Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Richard Ormond a prisoner at HMP Long Lartin on 11 January 2019

## 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 Richard Ormond died on 11 January 2019, from the effects of psychoactive substances (PS), while a prisoner at HMP Long Lartin. He was 45 years old. I offer my condolences to Mr Ormond's family and friends.

I am satisfied that Mr Ormond's healthcare was at least equivalent to that he could have expected to receive in the community. Staff at Long Lartin fully assessed his needs and offered a high standard of clinical and psychosocial support to help him address his substance misuse.

However, I am concerned that in spite of a comprehensive substance misuse strategy with a clear focus on PS and robust supply prevention procedures, drugs are evidently available at Long Lartin. The prison will need to review 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** **September 2019**

## Contents

# Summary

## Events

1. On 8 April 2009, Mr Richard Ormond was convicted of murder and sentenced to life imprisonment.

2. Mr Ormond had a history of substance misuse. He was initially prescribed methadone to manage his dependence on opiates. However, he repeatedly used illicit drugs in prison, including psychoactive substances (PS), so his methadone was withdrawn in June 2018, for safety reasons.

3. Mr Ormond transferred prisons 18 times and moved to HMP Long Lartin on 12 July 2018. He received full health screens and a drug recovery worker carried out a detailed one to one induction, offering advice and help from the Inclusion substance misuse service. Within two weeks of his arrival, he had a comprehensive mental health assessment, which found no evidence of severe or enduring mental illness. (A psychiatric assessment on 15 November 2018 endorsed this.)

4. Mr Ormond was a prolific complainer, who was dissatisfied with the decisions of successive doctors not to prescribe controlled drugs. He had requested this for anxiety and hip pain, but doctors regarded it as drug seeking behaviour and noted that he had declined alternative pain relief.

5. In August 2018, Mr Ormond had a seizure due to suspected PS use. Mr Ormond attributed it to an anxiety attack and epilepsy. In September, there was further evidence of PS use. A senior mental health nurse conducted a joint assessment with a member of the substance misuse service and Mr Ormond was then reviewed monthly. He sometimes admitted regular use of PS, but at other times denied he had ever used drugs in prison.

6. At 4.35pm on 11 January 2019, Mr Ormond was found unresponsive in his cell. Prison nurses and officers performed cardiopulmonary resuscitation (CPR) and he was taken to hospital, where he was pronounced dead at 6.54pm.

## Findings

7. Long Lartin has robust security procedures and a good substance misuse strategy with clear processes for managing and supporting prisoners. However, this has not prevented seemingly easy access to illicit drugs and this has to be addressed.

8. Mr Ormond was actively supported by clinical and psychosocial staff to help address his substance misuse. Generally, he received good mental and physical healthcare, at least equivalent to that he could have expected to receive in the community.

9. The resuscitation attempts by healthcare and prison staff were prompt and efficient.

## Recommendation

- The Governor should identify and address the key weaknesses in reducing the supply of drugs and revise the Substance Intoxication Strategy in light of the findings.

# The Investigation Process

10. The initial investigator issued notices to staff and prisoners at HMP Long Lartin informing them of the investigation and asking anyone with relevant information to contact her.

11. The initial investigator obtained copies of relevant extracts from Mr Ormond's prison and medical records.

12. NHS England commissioned an independent clinical reviewer to review Mr Ormond's clinical care at the prison.

13. The initial investigator and the clinical reviewer jointly interviewed five members of staff at Long Lartin on 18 and 19 March.

14. We informed HM Coroner for Worcestershire of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

15. The investigation was suspended between 21 January and 27 February 2019, while waiting for the cause of death. A second investigator assisted with the latter stages of the investigation.

16. One of the Ombudsman's family liaison officers wrote to Mr Ormond's mother, his next of kin, to explain the investigation and to ask if there were any matters she wanted the investigation to consider. Mr Ormond's mother had several concerns. She said that Mr Ormond had asked to move, as his wing was 'rife with drugs' but this had been refused. She wanted to know whether staff had told Mr Ormond that his stepfather had died on 5 January, as this might have made him more susceptible to substance misuse as a source of comfort. She was also concerned that he might not have received appropriate treatment for his mental health.

17. Mr Ormond's father also wrote to the family liaison officer. He was concerned that prison dealers might have tampered with drugs given to Mr Ormond to use him as an example to others in debt.

18. We have addressed the issues raised by Mr Ormond's family that fall within our remit.

19. Mr Ormond's mother received a copy of the initial report. She made no comments.

20. We shared the initial report with HM Prison and Probation Service (HMPPS), and they found no factual inaccuracies. The HMPPS action plan has been annexed to this report.

