Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derick Mileham a prisoner at HMP Lindholme on 11 September 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Derick Mileham died at HMP Lindholme on 11 September 2018, when he inhaled his own vomit as a result of using a psychoactive substance (PS). He was 42 years old. I offer my condolences to Mr Mileham's family and friends.

Although staff at Lindholme gave Mr Mileham significant support for his PS use, he continued to use illicit drugs. I am satisfied that the care provided to Mr Mileham was equivalent to that which he could have expected to receive in the community.

I am, however, concerned that when an officer found Mr Mileham unresponsive in his cell, he did not react with urgency because he thought it was 'just another PS-related incident'. Mr Mileham's death was the third PS-related death at Lindholme in 2018, and illustrates very clearly that the effects of PS use can be life-threatening.

Although the prison has taken measures to tackle the supply and demand of drugs, it is clear that more needs to be done. I am concerned that PS are so readily available at Lindholme and I repeat my view that the Prison Service needs to issue advice and guidance to prisons on the best ways of combatting the serious problem of illicit drugs.

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
Prisons and Probation Ombudsman **May 2019**

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Summary

Events

1. On 6 January 2018, Mr Derick Mileham was remanded into prison custody and was sent to HMP Leeds. On 4 May, he was convicted of robbery and sentenced to five years and seven months imprisonment. On 29 May, Mr Mileham was transferred to HMP Lindholme, a prison he had been to previously.

2. Mr Mileham had a history of illicit drug use. When he was at Leeds, Mr Mileham was found to be under the influence of illicit substances, thought to be a psychoactive substance (PS), on four occasions. On at least one occasion, Mr Mileham had been given an injection of naloxone (used in an emergency to reverse the effects of opioid overdose).

3. While at Lindholme, Mr Mileham continued to use illicit substances and talked openly about his use when challenged. After each event, staff warned him of the dangers of PS use and referred him to the substance misuse team (SMT) for help and support, but Mr Mileham did not fully engage with the services offered to him.

4. On 11 September, a prisoner told an officer that Mr Mileham was unresponsive in his cell. When the officer went to the cell he saw Mr Mileham slumped in the far corner, unresponsive. The officer then walked to the wing office to ask his colleagues for help.

5. The officers immediately went to Mr Mileham's cell. When they entered the cell, they found Mr Mileham unresponsive with a large amount of vomit around him and in his mouth. They immediately radioed for medical assistance using a medical emergency code, and began cardiopulmonary resuscitation (CPR.)

6. Nursing staff attended, and a defibrillator was attached, but it indicated that there was no shockable rhythm. CPR continued. Nursing staff administered naloxone, but this had no effect. Paramedics arrived at approximately 4.35pm. At 4.41pm, the paramedics confirmed that Mr Mileham had died.

Findings

Clinical care

7. Mr Mileham had a history of using PS and other illicit drugs. He was offered support from the substance misuse team, but did not always engage with their services. Both healthcare and prison staff provided advice and guidance and reminded Mr Mileham of the potential dangers of PS use.

8. The clinical reviewer found that Mr Mileham was seen regularly by a mental health nurse who provided a good standard of care, dealing with both his mental health and providing advice on his illicit drug use.

9. We are satisfied that Mr Mileham was offered appropriate support and that staff responded appropriately when he was found under the influence of drugs. Unfortunately, he chose to continue using drugs, with fatal consequences.

10. We agree with the clinical reviewer that the care Mr Mileham received at Lindholme was equivalent to that which he could have expected to receive in the community.

Emergency Response

11. We are concerned that an officer showed no urgency and did not call an emergency medical code when he found Mr Mileham unresponsive in his cell. As a result, there was a delay before an ambulance was called and healthcare staff arrived. While we cannot say whether this delay affected the outcome for Mr Mileham, such delays could be critical in other cases.

12. We are concerned that the officer justified his lack of urgency on the grounds that he thought this was 'just another PS related incident'. It is important that staff understand that PS use can be life-threatening, and that early intervention is essential when a prisoner is found unconscious, whatever the cause.

13. We are satisfied, however, that once other officers attended the cell, they appropriately called an emergency code and an ambulance was called immediately.

Tackling illicit drugs

14. Toxicology tests show that Mr Mileham had used PS before his death. His was the third PS-related death at Lindholme in 2018.

15. We are very concerned at the ready availability of drugs at Lindholme and that Mr Mileham was apparently able to access PS without difficulty. More needs to be done to reduce both the supply and the demand for PS across the prison estate. We have already made a recommendation to this effect to the Chief Executive of HM Prison and Probation Service.

