

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Nathan Nicholson a prisoner at HMP Hewell on 1 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 Nathan Nicholson died on 1 June 2018 of choking on vomit, caused by the combined effects of taking methadone and synthetic cannabinoids (known as PS) at HMP Hewell. Mr Nicholson was 30 years old. I offer my condolences to Mr Nicholson's family and friends.

Mr Nicholson had a long history of substance misuse and of being released and recalled to prison. Substance misuse issues were often part of the reason for his recall.

During 2018, Mr Nicholson told drugs workers that he was using psychoactive substances. They provided him with appropriate support but he said that he did not want to stop using.

We are satisfied that the prison provided Mr Nicholson with appropriate support for his drug misuse.

However, we identified some weaknesses in ensuring that relevant information was available to all staff about Mr Nicholson's ongoing drug abuse. This is an issue we have raised with Hewell before.

We are also concerned about the effectiveness of the portable suction units used in the emergency response and the fact that it took a long time for paramedics to reach Mr Nicholson.

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

Sue McAllister CB
Prisons and Probation Ombudsman

April 2019

Contents

Summary	1
The Investigation Process	3
Background Information	4
Key Events	6
Findings.....	9

Summary

Events

1. Mr Nathan Nicholson served four short prison sentences at Hewell over 2017 and early 2018. Prior to this he had been in prison numerous times before. He was often recalled to prison for breach of licence conditions, which involved his use of drugs. In December 2017, Mr Nicholson was found unconscious and taken to hospital where he required treatment in intensive care. It was suspected this was due to taking an illicit substance.
2. On 27 January 2018, Mr Nicholson was recalled to prison and underwent a detoxification programme and received regular support from a drugs worker. However, in March, April and May he told his drugs worker May that he continued to use psychoactive substances (PS) and he did not want to stop. She recorded this in his medical record but did not alert operational staff that he was using drugs.
3. On 11 May, Mr Nicholson was released but recalled back to Hewell on 28 May. He began another detoxification programme, was monitored during his stabilisation process and was allocated a drugs worker immediately.
4. On 1 June, at 5.28pm, prison officers found Mr Nicholson in his cell. He was slumped on a chair with vomit on his clothes. They called an emergency code and started cardiopulmonary resuscitation (CPR). The control room called an ambulance. Healthcare staff arrived and used suction to clear Mr Nicholson's airway but found it had little effect. Paramedics arrived at 5.42pm but did not reach Mr Nicholson until 5.50pm. They were able to clear Mr Nicholson's airway and provide oxygen. CPR was unsuccessful and Mr Nicholson was pronounced dead by a prison doctor at 6.19pm.

Findings

5. Hewell is aware of the very serious issues it faces with illicit drugs and is being proactive in trying to tackle them. The prison provided Mr Nicholson with appropriate support for his drug problems and the clinical reviewer found that Mr Nicholson received care that was equivalent to that which he could have expected to receive in the community.
6. Mr Nicholson told his drugs support worker that he was using PS and he did not want to stop despite understanding the consequences of use. The support worker only recorded this in his medical record and did not tell operational staff that he was using drugs. We are disappointed to make another recommendation to Hewell about the importance of reporting instances of substance misuse and repeat our previous recommendation.
7. The nurse who responded to the emergency when Mr Nicholson was found, said that the portable suction units available were not effective.
8. It took eight minutes for the paramedics to arrive at Mr Nicholson's cell after arriving at the prison which we consider to be too long.

Recommendations

- The Head of Healthcare should ensure that healthcare staff:
 - understand what medical information can be shared with operational staff; and
 - are aware of the importance and necessity recording and sharing incidents with prison staff and making security information reports when assessing and monitoring prisoners.
- The Head of Healthcare and Care UK should ensure that all healthcare staff have immediate access to efficient suction equipment in areas deemed appropriate and are trained in its use.
- The Governor should review the emergency response protocols to ensure that when an ambulance arrives at the prison there are no delays in paramedics getting to the scene.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Hewell informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Nicholson's prison and medical records.
11. The investigator interviewed seven members of staff at HMP Hewell on 10 July.
12. NHS England commissioned a clinical reviewer to review Mr Nicholson's clinical care at the prison. The clinical reviewer jointly interviewed staff with the investigator.
13. We informed HM Coroner for Worcester of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
14. The investigator Mr Nicholson's father and partner to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. They wanted to know if Mr Nicholson had been subject to any regular observations and what his cellmate knew about what had happened.
15. Mr Nicholson's family received a copy of the initial report. They did not make any comments.
16. The initial report was shared with HM Prison and probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan.

