Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Sean Gould a prisoner at HMP Wymott on 26 November 2017

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 Sean Gould died on 26 November 2017 of the toxic effects of synthetic cannabinoids while a prisoner at HMP Wymott. He was 31 years old. I offer my condolences to Mr Gould's family and friends.

I agree with the clinical reviewer that Mr Gould's healthcare was not equivalent to that which he could have expected to receive in the community. I am concerned that although Mr Gould had a history of using drugs, he was not referred to the substance misuse team at Wymott. When healthcare and prison staff suspected Mr Gould of diverting his medication and being under the influence of PS, they did not manage him in line with their local drugs strategy.

The prison will also need to reassess their substance misuse policy in line with the Prison Service's recently published Prison Drugs Strategy.

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 **September 2019**

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Summary

Events

1. On 27 January 2017, Mr Sean Gould was released on licence from HMP Risley. He was recalled to prison on 16 June and was sent to HMP Altcourse. On 8 September, Mr Gould was transferred to HMP Wymott.

2. Mr Gould had a history of history of substance misuse and mental ill health.

3. Mr Gould was suspected of diverting his prescribed medication on two occasions in October 2017 and was found under the influence of psychoactive substances (PS).

4. At 4.25pm on 26 November, an officer unlocked Mr Gould's cell door, found him unresponsive and radioed for healthcare assistance. Prison and healthcare staff arrived and started cardiopulmonary resuscitation. Paramedics arrived at 4.58pm and took Mr Gould to hospital where he died at 6.29pm.

5. Toxicology tests found that Mr Gould had used PS in the hours before his death.

Findings

6. We agree with the clinical reviewer that Mr Gould's clinical, substance misuse and mental health care fell below the standard he could have expected to receive in the community. Healthcare staff did not identify his substance misuse and mental health history and he did not have a second health screen.

7. Wymott has a substance misuse policy, with distinct processes for managing prisoners suspected of diverting their prescribed medication and using PS. Staff at Wymott did not comply with the procedures for managing a prisoner with a substance misuse history.

8. We are also concerned that Mr Gould did not receive the support of the substance misuse team before his death.

Recommendations

- The Head of Healthcare and the manager of the integrated mental health team should ensure that prisoners with mental health issues are referred promptly to the mental health team. Prisoners should receive appropriate reviews which are recorded and implemented.
- The Governor should ensure that prisoners suspected of diverting their medication and using psychoactive substances, or other illicit substances, are managed in line with the local drugs strategy.
- The Governor should ensure that the key drug issues at Wymott are identified and that the prison's local drugs strategy is revised by November 2019 to ensure that these key issues are being addressed.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with members of staff so that they are aware of the Ombudsman's findings.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Wymott 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 Gould's prison and medical records.

11. NHS England commissioned a clinical reviewer to review Mr Gould's clinical care at the prison. The investigator and clinical reviewer interviewed three members of staff at Wymott on 14 February 2019.

12. Our investigation was suspended while waiting for the cause of death and a suitable clinical reviewer. This has delayed the disclosure of the initial report.

13. We informed HM Coroner for Lancashire and Blackburn with Darwen of the investigation. He gave us the results of the post-mortem investigation. We have sent the coroner a copy of this report.

14. We wrote to Mr Gould's mother, his next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. She did not respond to our letter.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Wymott

16. HMP Wymott is a medium secure prison which holds over 1,100 adult men. Bridgewater Community NHS Trust and Greater Manchester Mental Health Trust provide healthcare services and Indigo Locum Agency provides GP services and out of hours care, including 24-hour nursing cover.

HM Inspectorate of Prisons

17. The most recent inspection of Wymott was in October 2016. Prisoners told inspectors that drugs were freely available and in the inspection survey, 63% of respondents said that it was easy to obtain illicit drugs, which was higher than at comparable prisons (43%).

18. Inspectors found that the prison's substance misuse strategy had improved, with effective communication and links between the safer prisons, security, offender management and drug strategy teams. This included a specific action plan to reduce the use of PS. Security and drug strategy meetings were well attended and detailed information-sharing took place between relevant departments.

