Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Dean Robinson a prisoner at HMP Liverpool 1 May 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*

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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 Robinson died on 1 May 2018, from the toxic effects of cocaine while a prisoner at HMP Liverpool. He had concealed for packages of cocaine internally and one ruptured, causing his death. Mr Robinson was 35 years old. I offer my condolences to Mr Robinson's family and friends.

I find that Mr Robinson's clinical and substance misuse care fell below the standard he could have expected to receive in the community, although I am satisfied that this did not contribute to his death.

I am also concerned that despite a comprehensive substance misuse strategy, Mr Robinson was able to traffic drugs into the prison. The prison will need to reassess their approach 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 **July 2019**

Contents

Summary 1

The Investigation Process 2

Background Information 3

Key Events 4

Findings 6

Summary

Events

1. On 1 February 2018, Mr Dean Robinson was released on licence from HMP Liverpool. He was recalled to prison on 30 April, and he was sent back to Liverpool.

2. Two officers searched Mr Robinson when he arrived at Liverpool and allocated him a single cell on the first night induction wing. Mr Robinson had a history of taking drugs and his urine tested positive for opiates. A prison GP diagnosed Mr Robinson with opioid drug type dependence and prescribed him methadone (a synthetic opioid used to treat heroin addiction).

3. At 8.07am on 1 May, a substance misuse worker assessed Mr Robinson and noted that he was showing mild signs of opiate withdrawal.

4. At approximately 9.15am, the prison chaplain found Mr Robinson unresponsive in his cell and called an emergency code. An ambulance was requested immediately and healthcare staff attended promptly. They performed cardiopulmonary resuscitation while awaiting the ambulance.

5. At 9.25am, the ambulance crew arrived and took over Mr Robinson's care. Mr Robinson continued to deteriorate and at 9.40pm, Mr Robinson died in hospital.

6. The post-mortem shows that Mr Robinson died from hypoxic-ischemic brain injury, cardiac arrest and cocaine toxicity. Mr Robinson had concealed four packages of cocaine internally, one of which had ruptured

Findings

7. We agree with the clinical reviewer that Mr Robinson's clinical and substance misuse care fell below the standard he could have expected to receive in the community. Healthcare staff did not use diagnostic tools appropriately and a GP did not prescribe Mr Robinson's opiate withdrawal medication in accordance with clinical guidelines. However, we note that the clinical reviewer is satisfied that the standard of care Mr Robinson received did not contribute to his death.

8. We are also concerned that despite the prison's comprehensive drug strategy, Mr Robinson was able to traffic drugs into Liverpool. Since Mr Robinson's death, the prison has introduced new procedures to improve substance misuse monitoring and to reduce incidents of prisoners bringing drugs into the prison.

Recommendations

- The Governor and Head of Healthcare should ensure that prisoners addicted to drugs are appropriately monitored and managed according to the relevant tools and guidelines.
- The Governor should ensure that the key drug issues at Liverpool 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 Investigation Process

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

10. The investigator visited HMP Liverpool on 15 May 2018. She obtained copies of relevant extracts from Mr Robinson's prison and medical records. Our investigation was suspended between 3 May and 9 November 2018, while we awaited the cause of death.

11. The investigator interviewed two members of staff at HMP Liverpool on 4 March and 27 March 2019.

12. NHS England commissioned a clinical reviewer to review Mr Robinson's clinical care at the prison.

13. We informed HM Coroner for Liverpool and Wirral Area of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. The investigator wrote to Mr Robinson's sister to explain the investigation and to ask if she had matters she wanted 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 pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Liverpool

16. HMP Liverpool is a local prison, serving the courts of Merseyside. It holds up to 994 men. Spectrum Community Health and Mersey Care Trust provide healthcare services. There is a 24-hour inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Liverpool was in September 2017. Inspectors reported that the prison failed to offer a safe, decent and purposeful environment. The inspection team could not recall having seen worse living conditions, which they described as squalid. Many cells were not fit to be used. Some had emergency cell bells that were not working but were still occupied, presenting a danger to prisoners. There were hundreds of unrepaired broken windows, with jagged glass left in the frames. Many toilets were filthy, blocked or leaking. There were infestations of cockroaches in some areas, broken furniture, graffiti, damp and dirt.

18. While primary health care had improved, staff shortages had a negative impact on all aspects of health services, especially mental healthcare. The integrated mental health and substance misuse team did not have capacity to meet the needs of a complex population.

19. Inspectors found that there did not appear to be effective leadership or sufficiently rigorous oversight to drive the prison forward in a meaningful way.