Background Information

HMP Hewell

17. HMP Hewell is an amalgamation of two prisons: the former HMP Blakenhurst and HMP Hewell Grange. The Hewell Grange site continues to operate as an open prison and the Blakenhurst site is a secure, local category B prison. Mr Nicholson was housed at the former Blakenhurst site, which comprises six houseblocks, holding around 1,100 men. Care UK provides health services at Hewell.

HM Inspectorate of Prisons

18. The most recent inspection of HMP Hewell was conducted in September 2016. Inspectors reported that the security was well-managed and generally proportionate but the availability of drugs remained very high. 60% of prisoners said that it was easy to obtain illegal drugs. Despite the prevalence of drugs, inspectors found that supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee.

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 September 2017, the IMB reported that staff and prisoners felt the prison was not safe. Incidents involving psychoactive substances (PS) were regularly reported in the daily briefings and the ready availability of these illicit substances continued to put staff and prisoners at risk.

Previous deaths at HMP Hewell

20. Mr Nicholson's is one of 16 deaths to take place at HMP Hewell since 2017. We have previously made a recommendation to Hewell about the importance of recording information related to suspicions about drug taking.

Psychoactive Substances (PS)

21. 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.
22. 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.

23. 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. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

24. Mr Nathan Nicholson served three short sentences at HMP Hewell in 2017 and had been in prison numerous times before. On 15 December, Mr Nicholson was found unconscious on the floor of his cell. He went to hospital and required ventilation in the intensive care unit. It was suspected that he had taken an illicit substance. Mr Nicholson recovered and was released from hospital. He was released from prison on 21 December 2017.

Recall to Hewell 27 January – 11 May 2018

25. On 27 January 2018, Mr Nicholson was recalled to HMP Hewell for a breach of licence conditions, a charge of common assault and for testing positive for class A drugs. On 16 March, he was sentenced to seven months imprisonment.
26. When he arrived at Hewell, Mr Nicholson denied that the incident that had occurred in December, prior to his release was due to using illicit drugs. He said it had been due to an accidental overdose of quetiapine (an antipsychotic drug). However, Mr Nicholson had not been prescribed this drug at the time of this incident. Mr Nicholson said that he used heroin and crack and drank heavily in the community. He began a detoxification programme.
27. On 8 February, Mr Nicholson told a drugs worker that he did not like attending a group work programme he had started in the community as it made him feel overwhelmed and he took an overdose of painkillers and quetiapine as a consequence. She offered him the support of one-to-one sessions, and discussed the dangers of overdoses. During February and March 2018, Mr Nicholson did not attend four appointments with a drugs worker.
28. On 28 March, Mr Nicholson admitted to using PS in prison during a one-to-one appointment with a drugs worker. He said that PS relieved his stress and he appeared to be agitated during the session. They discussed the dangers of using PS and his reasons for taking it. They agreed to meet fortnightly to discuss his drug use and she referred him for a doctor's appointment to help him consider alternatives in managing his stress.
29. On 6 April, a prison GP met with Mr Nicholson to discuss his mental health. Mr Nicholson said that he was anxious and not sleeping well. He prescribed Mr Nicholson a short course of sleeping tablets. On 9 April, a drugs worker followed up with Mr Nicholson who said he was still using PS. He said that he used a small amount and although he was aware of the risks of using it, he talked about using PS in positive terms.
30. During appointments with a drugs worker on 23 April and 9 May, Mr Nicholson admitted to using PS and said he did not want to stop. She reminded him of the dangers of using PS and later discussed his case at a multidisciplinary meeting. As his release was imminent, she discussed with Mr Nicholson the risks of using drugs in the community. She did not document any concerns about Mr Nicholson using PS in his prison record or convey these to security staff. Mr Nicholson was released from custody on 11 May.