19. Inspectors noted that all new arrivals were screened for substance misuse problems and about two thirds of prisoners had received support for drug and alcohol problems. Details in security information reports, prisoners' records and police reports were used to inform interventions. Drug testing after suspected use was too low, as testing staff were unavailable, but this had increased in line with requests from prison staff. Inspectors also noted that there was a broad mix of individual and group support activities, as well as good peer support. Dedicated nurses and visiting specialist substance misuse consultants assisted the drug services team; treatment regimes were flexible and reviewed regularly; and relationships between the psychosocial and clinical teams were excellent.

Independent Monitoring Board

20. 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 May 2018, the IMB reported that the standard of healthcare was poor and frequently fell below that which could be expected in the community. The Board also noted that increased bullying and debt had led to violence. The use of PS had resulted in injuries to prisoners and a high number of requests for ambulances, but improved strategies for dealing with such incidents had reduced the number of calls towards the end of the reporting year.

Previous deaths at HMP Wymott

21. Mr Gould was the fifteenth prisoner to die at Wymott since November 2015. Thirteen of the previous deaths were from natural causes, one was a non-natural death and one prisoner died from a drug overdose.

22. There have been six further deaths since Mr Gould's death. Two of those deaths were drug-related.

23. We have made previous recommendations about mental health care at the prison and the need to improve the local drugs strategy.

Psychoactive Substances (PS)

24. Psychoactive substances, previously known as 'legal highs' are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

25. 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.

26. 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. HMPPS continues to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

27. On 13 December 2012, Mr Sean Gould was sentenced to nine years and six months in prison for drugs related offences and was sent to HMP Holme House. Mr Gould spent time in several prisons before being released on licence from HMP Risley on 27 January 2017. On 16 June, Mr Gould was recalled to prison after he breached the conditions of his licence and was sent to HMP Altcourse. On 8 September, he was transferred to HMP Wymott.

Previous history

28. Mr Gould had a history of substance misuse and had used psychoactive substances (PS) and illicit subutex (an opioid which is used to treat opioid addiction) in prison. In October 2004, while at Wymott, he completed a detoxification using lofexidine to manage the physical symptoms of opioid withdrawal.

29. Mr Gould had a history of anxiety and depression. Prison staff monitored him under suicide and self-harm prevention procedures (known as ACCT) on four occasions at Wymott between January 2014 and October 2015 after he told staff he had taken more than the prescribed dose of his prescribed medication. In August 2017, at Altcourse, Mr Gould was suspected of using PS on three occasions and received support from the substance misuse team.

HMP Wymott

30. On 8 September 2017, a nurse from the prison's healthcare team, completed Mr Gould's reception health screen when he arrived at Wymott. She noted (incorrectly) that Mr Gould did not have a history of using illicit substances or self-harm. She assessed Mr Gould using the Clinical Opiate Withdrawal Scale (COWS, which assesses the severity of opiate withdrawal). Mr Gould's score was 0 (no signs of opiate withdrawal). She recorded his mood as normal and said he was suitable to have his prescribed medication in-possession. Mr Gould was prescribed dihydrocodeine (for pain relief), olanzapine (an anti-psychotic) and venlafaxine (an antidepressant). These are all highly tradeable in prison.

31. There is no evidence that Mr Gould received a secondary health screen or that the nurse referred Mr Gould to the prison's substance misuse team and mental health team.

32. On 14 September, a prison GP reviewed Mr Gould's medication and decided he was not suitable to have his medication in-possession. The prison GP re-prescribed Mr Gould's anti-psychotic and antidepressant medication. There is no evidence that the prison GP discussed Mr Gould's mental health or made a referral to the mental health team.

33. On 20 September, a workshop instructor expressed concerns to a healthcare administrator about Mr Gould's suitability to work in the workshop. The instructor said Mr Goud had told him he suffered from schizophrenia and that he appeared drunk. She made a referral to a prison GP and the mental health team. There is no evidence that Mr Gould saw a GP to discuss the instructor's concerns.

34. On 26 September, Mr Gould was discussed at a mental health team meeting and was allocated to the caseload of a mental health nurse. The mental health nurse noted that between January and June 2017 Mr Gould had been managed in the community under the NHS Care Programme Approach (CPA, used to coordinate the care of patients with mental health disorders). He made a referral to a psychiatrist. Mr Gould did not see a psychiatrist before he died. There is no evidence that the nurse created a mental health care plan.