# Background Information

## HMP Long Lartin

21. HMP Long Lartin is a high security prison in the Vale of Evesham, Worcestershire. It holds up to 609 men across five main wings and two support wings. All prisoners live in single cells. The healthcare contract is held by Care UK, with mental healthcare subcontracted to South Staffordshire and Shropshire NHS Foundation Trust Mental Health Team.

## HM Inspectorate of Prisons

22. The most recent inspection of HMP Long Lartin was in January 2018. Inspectors reported that the prison was well-controlled and most prisoners said they felt safe. Robust security procedures were in place to address a range of challenges and the problem of illicit drugs was less evident than at other prisons.

23. Inspectors found that there was a coherent prison-wide drug strategy and Inclusion, a drug, alcohol and psychological therapy service, delivered good integrated mental health and substance misuse treatment services. Its multidisciplinary model provided flexibility and a range of interventions, including specialist support for prisoners with complex mental health needs. All prisoners were seen on induction and given advice and the opportunity to access support. They could self-refer at any point during their stay, or be referred by prison staff after incidents such as positive drug tests. Inspectors noted detailed one-to-one work; appropriate coordination of care, with good care plans; and effective information sharing with other stakeholders, including the offender management unit and security.

24. Drug supply reduction was reasonably thorough and misuse had not generally destabilised the prison. Security intelligence reports were mostly of good quality and were processed and analysed quickly. However, the previous inspection (in October 2014) had found that drug testing facilities were unfit for purpose and this had not improved. In the inspection survey, 15% of prisoners said they had developed a drug problem since arriving at Long Lartin.

25. The prison had a full range of primary care services, long-term conditions were well managed and nurses liaised well with the mental health team, delivering a coordinated approach. All healthcare staff were trained to give intermediate life support and they responded promptly and efficiently to emergencies. Inspectors' concerns about resuscitation equipment were addressed by the prison during the inspection.

## Independent Monitoring Board

26. 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 January 2019, the IMB noted a high standard of care by staff at all levels. However, they reported that there had been significant staffing issues, owing to a high number of vacancies for nurses, with most posts covered by agency staff. There were also vacancies for

drug recovery workers and the Inclusion team had found difficulties in running support groups in the available facilities.

27. The Board noted that levels of violence had increased and described the volume of psychoactive substances within the establishment as 'unprecedented.'

## Previous deaths at HMP Long Lartin

28. Mr Ormond was the seventh prisoner to die at Long Lartin since January 2017 and there have been two subsequent deaths. Six of these deaths were self-inflicted, one was a homicide and one due to natural causes.

## Psychoactive Substances (PS)

29. Psychoactive substances (formerly known as 'new psychoactive substances' or '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.

30. 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.

31. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified psychoactive substances as part of established mandatory drugs testing arrangements.

# Key Events

32. On 8 April 2009, Mr Richard Ormond was convicted of murder and sentenced to life imprisonment, with a minimum term of 24 years (later reduced to 21 years). He was sent to HMP Bristol.

33. Mr Ormond had a history of substance misuse and used heroin, crack cocaine and cannabis. He had been prescribed methadone in the community and this was initially continued in prison.

34. On many occasions during his imprisonment, Mr Ormond was found with either drug paraphernalia, fermenting liquid, or under the influence of illicit substances. Security intelligence reports suggested that he was sometimes in considerable debt and that other prisoners might have used him as a 'spice pig' to test PS. Mr Ormond moved prisons 18 times. Some transfers were at his request due to debts. He was also violent to staff.

35. In January 2010, Mr Ormond told a mental health nurse that his community GP had diagnosed bipolar disorder, but he was unable to describe any symptoms. After a consultation with a psychiatrist, he was prescribed antipsychotic medication. (Subsequent consultations with several other psychiatrists generally found no symptoms suggestive of mental illness. In spite of this, the mental health team continued his medication and support.)

36. Mr Ormond underwent methadone detoxification in 2012. However, it was re-prescribed in October 2015, due to his persistent use of illicit Subutex (the brand name for buprenorphine, an opioid used to treat opioid addiction and chronic pain, which is highly tradable in prisons). He also admitted using heroin and cannabis. While receiving methadone in 2016 and 2017, Mr Ormond used illicit diazepam (a sedative used to treat conditions such as anxiety, alcohol withdrawal and seizures) and PS, daily. He said that he used drugs to block thoughts and feelings. As a result of his PS use, Mr Ormond was required to detoxify from pregabalin (which had been prescribed for anxiety but is also used to treat epilepsy and nerve pain. Pregabalin is also highly tradable in prisons and has recently been classified as a controlled drug).

