Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr David McMullen a prisoner at HMP Garth on 30 October 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 David McMullen was found hanged in his cell at HMP Garth on 30 October 2018. He was 37 years old. I offer my condolences to Mr McMullen's family and friends.

Mr McMullen was being monitored under Prison Service suicide and self-harm prevention procedures (known as ACCT) when he died. We found some failings in the way the ACCT procedures were managed.

On the morning Mr McMullen was found hanged, there was a delay in staff entering his cell because the officer did not follow the correct procedure when he found that Mr McMullen had covered his observation panel. I cannot say whether the delay affected the eventual outcome.

Mr McMullen had a history of drug misuse, which continued in prison. He had used psychoactive substances (PS) before his death. I am concerned that drugs are readily available at Garth and the prison needs to do more to tackle the supply of and demand for 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 **June 2019**

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Summary

Events

1. Mr David McMullen, who was serving a nine-year sentence for attempted robbery, arrived at HMP Garth on 15 September 2016. In October, he was moved to the prison's Therapeutic Community (TC) for support with his substance misuse issues, but he continued to use illicit drugs, including psychoactive substances (PS).

2. Mr McMullen struggled with the death of his partner and mother and would sometimes self-harm. He was managed under suicide and self-harm prevention procedures (known as ACCT) on five occasions at Garth, including at the time of his death.

3. On the morning of 30 October 2018, an officer went to Mr McMullen's cell to carry out an ACCT check, but Mr McMullen had covered his observation panel. The officer could not get a response from him so continued with other ACCT checks. He then asked another officer to go to the cell with him. They still could not get a response and when they opened the cell door, they found Mr McMullen hanging from a television bracket by a ligature made from a bedsheet. Staff and paramedics tried to resuscitate Mr McMullen, but he was pronounced dead at 9.55am.

Findings

4. There were failings in the way the ACCT procedures were managed. Case reviews were not multidisciplinary and no one from the TC attended any of them. Staff carried out ACCT checks at mostly regular and, therefore, predictable times, which meant Mr McMullen could have anticipated when he would be checked. Also, the caremap part of the ACCT was not well managed.

5. The officer who went to check on Mr McMullen and found his observation panel covered, did not stay by the cell and call for assistance, in line with prison procedure. Instead, he carried on with his ACCT checks and then went to the office to ask for help. This caused a delay in finding Mr McMullen hanging and in starting resuscitation attempts. We cannot say whether the delay affected the eventual outcome.

6. We found that staff did not follow the prison's Substance Misuse Strategy when Mr McMullen was found to be under the influence of PS. They did not always submit an intelligence report and did not refer Mr McMullen to the Integrated Mental Health and Substance Misuse Service.

7. We are concerned about the easy availability of drugs at Garth. More needs to be done to reduce supply and demand.

Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:
    - ensure a member of healthcare staff attends the first case review and hold multidisciplinary case reviews thereafter, with input from relevant staff involved in the prisoner's care;
    - set caremap actions designed to reduce a prisoner's risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT; and
    - vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.
- The Governor should ensure that when staff find an observation panel covered and the prisoner fails to respond, they follow local instructions by remaining at the cell door and radioing for assistance. The Governor should consider how best to remind staff of these instructions and establish a way to monitor compliance.
- The Governor and Head of Healthcare should ensure that staff follow the prison's Substance Misuse Strategy by submitting intelligence reports when a prisoner is suspected of using illicit drugs, and referring the prisoner to the Integrated Mental Health and Substance Misuse Service when necessary.
- The Governor should ensure that the key drug issues at Garth are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

The Investigation Process

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

9. The investigator visited Garth on 6 November 2018. She obtained copies of relevant extracts from Mr McMullen's prison and medical records.

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

11. They interviewed six members of staff at Garth on 26 November. The investigator interviewed seven members of staff and a prisoner on 27 November.

12. We informed HM Coroner for Preston and West Lancashire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

13. One of the Ombudsman's family liaison officers contacted Mr McMullen's family, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.

14. We shared our initial report with the Prison Service. They found one factual inaccuracy which has been amended in paragraph 32.