35. On 10 October, Mr Gould approached a nurse from the prison's mental health team, in a prison corridor. Mr Gould said he was struggling and asked for methadone (used for the treatment of opiate addiction). The nurse noted that he would assess Mr Gould in a more convenient location. There is no evidence that the nurse saw Mr Gould before he died or that he made a referral to a prison GP.

36. On 11 October, a nurse from the prison's healthcare team, witnessed Mr Gould attempting to divert (hide) his dihydrocodeine at the medication hatch. (Prisoners must be seen to swallow their tablets before they leave the medication hatch to prevent them hiding their medication and either stockpiling it or trading it.) The nurse made a referral to a prison GP. There is no evidence that the nurse spoke to prison staff about Mr Gould's behaviour.

37. The same day, a prison GP reviewed Mr Gould's medication and noted he took dihydrocodeine for back pain. He stopped Mr Gould's dihydrocodeine prescription and noted he would plan other options to manage his condition.

38. On 27 October, a nurse from the prison's healthcare team witnessed Mr Gould attempting to divert his prescribed medication by concealing it in his right cheek. The nurse noted that healthcare staff would monitor Mr Gould closely. There is no evidence that the nurse made a referral to the substance misuse team or a prison GP or spoke to prison staff.

39. On 3 November, a prison GP saw Mr Gould and discussed the decision to stop prescribing dihydrocodeine. He noted that Mr Gould could move around without difficulty and that he had recently attempted to divert his medication. He noted that Mr Gould could not be trusted to take his medication without supervision.

40. On 6 November, prison officers reported that Mr Gould appeared to be under the influence of an illicit substance. A nurse from the prison's healthcare team, attended to assess Mr Gould but he refused an examination. Prison staff submitted an intelligence report. As a result, Mr Gould was dismissed from his job in the workshop. There is no evidence that the nurse made a referral to the substance misuse team.

41. On 22 November, Mr Gould asked to see a member of the mental health team. A nurse from the prison's mental health team, assessed Mr Gould and noted there was no evidence of psychosis and that Mr Gould appeared to have capacity to make decisions. Mr Gould said he was struggling after he was dismissed from work. She arranged for another nurse to see Mr Gould.

42. On 23 November, a nurse spoke to Mr Gould through his cell door hatch because the prison was locked down (meaning cells could only be opened in exceptional circumstances or emergencies). Mr Gould asked to be excused from

work due to anxiety. The nurse assessed Mr Gould as fit for work and arranged a new job for him in the contracts shop from 27 November.

Events of 26 November 2017

43. On 26 November 2017, Mr Gould had a visit from his parents. He returned to his wing at approximately 4.15pm and was locked in his cell. At approximately 4.25pm, an officer unlocked Mr Gould's cell to allow him to collect his prescribed medication from the medication hatch. The officer found Mr Gould collapsed on the floor. He called a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing problems) and the control room immediately called an ambulance.

44. Two officers arrived and checked Mr Gould's vital signs. At approximately 4.30pm, a nurse and a healthcare assistant (HCA) arrived and started cardiopulmonary resuscitation (CPR). The HCA inserted an airway and the nurse gave Mr Gould oxygen and attached a defibrillator (which is used to restore the normal rhythm of the heart).

45. Paramedics arrived at approximately 4.58pm and took control of Mr Gould's care. At 5.45pm, the ambulance took Mr Gould to hospital. Two officers accompanied Mr Gould and did not use restraints.

46. Mr Gould's condition continued to deteriorate and at 6.29pm, it was confirmed that Mr Gould had died.

Contact with Mr Gould's family

47. A prison officer was appointed as the family liaison officer (FLO) when Mr Gould was admitted to hospital. Mr Gould's father was listed as his next of kin.

48. At 5.30pm, the Deputy Governor telephoned Mr Gould's father and arranged to meet him at the hospital. Mr Gould's parents arrived at 7.20pm and the FLO told them Mr Gould had died. He offered his condolences and support.

49. The FLO remained in contact with Mr Gould's parents until his funeral on 15 December. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

50. After Mr Gould's death, a prison 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.

51. The prison posted notices informing other prisoners of Mr Gould'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 Gould's death.

Post-mortem report

52. The post-mortem report found that Mr Gould died from synthetic cannabinoid cardiotoxicity (the toxic effects of PS on the heart).