Recommendations

- The Governor should initiate an investigation into an Officer's actions on 11 September 2018.

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

    - the effects of PS use can be life-threatening;
    - staff should call an emergency medical code when they find a prisoner unresponsive, irrespective of what they consider to be the cause; and
    - staff should enter cells as quickly as possible in a life-threatening situation.

- The Governor should ensure that radios are in good working order.

- The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

The Investigation Process

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

17. The investigator obtained copies of relevant extracts from Mr Mileham's prison and medical records.

18. The investigator interviewed six members of staff and one prisoner at Lindholme on 29 October 2018.

19. NHS England commissioned a clinical reviewer to review Mr Mileham's clinical care at the prison. He attended all interviews with the investigator.

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 wrote to Mr Mileham's next of kin, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The next of kin did not raise any issues and said they did not want to receive a copy of our report.

Background Information

HMP Lindholme

22. 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.

23. 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 focuses on improving living conditions, preventing drugs from entering the establishment and enhancing the leadership and training available to staff.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Lindholme was in October 2017.

25. At the previous inspection in March 2016, inspectors had noted that the safety of the prison was significantly compromised by the ready availability of drugs and the consequent debt, bullying and violence.

26. The October 2017 inspection showed that there had been some improvement in safety at Lindholme, and HMIP were able to lift the assessment from 'poor' to 'not sufficiently good'. However, this improvement was because of changes in reception and first night arrangements, and was not a reflection of any decrease in the amount of violence or the threat posed to the prison by illicit drugs, which remained severe.

27. Over two-thirds of prisoners said that it was very easy or quite easy to get illicit drugs, and almost half to get alcohol. Over a quarter of prisoners said that they had developed a drug problem while at Lindholme, which was far worse than at similar establishments. The availability and use of psychoactive drugs remained a serious problem.

28. Inspectors noted the substance misuse meeting was only held once every two months and attendance was poor, with 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

29. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its most recent published annual report for the year ending 31 January 2018, the Board noted the very prevalent use of PS by prisoners remained a major challenge to the day-to-day running and security of the prison, and to the substance misuse team and healthcare generally. The Board found that staffing levels had increased, but experienced officers continued to leave or retire.

Previous deaths at HMP Lindholme

30. Mr Mileham's was the third PS-related death at Lindholme in 2018.

Assessment, Care in Custody and Teamwork

31. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of the ACCT is to try to determine the level of risk posed, the steps that staff might take to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be at irregular intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Staff should hold regular multidisciplinary reviews and should not close the ACCT plan until all the actions of the caremap are completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Psychoactive Substances (PS)

32. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a genuine 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.

33. 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.

34. 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.

Key Events

35. On 6 January 2018, Mr Derek Mileham was remanded to HMP Leeds, charged with robbery. On 4 May, he was found guilty and was sentenced to five years seven months imprisonment.

HMP Leeds

36. Mr Mileham had a history of illicit drug use in the community. At his reception screen at Leeds, he told staff that he had used heroin in the last three days and provided a urine sample that indicated that he had used opioids. Staff also recorded that Mr Mileham had epilepsy and asthma, and was prescribed carbamazepine, zonisamide, sodium valproate and levetiracetam (all for epilepsy) and a salbutamol inhaler for asthma.

37. Because of his substance misuse, Mr Mileham was prescribed methadone when he arrived at Leeds.

38. On four occasions, between January and March, Mr Mileham was found to be under the influence of illicit substances, thought to be PS. On each occasion, Mr Mileham received healthcare treatment and on at least one occasion he was given an injection of naloxone (used in emergency medicine to reverse the effects of opioid overdose). After each event, Mr Mileham was warned of the dangers of PS use and was referred to the substance misuse team (SMT) but he did not fully engage with the service.

39. On 28 April, staff started suicide and self-harm procedures, known as ACCT, after Mr Mileham told staff that he felt suicidal because of family issues. Mr Mileham continued to be monitored under ACCT procedures before being transferred to Lindholme. An ACCT review was completed before he left Leeds. During the review, Mr Mileham said that he was feeling happier after speaking to his family, and he denied any thoughts or intentions to self-harm. It was decided that the ACCT document should remain open until Mr Mileham had settled into Lindholme.

HMP Lindholme

40. On 29 May, Mr Mileham was transferred to HMP Lindholme. When he arrived, a nurse completed a health screen. She confirmed Mr Mileham's current medications and medical history. Mr Mileham reported no significant problems and declined a referral to the GP or the substance misuse service.