15. We provided a copy of our initial report to Mr McMullen's mother. She did not comment on the report.

Background Information

HMP Garth

16. HMP Garth holds up to 846 men, many serving indeterminate sentences for public protection (IPP), life sentences, or other long sentences. Lancashire Care Foundation Trust provides health services, while NHS Greater Manchester Mental Health Trust provides the mental health team, which delivers an integrated clinical substance misuse and mental health service.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Garth was in January 2017. Inspectors found the prison had a major drug problem and that, despite good efforts to reduce supply and demand, the use of psychoactive substances (PS) was particularly problematic, as was the trading of prescribed medication. Inspectors found that the quality of assessment and suicide monitoring case management had improved. The report said that substance misuse services were good and the Therapeutic Community offered effective, in-depth support for drug or alcohol dependent prisoners.

Independent Monitoring Board

18. 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 30 November 2017, the IMB remained concerned about the increased use of illicit drugs, particularly PS, and the resulting increase in emergency calls for treatment.

Previous deaths at HMP Garth

19. Mr McMullen was the eighth prisoner to die at Garth since October 2016. Of the previous deaths, two were self-inflicted, one was drug-related and four were from natural causes. There have been five deaths since, four self-inflicted and one from natural causes. In two of the previous deaths, the prisoner had taken PS before they died and we made recommendations about reducing the availability of PS at Garth. We have also previously made a recommendation about ensuring staff follow the correct procedures when a prisoner covers his observation panel.

Assessment, Care in Custody and Teamwork

20. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of an ACCT is to try to determine the level of risk, how to reduce risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner’s main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

21. As part of the process a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the

caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, Management of prisoners at risk of harm to self, to others and from others.

Psychoactive Substances (PS)

22. 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.

23. 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.

24. HM Prison and Probation (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 NOMS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

25. On 19 December 2015, Mr David McMullen was remanded in custody, charged with attempted robbery, wounding with intent and possessing a bladed article, and sent to HMP Preston. On 23 June 2016, he was sentenced to nine years imprisonment.

26. Staff monitored Mr McMullen under suicide and self-harm prevention procedures (known as ACCT) between May and August 2016, after the death of his partner. Mr McMullen said that he had no reason to live anymore, was tearful and in a low mood, and made threats to self-harm. Staff noted that Mr McMullen seemed to be under the influence of an illicit substance when they started ACCT procedures.

27. Mr McMullen was moved to HMP Garth on 15 September 2016. Staff started ACCT procedures on 23 October because Mr McMullen felt he had nothing to live for. Mr McMullen told staff he wanted to be referred to the mental health team and to move into the prison's Therapeutic Community (TC). (The TC houses prisoners with substance misuse problems, and is an intense treatment and recovery unit. They run group sessions and allocate each prisoner a keyworker to work with the prisoner on drug rehabilitation.) Mr McMullen said he was constantly taking illicit drugs because he could not cope, and was concerned that he was to finish his methadone detoxification shortly.

28. Mr McMullen moved to the TC on 26 October, and staff stopped ACCT monitoring on 2 November after Mr McMullen said he was happy to have moved.

29. On 14 April 2017, Mr McMullen saw a prison GP. They discussed his anxiety, his partner who had died seven months earlier and his feelings about this mother's recent cancer diagnosis. He prescribed Mr McMullen medication for anxiety.

30. A mental health nurse saw Mr McMullen in the TC on 26 April. Staff from the TC were concerned about his low mood following the news that his mother had lung cancer. A drug worker started ACCT procedures.

31. Mr McMullen visited his mother in a hospice on 26 May, and she died three days later. Mr McMullen told staff he had no thoughts of suicide or self-harm, but said he used illicit drugs to cope. Staff stopped ACCT monitoring on 17 August.

32. Staff started ACCT procedures on 13 October after Mr McMullen told a TC worker, that if he could not sort his head out, he would end up killing himself. He said he had not used illicit drugs for a week, but she noted he appeared to be under the influence of drugs. Mr McMullen said he saw a bereavement counsellor weekly, which he found helpful. Staff stopped ACCT monitoring on 18 October. Because of his continued illicit drug use, Mr McMullen was transferred out of the TC.

33. An officer started ACCT procedures on 10 November, after Mr McMullen carved 'Satan' and 'evil' on his arms. Mr McMullen explained that he had lost both his parents and his partner recently. He said due to his lifestyle, he felt he would be better off dead. He said he could not forget how his mother looked when he saw

her in a hospice, spoke of his illicit drug use and wanted to see a doctor as he was complaining about stomach pains.

34. On 22 November, Mr McMullen self-harmed by cutting 'anti-Christ' on his arm. He said he felt alone, had given up, had fallen into debt and sold many of his possessions, and had written a suicide note. Staff placed him on constant watch which he remained on until 28 November, when he said the crisis, which he said was caused by over-using PS, had passed. Staff continued to monitor Mr McMullen under ACCT but reduced his observations.

