected the outcome for Mr Goodwin, but in a medical emergency every minute may make the difference between life and death.
101. We are also concerned that the OSG officer handed Mr Goodwin's cell key to another prisoner. The custodial manager told us that he had "no issue" with her doing that in an emergency and we agree that, in the circumstances it was not an unreasonable action. However, it is not clear whether this is the established procedure at Lindholme for potential medical emergencies. The spurred wings at Lindholme are not standard prison accommodation and we consider that there needs to be clear guidance to staff, particularly night staff, on what to do in a potential emergency situation.
102. We make the following recommendation:

The Governor should issue clear guidance to staff working on the spurred wings at night on:

- **the circumstances in which they should call a medical emergency code if they are not able to see the prisoner themselves; and**

- **the circumstances in which it might be appropriate to give cell keys to prisoners.**

Contact with Mr Goodwin's family

103. Prison Service Instruction 64/2011 requires that where possible, the family liaison officer and another member of staff should visit the next of kin in person and that this should be done quickly to ensure that the prisoner's family does not hear of the death by other means.
104. Although Mr Goodwin's next of kin lived only an hour from the prison, it took staff 12 hours after Mr Goodwin's death to inform his mother in person. The prison told the investigator that it was agreed that it was best to break the news at a reasonable time and when the governor was able to pass the news directly to the next of kin. The prison also said that it was deemed safer for staff to attend during daylight hours.
105. We consider that the prison could have made efforts to deliver the news earlier given that the next of kin's address was not a long distance from the prison. Alternatively, staff could have approached the police to check whether it was safe to attend the next of kin's premises at night. We make the following recommendation:

The Governor should ensure that, whenever possible, prison staff deliver the news of a prisoner's death without delay.

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