41. An ACCT review was completed, chaired by a Custodial Manager (CM). Mr Mileham said that a few weeks earlier, he had tried to take his life by hanging after receiving 'bad news' about his family. He said that he was now feeling much happier and had no thoughts of self-harm. He said that if his mood changed, he would speak to staff. Mr Mileham was on two observations per hour when he arrived at Lindholme and the CM recorded that he should remain on the same frequency until he had settled in, with a further review to take place on 30 May.

42. The CM recorded that Mr Mileham was known to him and other staff because he had been at Lindholme on previous occasions. He asked Mr Mileham about his health and recorded on the ACCT document that he was aware that Mr Mileham had undergone surgery on his brain some years earlier, resulting in epilepsy. Mr Mileham told him that his health was much better and he was happy to be at Lindholme.

43. A further ACCT review was carried out as planned on 30 May, chaired by a CM. He recorded that Mr Mileham seemed very low in mood. Despite his appearance, Mr Mileham said that he was alright, but he recorded that he was not convinced by the responses Mr Mileham was giving. A CM discussed Mr Mileham's care with staff from the safer custody team who were present, and it was agreed that a representative from the healthcare team would be asked to attend a review the following day. Observations remained at two per hour.

44. Later that day, Mr Mileham was seen by a nurse as he was thought to be under the influence of PS. Mr Mileham did not need any medical treatment but was reminded of the dangers of illicit drug use.

45. Regular ACCT reviews continued to be held, chaired by a CM and attended by a Mental Health Nurse. The Mental Health nurse told the investigator that reviews were attended by both herself and the CM to ensure continuity. The ACCT was closed on 19 July.

46. Soon after arriving at Lindholme, Mr Mileham stopped his methadone treatment and told the Mental Health nurse that he felt ready to stop rather than reducing his dose slowly. During her sessions with Mr Mileham, she said that although he spoke about recent family issues being a cause of his recent suicide attempt, he also said that his use of PS was a contributing factor. Despite this, Mr Mileham declined to engage with the substance misuse team (SMT).

47. Around 15 June, Mr Mileham began working in the gardens and reported to staff that he enjoyed the work. At the same time, an intelligence report was submitted by a member of staff raising concerns that another prisoner had taken medication prescribed for Mr Mileham. On 16 June, having been alerted that Mr Mileham might be concealing medication, nursing staff caught him concealing his carbamazepine when he went to collect his prescription. Because of his behaviour, a GP decided to withdraw his medication.

48. On 22 June, Mr Mileham was seen by a nurse from the prison's SMT. Mr Mileham told her that he did not feel the need to be seen or supported by the team because he was not using any illicit drugs and was no longer on a methadone programme. She told him that if he changed his mind he could contact the SMT at any time. She told Mr Mileham about tolerance levels and risk of overdose, and explained that due to his medical conditions, using illicit substances could prevent his prescribed medication from working.

49. On 26 June, Mr Mileham was removed from work and returned to his wing because staff believed that he was under the influence of PS. He was seen by healthcare staff but he did not need further medical intervention. The following evening, Mr Mileham was found under the influence of what was again believed

to be PS. He was seen by healthcare staff but he did not need treatment. On both occasions, Mr Mileham said that that he had not used PS.

50. On 29 June, Mr Mileham told a CM that he had used 'spice' (PS) after receiving a letter from his step-father describing how his mother had died. The CM spoke to Mr Mileham about numerous ways of coping with distress that did not involve the use of illicit drugs, including the use of prison Listeners, Samaritans or the chaplaincy team.

51. On 6 July, Mr Mileham was moved to G wing, a standard residential wing. The Mental Health nurse said that he appeared to settle and asked to share a cell with his nephew. Mr Mileham subsequently moved into a cell with his nephew and told the nurse and a CM that his nephew would be a positive influence on him as he was not using illicit drugs.

52. On 18 July, Mr Mileham told the prison's SMT nurse at a routine appointment that he had used heroin on 14 July. On 19 July, he told her that he was using heroin weekly and wanted to start methadone again. He agreed to participate in one-to-one sessions with a substance misuse worker.

53. On 23 July, a code blue medical emergency code (indicating that a prisoner is either unconscious or having difficulty breathing) was called. A nurse responded and found Mr Mileham unresponsive but breathing. She found no signs that he had suffered an epileptic seizure, so suspected PS use and an ambulance was called. Nursing staff gave Mr Mileham two doses of naloxone, the first having no effect. Mr Mileham regained consciousness after the second dose of naloxone and the ambulance was stood down. Mr Mileham was returned to the wing and medical staff advised officers to check on him and report any changes to healthcare staff. Mr Mileham lost his job in the gardens as a result.