37. Mr Ormond frequently complained. His complaints were mostly about healthcare (notably prison GPs' refusals to prescribe pregabalin and other medication), as well as perceived mistreatment and unfairness by prison staff.

38. On 3 May 2018, a urine test was positive for PS and Subutex. A substance misuse GP placed Mr Ormond on a rapid detoxification programme. Shortly afterwards, Mr Ormond told his drug recovery worker that he would agree to stop the methadone but would need medication for pain. On 7 June, after a further incident of PS use, Mr Ormond's methadone was stopped immediately, for his own safety (as mixing methadone with other drugs can lead to overdose, coma and death). He was again suspected of PS use on 16 June.

### Transfer to HMP Long Lartin

39. Mr Ormond transferred from HMP Hewell to HMP Long Lartin on 12 July 2018, for psychosocial substance misuse treatment. At an initial health screen with a

nurse, he said that he used PS and cannabis. The nurse recorded his history of opiate misuse and the potential for drug withdrawal; hepatitis C and the need for pain management. The nurse booked a secondary health screen and a GP appointment. She also referred Mr Ormond to the primary care mental health team, asking for an urgent review because of his extensive history. (Healthcare staff later created a chronic hepatitis C management plan to treat him.)

40. On 13 July, a nurse conducted a secondary health screen. In addition to the previous medical conditions recorded, Mr Ormond reported diagnoses of bipolar disorder and irritable bowel syndrome. He declined referrals to the smoking cessation service and the healthy lifestyle programme and the nurse gave him advice on the effects of smoking and alcohol on health.

41. The same day, a member of the psychosocial team held a detailed one to one induction. They discussed Mr Ormond's use of PS and other illicit substances and the help available from the Inclusion drug and alcohol service. Mr Ormond said he used PS daily, often mixed with fentanyl (a strong opiate painkiller, which is also used as a recreational drug) as well as cannabis, when available. He felt he had been treated unfairly when his pregabalin was stopped in September 2017.

42. The psychosocial team member advised Mr Ormond on harm minimisation, tolerance levels and the risks of overdose. He also spoke about debt and bullying relating to drug use and how PS can severely worsen mental health problems. Mr Ormond showed a good knowledge of the issues. He said that he had seen the effects of PS on himself and others, but intended to continue using it, as he no longer received medication and felt that PS was his only option. He was aware of the risks, including death and said he was "not bothered." In response to this, the psychosocial team member advised him of safer methods, such as taking less and using in groups to safeguard each other.

43. Mr Ormond and the psychosocial team member also discussed the dangers of illicit alcohol and the damage it can cause, including blindness. Mr Ormond admitted that he brewed alcohol to finance his drug use. He said that he had moved around prisons due to poor behaviour relating to his medication issues and would continue to self-medicate until he received the help that he believed he needed.

44. On 18 July, Mr Ormond had an appointment with a locum prison GP. He asked for pregabalin and buprenorphine (Subutex) patches for neurological damage from an abscess in his right leg. The GP noted his history of drug addiction and many previous medical entries indicating that this medication was unnecessary. He offered several alternative painkillers, but Mr Ormond declined them all and threatened to take legal action against every doctor that had seen him.

45. Mr Ormond then asked a nurse if he could see another GP. He said he had been offered nefopam (a painkiller for moderate pain) and amitriptyline (which treats mental disorders and neuropathic pain) but had declined as they "make you nuts." The nurse encouraged him to try the medication, but he refused and asked to be put back on the GP list. He commented that he would have to try more doctors at other prisons. In the evening, Mr Ormond threatened to assault

an officer and when questioned about this the next day, he said that it was because healthcare staff had not given him the medication he expected.

46. Over the next few days, Mr Ormond complained to several healthcare staff about his treatment. He was often hostile and abusive. Due to the frequency and volume of his complaints, he had been classified as a serial complainer, so there were restrictions on the number of formal complaints he could make each day.

47. On 25 July, Mr Ormond had a comprehensive mental health assessment with a senior mental health nurse and the psychosocial team member. Mr Ormond said that he had an anxiety disorder. He wanted pregabalin to be re-prescribed and to see a psychiatrist. He said he had not been using as much PS as he could not afford it but had taken some the previous day. They discussed his history of self-harm by cutting and Mr Ormond said it was "a means to an end" to get what he wanted. The nurse found no evidence of severe or enduring mental illness and noted that Mr Ormond needed further assessments to determine areas of need, care plans and whether he needed to see a psychiatrist. He agreed to this.