53. The toxicology examination found that Mr Gould had used a synthetic cannabinoid (a PS) in the hours before his death. Toxicological analysis of Mr Gould's blood also found the presence of venlafaxine (his prescribed antidepressant medication) and olanzapine (his prescribed anti-psychotic medication), as well as propranolol (an anti-anxiety medication which he had not been prescribed).

Findings

Clinical care

54. The clinical reviewer concluded that Mr Gould's healthcare was not equivalent to that which he could have expected to receive in the community.

55. The clinical reviewer considered that the standard of Mr Gould's reception health screen at Wymott was poor and that there were missed opportunities to make a prompt referral to the mental health team and the substance misuse team.

56. The Head of Healthcare told us that he had made changes to improve the reception health screen process since Mr Gould's death. Nurses are now unable to complete a prisoner's reception health screen independently until a Band 6 nurse is satisfied they are able to search the electronic medical records system for a prisoner's previous medical history and they understand how to make immediate referrals to secondary care.

57. The National Institute for Health and Care Excellence (NICE) recommends that prisoners should receive a second health screen within seven days of entering a prison to explore any health conditions and to ensure they receive appropriate treatment and support. Mr Gould did not receive a second health screen at Wymott.

58. The Head of Healthcare told us that second health screens often had a low uptake and a high number of prisoners did not attend their appointments. As an interim measure, the reception nurse now completes the first and second health screen together. However, the Head of Healthcare said that he intends to introduce a new procedure where nurses will complete the second health screen during a prisoner's induction period, thus enabling further exploration into issues identified when they entered the prison.

59. We acknowledge the efforts of healthcare to improve the reception screening process at Wymott and the clinical reviewer's opinion that the quality of care issues did not directly contribute to Mr Gould's death. However, we recommend that:

    The Head of Healthcare should ensure that prisoners receive a secondary health screen within seven days in accordance with NICE guidance.

Mental healthcare

60. Mr Gould had a history of mental health problems. The clinical reviewer found that nurses did not obtain an accurate summary of Mr Gould's mental health history and incorrectly recorded that he had no history of self-harm. Mr Gould had, in fact, been managed under the CPA approach in the community and had attended two counselling sessions with the mental health team at HMP Altcourse.

61. The clinical reviewer considered that there was a lack of continuity of Mr Gould's mental healthcare. Although Mr Gould was prescribed anti-psychotic medication, his diagnosis of psychosis was not confirmed, his mental health was not appropriately assessed and there was no documented mental healthcare plan. We recommend that:

The Head of Healthcare and the manager of the integrated mental health team should ensure that prisoners with mental health issues are referred promptly to the mental health team. Prisoners should receive appropriate reviews which are recorded and implemented.

Substance misuse

62. Mr Gould had a history of substance misuse. Despite concerns that he was attempting to divert his prescribed medication and staff suspicions that he was under the influence of PS, no one referred him to the substance misuse team. We recommend that:

The Governor should ensure that prisoners suspected of diverting their medication and using psychoactive substances, or other illicit substances, are managed in line with the local drugs strategy.

Reducing the supply of illicit substances

63. At the time of Mr Gould's death, Wymott had a substance misuse strategy which set out a number of measures to reduce the demand for and supply of illicit drugs. It said:

- any prisoner found to be under the influence of illicit substances or involved in their supply and distribution should be placed on the basic IEP level for 28 days;
- when prisoners had a disciplinary hearing and were suspected of PS use, they should be referred to the substance misuse team; and
- when healthcare staff attended a suspected PS incident, they should refer the prisoner to the substance misuse team to be seen within 48 hours.

None of this happened in Mr Gould's case.

64. In August 2018, Wymott's substance misuse strategy was reissued and added more robust processes, such as a protocol to manage prisoners suspected of using PS and a requirement for mandatory drug testing, including where prisoners were suspected of using PS.

65. Drug trafficking, drug taking and trading are serious problems across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problems by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works. We welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

66. In relation to reducing the supply of drugs, the new Prison Service strategy says:

> "Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This

resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

We, therefore, recommend:

The Governor should ensure that the key drug issues at Wymott are identified and that the prison's local drugs strategy is revised by November 2019, to ensure that these key issues are being addressed.

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