54. Because of Mr Mileham's PS use, an automatic alert was sent to the SMT. On 24 July, a member from the SMT visited Mr Mileham on the wing to discuss his drug use the previous day. Mr Mileham said that he was using PS and he wanted to stop. She told Mr Mileham that he would be allocated a keyworker, and discussed the dangers of PS use. Mr Mileham said that he was aware of the dangers and was willing to work with the SMT to reduce his current use.

55. On 27 July, Mr Mileham went to collect his medication and was observed to be under the influence of an illicit substance. His speech was very slurred, his eyes were red and another prisoner was holding him up as he kept swaying. He denied he had taken anything. Mr Mileham was escorted back to his cell and was kept under observation by wing staff. The SMT was also informed.

56. On 30 July, a member of the SMT saw Mr Mileham. She recorded that Mr Mileham admitted to using PS and when asked how much he replied, 'As much as I can.' She discussed the potential dangers of using PS with Mr Mileham again, emphasising to him the unknown ingredients that could result in death. She recorded that Mr Mileham had showed that he understood these facts, and had told her that he had naloxone injections administered to him following two separate incidents. She told Mr Mileham that a member of the SMT would be his key worker and she would book a follow up appointment to review his care and complete an assessment.

57. On 9 August, a Mental Health nurse visited Mr Mileham on the wing. She recorded that although Mr Mileham did not present as being under the influence of drugs at that time, he admitted to using PS daily. she encouraged Mr Mileham to request a cell change as he told her that his nephew was using PS, despite having previously said that his nephew did not use illicit drugs and citing this as a positive reason for them to share. Mr Mileham said that his mood thoughts was low, but he could see how his PS use was influencing this. He denied any self-harm or suicide.

58. The Mental Health nurse saw Mr Mileham again on 15 August, and recorded that he was looking much better and had begun working in the lighting workshop. Mr Mileham told her that he had not used PS for three days and that his mood had already improved. She said that she recognised the positive steps Mr Mileham had made and gave him positive feedback but reiterated that the motivation and desire for change needed to come from him first. They discussed how Mr Mileham's PS use had been the start of the deterioration in both his behaviour and well-being, with debt, loss of employment and loss of privileges as a result. She recorded that Mr Mileham had now completed work on coping skills and the real benefits would only occur if he applied them.

59. The Mental Health nurse and Mr Mileham agreed to one further session, after which he would be discharged from her caseload as he was on the SMT caseload and awaiting an assessment. She explained to Mr Mileham that he could always re-refer himself to the mental health team if needed, following discussion with his SMT key worker.

60. On 18 August, an officer went to Mr Mileham's cell after he had pressed his cell bell. Mr Mileham threatened to harm himself because he had fallen out with his nephew. ACCT procedures were started.

61. At approximately 2.00pm that day, Mr Mileham's cell was searched following intelligence that his cellmate (nephew) had unauthorised articles in the cell. Various items were found during the search, including an improvised smoking device, a cigarette lighter, a makeshift shank (knife), and piece of wood with a shoe lace attached. Both Mr Mileham and his nephew were placed on report as neither admitted to owning the items.

62. Mr Mileham and his nephew were later separated. On 27 August, during an ACCT review, Mr Mileham said that he had not had any issues since his nephew had moved. He said that he was working and engaging with the SMT.

63. On 31 August, a Supervising Officer (SO) chaired an ACCT review attended by the Mental Health nurse. He recorded that Mr Mileham had interacted well and had said that he was 'very settled' on G wing. Mr Mileham said that he was happy working in the lighting workshop. The nurse said that Mr Mileham would be discharged from the care of the mental health team because he did not need any further intervention, but he knew how to access it if things changed.

64. Mr Mileham said that he had not used PS for over five weeks. A further referral had been made for Mr Mileham to be assessed by the SMT, but due to staffing levels and high work load the SMT had not arranged the assessment. A SO

recorded that Mr Mileham said that he had no thoughts of self-harm and the review agreed to close the ACCT.

65. On 3 September, an officer recorded that Mr Mileham was under the influence of what was believed to be PS. Staff were called to collect him from the workshops and bring him back to the wing. A code blue was also called. A nurse recorded that when she arrived at the workshop, Mr Mileham was sitting outside on a chair and appeared to be asleep. He did not require any treatment and was escorted back to the wing by officers. She told the officers that regular checks should be made for the next hour and to report to healthcare staff if further assessment was needed.