35. On 14 December 2017, Mr McMullen was moved back to the TC. Staff stopped ACCT monitoring on 15 December. Mr McMullen told staff that he attributed his behaviour and thoughts to illicit drug use, had no thoughts of suicide or self-harm and was glad to have returned to the TC.

36. From February 2018 onwards, staff submitted several intelligence reports saying that Mr McMullen continued to use PS.

37. On 18 April, Mr McMullen attended a hospital appointment for hepatitis C, and on 1 June, he had an abdominal ultrasound as he was concerned about abdominal pains. (A further hospital appointment, scheduled for 23 October, was cancelled by the hospital.)

38. On 24 July, staff called a medical emergency code blue (used to indicate a prisoner is unconscious or having breathing difficulties) after finding Mr McMullen under the influence of PS. He refused to be assessed by healthcare staff. On 7 August, staff asked a nurse to visit Mr McMullen as they suspected he was under the influence of PS again.

39. On 8 October, a nurse assessed Mr McMullen. He had reported that his skin was yellow and that he was concerned about his kidneys, and said he was in pain. A doctor reviewed Mr McMullen's blood, liver function and blood sugar tests. They were all within normal range.

40. On 14 October, another nurse assessed Mr McMullen because he was worried he had something wrong with his kidneys. He appeared distressed and said he was in a lot of pain. He said he thought he had cancer and was dying. The nurse booked a blood test and added Mr McMullen to the doctor's list. She asked if he would like to see anyone from the mental health team, but he declined.

41. Later that day, Mr McMullen made cuts to his arm, writing 'death' and 'curse'. He told staff he had done so to distract him from his thoughts and he had no intention of taking his life. Staff started ACCT procedures and completed an immediate action plan which said Mr McMullen should remain in a single cell on the TC, staff should check him three times an hour and refer him to the mental health team.

42. During the ACCT assessment interview, Mr McMullen told an officer that he thought he was ill, that he was in pain, and might have organ failure like his mother had. He said this had played on his mind which is why he had cut the words into his arm. Mr McMullen said he felt cursed and that it was only a matter of time before the 'Grim Reaper' came for him. Mr McMullen said he had seen a

nurse twice, but felt fobbed off and wanted to see a doctor. He said that being on an ACCT would not save him and he would either hang himself or cut his wrists. The officer and Supervising Officer (SO) met with Mr McMullen later that afternoon for the first case review. They noted on the caremap that Mr McMullen had applied to see a doctor.

43. Staff held a second case review the next day. The SO was present with Mr McMullen and a nurse. Mr McMullen repeated his concern about his pain from the previous day, and said he ached all over. He said he had no thoughts of suicide or self-harm and that his actions the day before were to distract him from thinking about his mother. Staff assessed that Mr McMullen's level of risk had reduced and they lowered his observations from three times an hour to once an hour.

44. Staff scheduled a third case review for 22 October. Mr McMullen refused to attend, saying he did not want his review at that time, so he continued to be checked hourly and staff set another case review for 24 October.

45. Mr McMullen attended the third case review on 24 October, with a SO, a mental health nurse, and a chaplain. Mr McMullen said he was frustrated about the pain he felt and blamed it on years of drug use. He said, 'my head's gone', that he was sick of everybody and nobody did anything for him. He said he had two years left to serve and would struggle when he was released from prison. Mr McMullen said he had last used PS a week earlier. He said he felt anxious and paranoid, but had no thoughts of harming himself.

46. Mr McMullen wanted the ACCT monitoring to stop but staff were concerned about his attitude and how emotional he was, so continued to monitor him with the same level of observations. They scheduled the next case review for 31 October.

Events of 30 October 2018

47. On the morning of 30 October, staff put leaflets under every cell door in the TC informing prisoners that they would not be unlocked that day as their cells were due to be searched by a national drugs team.

48. At 8.00am on 30 October, an officer carried out welfare checks on the TC. He told the investigator he remembered seeing Mr McMullen lying on his bed asleep. He said he waited until he was satisfied he could see Mr McMullen moving, then carried on.

49. A prisoner in the cell next to Mr McMullen, said that at around 8.55am, Mr McMullen called to him to ask why they had not been unlocked. He told him it was because of a wing search.