48. Mr Ormond continued to complain about his treatment. On 7 August, he had a meeting with an information officer. He spoke about his difficulties with pain management and claimed that Care UK had ignored specialist advice that he should be prescribed pregabalin. The information officer agreed to investigate the prescribing decisions to ensure they were safe and balanced and reassured him that healthcare staff acted in his best interests and would manage his pain appropriately and safely.

49. Mr Ormond's offender supervisor had an introductory meeting with Mr Ormond on 9 August and referred him to the psychology department for a full assessment.

50. At 12.14pm on 18 August, an officer found Mr Ormond slumped on the floor apparently fitting, and called a code blue medical emergency. (A code blue indicates that a prisoner has breathing difficulties, or is unresponsive.) A nurse examined him and he appeared to be under the influence of drugs. Mr Ormond denied using PS and said it was due to an anxiety attack. When the nurse reviewed him again later, he claimed it was an epileptic fit and said that he would continue to have fits until he was given medication. She checked his medical record and found no history of epilepsy.

51. After searching Mr Ormond's cell, the security team found a damaged kettle with the wire exposed (a method prisoners use to obtain a light to smoke drugs) and confiscated his vape device. They also scanned two pieces of paper on the itemiser drug detection machine, which tested positive for PS. In line with the prison's substance misuse policy, Mr Ormond was reported for disciplinary action and downgraded to the basic regime under the prison's incentives and earned privileges scheme (IEP) for a period of 28 days. When staff removed his TV, they noticed the power cable had been tampered with. Mr Ormond refused to sign a PS compact.

52. Two days after the incident, Mr Ormond made a formal complaint, stating that the episode had been a fit due to the lack of pregabalin or any medication for bipolar and other mental health conditions. A suspicion drug test taken on 20 August

was found to be negative on 4 September and Mr Ormond was reinstated to the standard level of IEP.

53. On 8 September, following an adjudication hearing, Mr Ormond was restrained after refusing to return to his cell. He was taken to the segregation unit and reduced to 'basic.' At the end of his 14-day period in the segregation unit, he refused to return to his wing (and remained in the unit until 25 October). Healthcare staff reviewed him daily and he continued to complain about not receiving pregabalin.

54. On 13 September, a senior mental health nurse and the psychosocial team member held a 45-minute review to discuss Mr Ormond's Inclusion needs. Mr Ormond said he had not used illicit drugs for months and wanted appropriate treatment for his mental health conditions. They agreed to a psychiatric assessment to move forward and enable the Inclusion team to work with Mr Ormond and to assess whether pregabalin should be re-prescribed. Mr Ormond accepted some Inclusion workbooks to refresh his memory. (He did not complete them.) The nurse told the investigator that they did not believe that he had stopped using PS.

55. Mr Ormond refused to comply with the unlock procedure on 17 September and ran at an officer with clenched fists. He sustained a nosebleed, bruising and swelling during control and restraint procedures and was placed on two-hourly observations, in line with the head injury policy. (Mr Ormond later made a formal complaint that staff had assaulted him and his nose had been broken.)

56. On 22 September, Mr Ormond and a prisoner in a neighbouring cell were caught using a line to send items to each other. Staff confiscated the line and sent it to the security department for analysis. Three days later, Mr Ormond and the same prisoner were suspected of smoking PS because of their demeanour and the smell of burning from the latter's cell.

57. On 24 October, a prison GP reviewed Mr Ormond, who complained of hip pain and said that pregabalin and buprenorphine were the only medications that helped. The GP prescribed a low dose of gabapentin (a medication primarily used for epilepsy and nerve pain.)

58. The same day, the psychosocial team member had a 15-minute talk with Mr Ormond. He tried motivational techniques to persuade him of the benefits of returning to a wing, but Mr Ormond insisted that he would not move. They had a longer discussion on 25 October. Mr Ormond said that completing the workbooks was not a priority and he found it difficult to concentrate. He admitted that he had used some PS, but also believed he was 'over it.' The psychosocial team member noted his lack of motivation to engage and that he was finding it difficult to settle at Long Lartin.

59. A random drug test taken on 27 October was noted as negative on 1 November.

60. On 7 November, Mr Ormond asked a prison GP to increase the dosage of gabapentin. The GP felt it was drug seeking behaviour and refused, so Mr Ormond walked out of the consultation. (On 28 December, Mr Ormond repeated the request and the GP again said no.)