66. On 4 September, Mr Mileham was placed on the basic regime (which meant that he had less time out of his cell) because of his, but he kept his job. When Mr Mileham was told about the reduction to the basic regime, he smashed the glass observation panel of his cell door in protest.

67. On 10 September, Mr Mileham was again found to be under the influence of illicit substances in the workshops. He lost his job and was placed on report.

Events of 11 September

68. On 11 September, Mr Mileham remained on the wing during the day because he had lost his job. A prisoner and friend of Mr Mileham told the investigator that he saw Mr Mileham at lunchtime when he collected his meal. He said they spoke briefly and he thought that Mr Mileham was under the influence of something. He said that he did not tell staff because it was not unusual for Mr Mileham to use illicit substances.

69. Mr Mileham's friend said that his cell was unlocked at around 4.00pm so that he could help deliver canteen order sheets to each of the cells. He went to Mr Mileham's cell and looked in through the observation panel. He recalled that the glass had been smashed out. He saw Mr Mileham kneeling and 'hunched' over in the far-left hand corner of the cell. He called to Mr Mileham but got no response. He said that he was not initially concerned as Mr Mileham regularly used illicit drugs and he thought that perhaps he was 'on one'. He continued delivering the canteen sheets around the wing before returning to Mr Mileham's cell about twenty minutes later.

70. When Mr Mileham's friend looked into the cell, Mr Mileham was still in the same position and he still got no response when he called to him. He said that the cell smelt funny and 'airy'. He went downstairs and told an officer that he needed to check on Mr Mileham because he was unresponsive. The officer went upstairs to Mr Mileham's cell.

71. The officer said that when he initially looked into the cell through the observation panel, he did not immediately notice Mr Mileham, but then he saw him in the far left hand corner. He banged on the door and kicked it, but got no response.

72. CCTV footage shows the officer at Mr Mileham's door. He then walks away and back downstairs. The officer told the investigator that he did not want to go into the cell alone so he went to the wing office to ask for assistance.

73. An officer was in the wing office when the other officer came in and said that he could get no response from Mr Mileham. CCTV shows four members of staff – four officers - going onto the landing and straight to Mr Mileham's cell at approximately 4.20pm.

74. One of the officers said that he got to the door first and opened the observation panel. He said that he could not see Mr Mileham at first as the cell was quite dark. He entered the cell and found Mr Mileham unresponsive. Another officer called a code blue medical emergency over his radio at 4.21pm. An officer pulled Mr Mileham from the corner of the cell, turned him onto his back and began cardiopulmonary resuscitation (CPR). Mr Mileham had vomited a lot and further vomit was expelled on each chest compression.

75. A Clinical Matron responded, arriving at the cell at 4.25pm. She said that when she arrived, officers had already started CPR. She asked officers to collect the emergency bag from the wing treatment room while she assessed Mr Mileham's condition.

76. Mr Mileham was cold to touch but there were no signs of rigor mortis. The defibrillator was attached but it indicated that there was no shockable rhythm, and CPR continued. The matron inserted an airway into Mr Mileham's throat, but this was difficult due to vomit being expelled as chest compressions were applied.

77. A nurse arrived to support the matron and administered naloxone, but this had no effect. CPR continued, and paramedics arrived at approximately 4.35pm. At 4.41pm, the paramedics confirmed that Mr Mileham had died.

Contact with Mr Mileham's family

78. After Mr Mileham's death, the prison appointed a member of staff as a family liaison officer (FLO). The member of staff went to Mr Mileham's step-father's home and informed him of Mr Mileham's death.

79. The prison contributed to the funeral costs in line with national guidance.

Support for prisoners and staff

80. After Mr Mileham's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

81. The prison posted notices informing other prisoners of Mr Mileham'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 the death.

Post-mortem report

82. Toxicology tests showed that Mr Mileham had used PS before his death. The post-mortem gave Mr Mileham's cause of death as aspiration pneumonitis

(swelling of the lungs as a result of the airways being blocked by vomit) with PS toxicity (poisoning) as a contributory factor.

Findings

Clinical care

83. The clinical reviewer found that Mr Mileham was seen regularly by a Mental Health Nurse who provided a good standard of care, dealing with both his mental health issues and providing advice on his illicit drug use.