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 December 2017, the IMB was concerned about the increased use of psychoactive substances (PS) within the prison, which it noted was the drug of choice there.

21. The Board said that the healthcare team generally enjoyed good morale despite difficulties within the environment at Liverpool. However, they were concerned about long waiting lists for treatment. They were also concerned about the heavy workload experienced by mental health teams.

Previous deaths at HMP Liverpool

22. Mr Robinson was the tenth prisoner to die at HMP Liverpool since May 2016. Three prisoners died from natural causes and six were self-inflicted deaths. Six prisoners have died from natural causes since Mr Robinson's death, and there have been three self-inflicted deaths.

23. We have made a recommendation to Liverpool before about the need to manage prisoners addicted to drugs in accordance with relevant tools and guidelines.

Key Events

24. On 4 April 2017, Mr Dean Robinson was sentenced to one year and nine months in prison for possession of an offensive weapon and was sent to HMP Liverpool. On 1 February 2018, Mr Robinson was released on licence. On 30 April, Mr Robinson was recalled to prison after he breached the conditions of his licence and he was returned Liverpool.

25. Two prison officers searched Mr Robinson when he arrived at Liverpool. An officer completed Mr Robinson's cell sharing risk assessment and assessed him as high risk due to his previous custodial behaviour. A prison manager agreed with the officer's assessment that Mr Robinson was unsuitable to share a cell and he was allocated a single cell on A wing, the first night induction centre.

26. A nurse completed Mr Robinson's reception health screen. Mr Robinson had a history of using illicit substances and said he had used cocaine and heroin in the past month. The nurse assessed him using the National Early Warning Score (NEWS, which determines the degree of illness of a patient using six physiological findings and one observation) and noted his score of zero (no intervention required). Mr Robinson's blood pressure was 125/76mmHG (normal), his temperature was 36.2 degrees (normal) and his pulse was 74bpm (normal). The nurse made a referral to a prison GP and the Substance Misuse Service (SMS).

27. At 1.40pm, a substance misuse support worker assessed Mr Robinson. She noted that his urine tested positive for opiates and cocaine. Mr Robinson said he did not inject drugs and said he felt irritable and anxious. She assessed him using the Clinical Opiate Withdrawal Scale (COWS, which assesses the severity of opiate withdrawal). Mr Robinson's score was 18 (moderate signs of opiate withdrawal). Mr Robinson said he was under the care of a Community Drug Team but had not collected his methadone prescription for four weeks.

28. At 1.50pm, Mr Robinson saw a prison GP and told him he had smoked heroin and crack cocaine fifteen hours ago. He diagnosed him with opioid type drug dependence and prescribed 15ml of methadone. Mr Robinson was not monitored overnight.

29. At 8.07am on 1 May, a substance misuse worker assessed Mr Robinson on A wing. Mr Robinson's NEWS score was 2 (which indicates observations every 4-6 hours) and his COWS score was 5 (mild signs of opiate withdrawal). Mr Robinson's blood pressure was 163/105mmHG (high) and his pulse was 114bpm (fast). She did not record Mr Robinson's temperature and he was not prescribed his morning dose of methadone.

30. At approximately 9.15am, the prison chaplain went to Mr Robinson's cell to complete a routine welfare check. The prison chaplain saw Mr Robinson lying on his bed but he could not get a verbal response. He entered Mr Robinson's cell and radioed an emergency code blue (which indicates that a prisoner is unconscious or has breathing problems), and the control room immediately called an ambulance. Three nurses attended and started cardiopulmonary resuscitation (CPR). At 9.25am, the paramedics arrived and took control of Mr Robinson's care.

31. At 10.08am, the ambulance left the prison and took Mr Robinson to hospital. Two officers accompanied Mr Robinson and did not use restraints.

32. Mr Robinson continued to deteriorate and at 9.40pm, it was confirmed that Mr Robinson had died.

Contact with Mr Robinson's family

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

34. At 11.20am on 1 May, the FLO and a prison manager visited Mr Robinson's sister and told her that Mr Robinson was in hospital. The FLO arranged for Mr Robinson's sister to visit him in hospital and offered support. Mr Robinson's sister was present when he died on 1 May.

35. The FLO remained in contact with Mr Robinson' sister until his funeral on 22 May. The prison contributed to the funeral costs in line with national instructions.

Support for prisoners and staff

36. After Mr Robinson'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.

37. The prison posted notices informing other prisoners of Mr Robinson'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 Robinson's death.