50. An officer began his ACCT checks at 9.00am, and arrived at Mr McMullen's cell at 9.05am. He could not see into the cell as the observation panel was covered with toilet roll. CCTV shows the officer spent 33 seconds at Mr McMullen's door. In his statement, the officer said he called to Mr McMullen and banged on his door, but received no response. He said he went back to the office to get the help of another member of staff and carried out the other ACCT checks on the way. (The Officer said the same when interviewed by the investigator but he

later made an amendment to say he had made a mistake and he went straight to the office to ask for help without carrying out the other ACCT checks.)

51. The officer asked another officer, who was in the office in the TC, to check Mr McMullen with him. CCTV shows the other officer arrived at Mr McMullen's cell at 9.08am, followed by the first officer ten seconds later. He rattled the cell door and shouted for Mr McMullen to remove the toilet roll. The officer was concerned that they still got no response from Mr McMullen, which he thought was unusual, and felt something was wrong. The officer opened the cell door at 9.09am and saw Mr McMullen with a bedsheet around his neck, hanging from a television bracket. He immediately told the other officer to radio an emergency code blue, which he did at 9.11am, and the control room called an ambulance straightaway.

52. The officer used his anti-ligature knife to cut the ligature. He thought that Mr McMullen had already died, but he and the other officer started cardiopulmonary resuscitation (CPR). An officer took a defibrillator to the cell in response to the code blue call. It advised to continue CPR. Three nurses also responded and arrived at the cell three or four minutes after the code blue call. A nurse inserted an airway and staff took turns to administer chest compressions.

53. The paramedics arrived at 9.25am, followed by a senior paramedic ten minutes later, and an ambulance a minute later, at 9.36am. A prison doctor, arrived at 9.45am. Ten minutes later, at 9.55am, he pronounced Mr McMullen's death.

Contact with Mr McMullen's family

54. The prison's family liaison officer (FLO) broke the news of Mr McMullen's death to his brother, who was also at Garth. The Head of Chaplaincy telephoned HMP Preston, where another brother, was serving a prison sentence. Staff arranged a telephone conversation between the two brothers. A brother said he would like to let his sister know what had happened, so the FLO and a chaplain visited Mr McMullen's sister. The prison contributed to the cost of Mr McMullen's funeral, in line with national guidelines

Support for prisoners and staff

55. After Mr McMullen'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.

56. The prison posted notices informing other prisoners of Mr McMullen'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 McMullen's death.

Post-mortem report

57. Mr McMullen's post-mortem report concluded that Mr McMullen died from hanging. A toxicology test showed Mr McMullen had taken his prescribed

medication and PS before he died, although it was not possible to say when Mr McMullen had taken it.

Findings

Management of Mr McMullen's risk of suicide and self-harm

58. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, requires all staff who have contact with prisoners to be aware of the triggers and risk factors that might increase the risk of suicide and self-harm and take appropriate action. Mr McMullen was sentenced for violent offences, had a history of mental health problems and substance misuse, and of attempted suicide and self-harm. Mr McMullen's risk of suicide and self-harm was recognised on several occasions and he was appropriately monitored by the ACCT process.

59. An officer started Mr McMullen's last period of ACCT monitoring on 14 October 2018, as he was struggling to deal with his bereavements and had self-harmed. Mr McMullen was put on three observations an hour, which were carried out at regular and, therefore, predictable intervals, contrary to the guidance in PSI 64/2011.

60. Staff held the first case review on 15 October, with just a supervising officer and Mr McMullen, although an officer contributed beforehand. The PSI says that ACCT case reviews should be multidisciplinary and that a member of healthcare staff should be present at the first review. We are concerned that there were no other members of staff present at the first case review. No members of staff from the TC ever attended Mr McMullen's case reviews, or had any input into them. (The Head of Safer Custody told the investigator that following Mr McMullen's death, a member of TC staff is invited to every case review involving TC prisoners.)

61. The care map, which sets out the actions to be taken to reduce a prisoner's risk to himself, is a key part of ACCT procedures. Mr McMullen's caremap of 14 October 2018, had only two actions on it: for him to apply to see a doctor and to engage with the ACCT process. We consider the caremap was inadequate and that there were other actions that could have been added, such as further bereavement counselling or a mental health review. The caremap actions were both noted as completed on 24 October, despite staff not knowing whether Mr McMullen had seen a doctor.