84. The clinical reviewer concluded that overall, the care Mr Mileham received at Lindholme was equivalent to that which he could have expected to receive in the community.

85. Mr Mileham had a history of using PS and spoke openly about doing so in his conversations with staff.

86. Mr Mileham was offered support from the SMT, although he did not always agree to engage, and also had regular engagement with the prison's mental health team, particularly the nurse. Both teams provided advice and support and warned him of the dangers of PS use. Prison staff also provided advice and guidance, reminding him of the potential dangers of PS use.

87. We are satisfied that Mr Mileham was offered appropriate support and that staff responded appropriately when he was found under the influence of drugs. Despite this, and despite being aware of the risks, he chose to continue using illicit drugs.

Emergency Response

88. PSI 03/2013, on medical emergency response codes, requires prisons to have a protocol on communicating the nature of a medical emergency and the type of equipment to take to the incident, and to ensure that there are no delays in calling an ambulance. It states that if a medical emergency code is radioed, an ambulance must be called immediately.

89. Lindholme's local policy requires that staff should radio a code blue emergency when a prisoner has difficulty breathing or is unconscious.

90. We are concerned that an officer showed a lack of urgency when he found Mr Mileham unresponsive in his cell. He did not call a code blue and instead walked to the wing office, which was along the landing and down the stairs, to alert other staff. As a result, there was a delay before healthcare staff were alerted and an ambulance was called.

91. The investigator asked the officer why he showed no urgency after seeing Mr Mileham slumped on the floor unresponsive, and why he walked away. He said that he did not attempt to call for assistance with his radio because it was not working. There were no other staff on the landing and he did not want to enter the cell alone so he went to the wing office to ask for assistance.

92. He said that he did not respond with any urgency because he thought it was 'just another PS related incident' which were commonplace, daily events on the wing. He also said that he did not think that Mr Mileham was at any risk.

93. We are very concerned by the officer's attitude and lack of urgency when he was faced with an unresponsive prisoner. Whatever the cause of Mr Mileham's collapse, he was unresponsive and needed urgent medical assistance. PS use may be common in prisons, but that does not mean that it is not dangerous – as Mr Mileham's death unfortunately illustrates. It is worrying that the officer had only been in post for six months, but in this brief time, had developed such an indifferent and matter of fact attitude towards PS use at Lindholme.

94. While we cannot say whether the delay affected the outcome for Mr Mileham, it is important that prison staff understand their roles in a medical emergency. Early intervention when someone is found unconscious or unresponsive can save their life. We make the following recommendations:

The Governor should initiate an investigation into the officer's actions on 11 September 2018.

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **the effects of PS use can be life-threatening;**
- **staff should call an emergency medical code when they find a prisoner unresponsive, irrespective of what they consider to be the cause; and**
- **staff should enter cells as quickly as possible in a life-threatening situation.**

The Governor should ensure that radios are in good working order.

Tackling illicit drug use

95. We are very concerned about the availability of drugs at Lindholme. We recognise that the prison is actively trying to combat the problem. In March 2018, the prison introduced machines to test all mail and property entering the prison for illicit substances. The process for searching both domestic and legal visitors has been reviewed, and several prisoners who were identified as being involved in the supply and distribution of illicit items, and/or violence and bullying associated with PS, have been transferred to other prisons. Increased searching, patrols and joint initiatives with local police have also been introduced.

96. With funding from the 10 Prisons Project, Lindholme also has plans for an additional body scanner in the visits area, additional mobile telephone blockers and detectors, an upgrade to CCTV, improvements to fencing to deter items being thrown over, and additional staffing to support the security function.

97. Lindholme is not alone in facing the problem of drugs – it is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, in the PPO's view there is now an urgent need for national guidance to prisons from HMPPS providing evidence-based advice on what works.

98. In a previous investigation, we recommended that the Chief Executive of HM Prison and Probation Service (HMPPS) should issue detailed national guidance on measures to reduce the supply and demand of drugs, including PS, in prisons. The Acting Ombudsman also wrote to the Prisons Minister raising her concerns about the high number of drug-related deaths she was investigating. The Chief Executive told us in response that HMPPS planned to issue a national drug strategy in the autumn of 2018. We are concerned that at the time of writing (January 2019), this strategy has still not been issued, although we have been told this will happen 'shortly'. We therefore repeat the following recommendation:

The Chief Executive of HMPPS should provide the Ombudsman with a revised date for issuing detailed national guidance on measures to reduce the supply and demand of drugs in prisons, and an assurance that this new date will be met.

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