Post-mortem report

38. The post-mortem report found that Mr Robinson died from hypoxic-ischemic brain injury, cardiac arrest and cocaine toxicity. The post-mortem examination found that Mr Robinson had four packages of cocaine in his intestinal tract, one of which had ruptured. Two packages were removed in hospital and two were removed during the post-mortem examination.

39. The toxicology examination showed significant ingestion of cocaine by Mr Robinson.

Findings

Clinical and substance misuse care

40. When Mr Robinson arrived at Liverpool, he told healthcare staff that he regularly used drugs and had not collected his medication in the community for four weeks. The clinical reviewer noted that *Spectrum Healthcare's reception prescribing policy* states that for patients who are not confirmed to be on a current opioid substitute, clinical intervention should be based on their COWS score. Patients who score more than 12 should be prescribed 10ml of methadone in reception and 20ml the next day. As Mr Robinson said he had not collected his methadone prescription for four weeks, this prescribing policy applied to him.

41. The clinical reviewer found that a prison GP did not consider Mr Robinson's COWS score of 18 when he prescribed Mr Robinson 15ml methadone and he did not prescribe Mr Robinson 20ml of methadone for the next morning. There was no evidence in Mr Robinson's medical record to explain why he had prescribed a methadone dose which was not in accordance with the healthcare provider's prescribing policy.

42. Mr Robinson was located on A wing, the first night induction wing. The clinical reviewer noted that the '*Drug Misuse and dependence: UK guidelines on clinical management*' recommends that drug withdrawal needs to be properly managed on the first night and any dependence disorder needs to be assessed and treated appropriately. Patients should be subject to enhanced observation over the first five days of methadone treatment, at least twice a day with unrestricted observation where possible.

43. The Head of Transformation at Spectrum told us that since Mr Robinson's death, Liverpool intends to introduce measures to ensure that detoxing prisoners are monitored overnight. In response to a Care Quality Commission (CQC) inspection report in January 2019, which said that overnight observations of detoxing prisoners were inconsistent, the prison plans to fit six cells on the induction wing (which is now located on B wing) with stabilisation doors. This allows healthcare staff to observe prisoners overnight without un-locking their cells.

44. In July 2019, the prison fitted 12 stabilisation doors to cells on A wing, the detoxification wing. We are satisfied that this measure ensures that healthcare staff are now able to monitor detoxing prisoners overnight.

45. We agree with the clinical reviewer that Mr Robinson was appropriately assessed for his drug addiction and placed under the supervision of the substance misuse team for close monitoring. However, the investigation found that healthcare staff did not monitor Mr Robinson overnight and did not use the NEWS scoring tool appropriately. Morning observations were not completed by a registered nurse in accordance with clinical guidelines.

46. The clinical reviewer concluded that Mr Robinson's clinical and substance misuse care was not equivalent to that which he could have expected to receive in the community.

47. However, we note the clinical reviewer's opinion that the standard of care Mr Robinson received during his short time at Liverpool did not contribute to his death and that the sudden deterioration in his condition was caused by the secreted drug packages in his bowel. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners addicted to drugs are appropriately monitored and managed according to the relevant tools and guidelines.

Reducing the supply of illicit substances

48. At the time of Mr Robinson's death, Liverpool had a drug strategy and policy in place to tackle illicit drug use and to reduce trafficking of drugs into the prison. There was no evidence or intelligence indicating that Mr Robinson was a user of illicit drugs in Liverpool before he was released on licence in February 2018.

49. *The National Security Framework - searching of the person,* says that male prisoners should be given a full search on arrival at the prison. If there are grounds to suspect that a male prisoner has an item hidden in the anal or genital area, a closer visual inspection must be undertaken as part of the full search.

50. The Head of Security told us that there was no police intelligence indicating that Mr Robinson had concealed drugs internally and two officers completed a full search in accordance with searching procedures.

51. The Head of Security said that since Mr Robinson's death, Liverpool has introduced measures to reduce the trafficking of drugs into the prison. Since June 2018, the security department has monitored prisoners who are released on licence and recalled to prison and those who regularly serve short-term sentences (since such prisoners may be deliberately returning to prison for short periods to earn money by smuggling drugs in). In situations where the police have provided intelligence indicating that a prisoner may have concealed drugs internally, the prisoner is sent to HMP Altcourse for a full body scan.

52. The Head of Security told the investigator that there was evidence to suggest that prisoners were more likely to conceal drugs before entering Liverpool because the prison did not have a full body scanner. He said that eight prisoners who were recently relocated to Altcourse because Liverpool had reached maximum capacity, had concealed drugs which were detected during a fully body scan.

53. Drug trafficking, drug taking and trading 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, 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.

54. 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 Liverpool 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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