62. The Head of Safer Custody at Garth told us that they had recognised that ACCT management needed to improve. Staff were receiving training and refresher training in ACCT management, and Garth had issued a staff information notice to remind staff that ACCT checks should be irregular and unpredictable. While we acknowledge that Garth has already taken steps to improve the ACCT process, we make the following recommendation:

    The Governor should ensure that staff manage prisoners at risk of suicide and self-harm in line with national guidelines. In particular, staff should:

    - **ensure a member of healthcare staff attends the first case review and hold multidisciplinary case reviews thereafter, with input from relevant staff involved in the prisoner's care;**

- **set caremap actions designed to reduce a prisoner's risk of suicide and self-harm, review them at each case review and complete them all before closing an ACCT; and**
- **vary the times of ACCT checks, while remaining within set observation periods, to avoid prisoners being able to predict when they will be checked.**

Emergency response

63. When an officer went to Mr McMullen's cell to carry out an ACCT check at 9.05am on 30 October, he found that McMullen had covered his observation panel. He could not get a response from him when he rattled the door and shouted to him. A staff information notice, issued in March 2018, says that if a prisoner's observation panel is covered and staff are unable to get a response from the prisoner, they should remain at the cell door and radio for assistance.

64. The officer did not stay outside McMullen's cell and radio for assistance. He went to the office to get help and asked another officer to return to Mr McMullen's cell with him. This caused a delay of a few minutes before staff entered the cell and tried to resuscitate Mr McMullen. Given that Mr McMullen's neighbour told the investigator that Mr McMullen was still alive at 8.55am, it is possible that the delay in entering his cell could have made a crucial difference to the outcome for Mr McMullen, although we cannot be sure. We make the following recommendation:

    The Governor should ensure that when staff find an observation panel covered and the prisoner fails to respond, they follow local instructions by remaining at the cell door and radioing for assistance. The Governor should consider how best to remind staff of these instructions and establish a way to monitor compliance.

Mental healthcare

65. The clinical reviewer noted that Mr McMullen received prompt mental health assessments, support and advice. This was particularly challenging as his presentation and mood fluctuated due to illicit drug use, which may have been difficult to distinguish from mental health issues. He also had regular psychological therapy sessions and mental health nurses had input into most of Mr McMullen's ACCT reviews.

66. The clinical reviewer concluded that Mr McMullen received good mental health care, equivalent to that he might have expected in the community.

Substance Misuse

67. Garth has an Integrated Substance Misuse Strategy, published in January 2018. Its aim is to reduce the supply of illegal substances and illicit drugs; provide effective advice, treatment and support and recovery opportunities for prisoners; encourage prisoners to abstain and recover; and to respond to local and national drug trends. Part of the strategy to reduce the supply of illicit drugs at Garth is for staff to submit intelligence reports if they suspect a prisoner to be involved in

the supply, distribution or misuse of illicit drugs. A minimum action is to refer the prisoner to the Integrated Mental Health and Substance Misuse Service.

68. The clinical reviewer noted that Mr McMullen was clearly struggling to stay off illicit drugs and continued to use them throughout his time in custody. Despite this, Mr McMullen remained on the TC, where prisoners were responsible for their own medication. Despite several entries in his prison records that staff suspected he was under the influence of PS, staff did not always submit an intelligence report, or refer him to the Integrated Mental Health and Substance Misuse Service. There is also evidence that Mr McMullen got into debt through trading drugs. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff follow the prison's Substance Misuse Strategy by submitting an intelligence report and referring the prisoner to the Integrated Mental Health and Substance Misuse Service whenever a prisoner is suspected of using illicit drugs.

69. At the time of Mr McMullen's death, the TC had a system for prisoners to keep their medication in a locker and to manage it themselves. This meant that no-one monitored how much of their medication prisoners were taking. After Mr McMullen died, staff discovered that he had taken too much of some of his prescribed medication, but not taken others, particularly propranolol for anxiety. The practice has changed – staff now monitor medication use in the TC and prisoners on ACCTs can no longer keep their medication in their possession.

Drug Strategy

70. It is clear that Mr McMullen was able to obtain illicit drugs at Garth. There is also evidence that Mr McMullen got into debt through trading drugs.

71. Garth is not alone in facing this problem – drug use 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, and 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.

72. 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 Garth are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Physical healthcare

73. Mr McMullen had hepatitis C, which staff managed well, although healthcare staff did not always record everything related to this condition in his clinical records. However, the clinical reviewer concludes that, generally, Mr McMullen was treated promptly and appropriately for his physical conditions and that healthcare was equivalent to that he could have expected in the community.

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