Recall to Hewell - 28 May 2018

31. On 28 May 2018, Mr Nicholson was recalled to prison for using drugs while on licence. At reception, he said that he had been homeless on release and immediately relapsed into smoking crack and heroin and began drinking. A prison GP prescribed methadone and Mr Nicholson was allocated a substance misuse worker to see him as a priority.
32. Mr Nicholson said that he was in debt on the wing where prisoners requiring detoxification are located, so he was placed on a regular wing. A nurse saw Mr Nicholson during his stabilisation period. She told the investigator that Mr Nicholson continued to receive his detoxification medication as planned but she was unsure whether she could share information with prison officers about his risk of using drugs due to confidentiality issues.
33. On 30 and 31 May, a drugs worker attempted to meet Mr Nicholson but he was unavailable. She arranged to see him on 1 June.

1 June 2018

34. On the afternoon of 1 June, Mr Nicholson's cell was opened for association. He was seen walking around his wing. CCTV footage showed him and other prisoners going in and out of his cell and he was last seen going into his cell at 5.01pm.
35. Two officers were working on his wing and were on the landing. At around 5.28pm, both officers noticed a lot of prisoners gathered around Mr Nicholson's cell, and went to investigate. They found Mr Nicholson slumped in a chair with vomit on his clothing. One of the officers used her radio to call a code blue emergency. (This indicates a medical emergency when a prisoner is unconscious, not breathing or having breathing difficulties.) She checked Mr Nicholson's neck for a pulse but was unable to find one. She also lifted his top and could not see his chest moving. The other officer told the investigator that staff tried to rouse him but could not do so. She said that a prisoner helped them to lift Mr Nicholson onto the bed where officers started CPR. They told the prisoners to leave the cell. Mr Nicholson's bed was found to be too soft for CPR to be effective so he was moved onto the floor where staff continued with chest compressions.
36. A staff nurse was the first nurse to respond to the emergency call as she was working on the wing. She used her radio to request assistance from the emergency healthcare responder that day, the lead nurse. The lead nurse told the investigator that she could not hear the message clearly but was already on her way to the scene and had a defibrillator machine with her. The lead nurse assumed the staff nurse had brought an emergency bag with her but on arrival, found she had not done so due to having a back problem. The staff nurse asked an officer to collect the emergency bag which arrived within seconds.
37. The lead nurse assessed the scene and noted that Mr Nicholson had blue ear tips which she said she had not seen before. She used a hand held suction device to remove vomit from Mr Nicholson's throat and applied the defibrillator which advised for no shock to be given. Mr Nicholson continued to receive

oxygen and chest compressions and the lead nurse administered a dose of naloxone at 5.35pm. (This is medication designed to quickly reverse the effects of a drugs overdose.)

38. Mr Nicholson vomited a large amount and was moved onto his side where the vomit was cleared. The lead nurse administered a second dose of naloxone and a first shock from the defibrillator was administered at 5.46pm. Paramedics arrived at the establishment at 5.42pm and reached Mr Nicholson's cell at 5.50pm where they took over. She said that the paramedics were able to insert an airway into Mr Nicholson's throat and to remove a large amount of vomit obstructing his airway. She and the officers administering CPR left the cell. A GP pronounced Mr Nicholson dead at 6.19pm.

Contact with Mr Nicholson's family

39. A family liaison officer (FLO) was appointed shortly after Mr Nicholson died. Accompanied by the Deputy Governor, the FLO left Hewell at 7.45pm to break the news of Mr Nicholson's death to his partner. They attended the address on file and met with Mr Nicholson's grandmother. They all went on to a different address to find his partner. Both were very shocked and upset. The FLO arranged to make contact again the next day.
40. On 2 June, the FLO also spoke with Mr Nicholson's father and provided support in making funeral arrangements. The funeral took place on 15 June and the FLO and prison chaplain attended. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

41. After Mr Nicholson's death, an operational manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.
42. The prison posted notices informing other prisoners of Mr Nicholson's death, 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 Nicholson's death.

Post-mortem report

43. The post-mortem report concluded that the cause of Mr Nicholson's death was gastric aspiration (inhalation of vomit) due to the combined effects of methadone (which Mr Nicholson was prescribed) and synthetic cannabinoids (PS).

Findings

Availability of illicit substances

44. The toxicology report showed that Mr Nicholson had used PS and this contributed to his death. Mr Nicholson was a known drug user and admitted to using PS in prison. He was aware of the consequences of using PS but he spoke of taking it in positive terms and did not want to stop.
45. At Hewell's last HMIP inspection in August 2016, inspectors found that although drugs were widely available, supply reduction initiatives were developing well and there was effective joint working between security and other departments represented at the drug strategy committee. Hewell holds a weekly PS meeting and a monthly drug strategy meeting and has implemented a number of strategies to reduce the availability of illicit substances in the prison. These strategies include mandatory drug testing, the use of drug detection dogs and taking action to prevent drones from being able to access certain areas of the prison. The prison is also trialling a swab machine to check mail, an X-ray machine to scan parcels and a body scanner for all visitors.
46. We are satisfied that the prison is aware of the very serious issues it faces with illicit drugs and, while it has much still to do, it is being proactive in trying to tackle them. We therefore make no recommendation in this respect.

Substance misuse services

47. Mr Nicholson had long-term problems with drugs and alcohol. Substance misuse concerns were a factor in him being recalled to prison regularly. On arrival at Hewell, Mr Nicholson promptly began detox programmes and was stabilised on methadone. He also received good support from drugs workers who met with him regularly to address his substance misuse problems. We agree with the clinical reviewer that the healthcare staff at Hewell should be commended for the attention and support they gave to Mr Nicholson and the care he received was equivalent to that he could have expected to receive in the community.

Reporting instances of substance misuse

48. Mr Nicholson told his substance misuse worker that he was using PS in prison and there is no record of her sharing this information, other than recording it in his medical record. A nurse told the investigator that although Mr Nicholson was located on a general residential wing during his detoxification she was unsure if she was able to notify officers of his substance misuse issues due to confidentiality concerns.
49. The Head of Healthcare told the investigator that it was his expectation that all staff should report any instance of prisoners using drugs to the security department and in the prisoner's record. We are concerned that healthcare staff do not understand this position and we have previously made a recommendation to Hewell on this issue. We repeat our recommendation:

The Head of Healthcare should ensure that healthcare staff:

- **understand what medical information can be shared with operational staff; and**
- **are aware of the importance and necessity recording and sharing incidents with prison staff and making security information reports when assessing and monitoring prisoners.**

Emergency response

50. When Mr Nicholson was found unresponsive in his cell, officers acted quickly to call an emergency medical code and begin CPR. It was unfortunate that the emergency medical equipment was not brought to the scene immediately but we accept that this was not the responsibility of the nurse who first responded. We are satisfied that the emergency bag was brought to the scene promptly when requested.
51. When the lead nurse arrived at the scene, she assessed Mr Nicholson and told the investigator that although she used a portable suction device on his airway, this hand-held suction device had little effect. When the paramedics arrived, they removed more vomit with their own equipment and were able to insert an airway.
52. The clinical reviewer concluded that it is not possible to say whether better suction equipment would have affected the outcome for Mr Nicholson. The Head of Healthcare and lead nurse recognised that the suction equipment in the emergency bag was not ideal. The Head of Healthcare said that he had been investigating the possibility of portable suction devices on each wing, given that the incidences of vomiting following the use of PS was increasing. The clinical reviewer was satisfied that the suction equipment available at the time of Mr Nicholson's death was equivalent to what would be available in community facilities. However, she had made a recommendation about suction equipment which we repeat:

The Head of Healthcare and Care UK should ensure that all healthcare staff have immediate access to efficient suction equipment in areas deemed appropriate and are trained in its use.

53. Paramedics were called at 5.28pm, and arrived at the prison at 5.42pm. They reached Mr Nicholson's cell at 5.50pm. The operational manager was the duty governor at the time of the incident. She told the investigator that she told the gate staff that the ambulance should be allowed through as quickly as possible. She said that the time the ambulance took to enter the prison was reasonable, given the number of gates to drive through and the fact that the house block that Mr Nicholson was on was the furthest away from the gate. We do not agree. We are concerned that it took too long for the ambulance to get to the scene and we make the following recommendation:

The Governor should review the emergency response protocols to ensure that when an ambulance arrives at the prison there are no delays in paramedics getting to the scene.

**Prisons &
Probation**

Ombudsman
Independent Investigations