61. On 15 November, a psychiatrist and a mental health nurse assessed Mr Ormond. Mr Ormond felt that he was considered a control issue due to his dependence on substances. He wanted to see a psychiatrist, so that he could be seen to be willing to engage with treatment and said that he had not used PS in prison. He asked for a letter stating he had no mental illness and left abruptly. The psychiatrist noted that although he had not fully completed the assessment, there was no evidence of severe mental illness and it was likely that Mr Ormond had antisocial personality disorder with narcissistic traits. He discharged Mr Ormond from any psychiatric follow up.

62. Later that day, a prison GP noted that it was inappropriate to prescribe gabapentin for a low-grade osteoarthritis hip pain. He wrote to Mr Ormond to explain this and told him that he was not prepared to renew the prescription.

63. The psychosocial team member had another session with Mr Ormond on 27 November. At that time, Mr Ormond was employed as a support worker and used the gym. This seemed to have helped him as he said he felt calmer and more settled. They discussed the allegation that he had been found with PS. Mr Ormond replied that he had been "stitched up", that he did not use PS and the results of the analysis of the sample had yet to be received. He gave some insight into links between his childhood and substance misuse. He wanted to be supported by Inclusion and thought he might have the best chance at Long Lartin. He agreed to monthly sessions to explore his substance misuse and they met again on 21 December.

64. On 27 December, Mr Ormond asked to move to Perrie wing as he said he was under threat, but he would not give the names or any details of those involved. Staff were, therefore, unable to investigate or resolve the problems, but they monitored Mr Ormond for signs of bullying under the violence reduction strategy. Several entries in his personal record noted that there was no evidence of bullying or intimidation.

65. On 1 January, it was noted that Mr Ormond did not associate with anyone and kept to himself. On 4 January, he moved to F wing and he believed this had solved his problems. Staff told him that he should report any further incidents to them so that appropriate support measures could be put in place.

66. On 7 January, Mr Ormond's sister informed the prison that Mr Ormond's stepfather had died. (Mr Ormond was aware that he had a terminal illness.) Prison staff complied with his family's request not to tell Mr Ormond, so that they could tell him personally during a visit booked for 12 January.

67. At around 4.35pm on 11 January, an officer was locking cells for the evening. When he looked through the observation panel of Mr Ormond's cell, he could not see him. He then looked round the door and saw Mr Ormond curled up on the floor next to his bed. He did not respond when the officer called out to him. His face was blue and there was vomit and blood around his nose and mouth. As the officer had earlier been assigned to canteen duties, he did not have a radio, so he called out to another officer who was on the other side of the landing. The officer radioed a code blue at 4.36pm and the control room called an ambulance. The officers tried to find a pulse and noted that Mr Ormond's arm and wrist were warm. An officer began CPR.

68. The first response nurse went directly to the cell, while another nurse collected the emergency bag and defibrillator. The first response nurse found no pulse and asked for all healthcare staff to attend. She applied the defibrillator, while the officers continued CPR. The nurses then gave Mr Ormond oxygen and continued ventilation and chest compressions in rotation with other staff. The defibrillator gave one shock. Around 15 minutes into the CPR process, a prisoner told a custodial manager that Mr Ormond might have taken PS.

69. The first ambulance arrived at 5.09pm. The paramedics requested additional equipment and two more ambulances arrived by 5.21pm. The nurses continued CPR while the paramedics injected adrenalin and anti-narcotic medication and they did not stop until Mr Ormond was in the ambulance. The paramedics took Mr Ormond to Worcestershire Royal Hospital at 6.15pm. They arrived at 6.45pm and the hospital recorded that Mr Ormond had died at 6.54pm.

70. Prison staff found that the wires for Mr Ormond's electrical items were exposed and had been tampered with.

### Contact with Mr Ormond's family

71. A Supervising Officer (SO) was appointed as the prison's family liaison officer (FLO). Immediately after the ambulance left the prison, the FLO telephoned to inform Mr Ormond's mother and sister that Mr Ormond was gravely ill and they should go to the hospital. The FLO went to support them at the hospital once he found out that Mr Ormond had died. He kept in touch with them and provided further information over the following weeks.

72. Mr Ormond's funeral was held on 7 February. In line with national policy, the prison contributed to the funeral expenses.

### Support for prisoners and staff

73. Shortly after Mr Ormond was taken to hospital, 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 of the staff care team.

74. The prison posted notices informing staff and other prisoners of Mr Ormond'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 Ormond's death.

### Post-mortem report

75. The post-mortem report concluded that Mr Ormond's death was due to synthetic cannabinoid (PS) toxicity.

76. The pathologist noted that there was no evidence that natural disease had caused or contributed to Mr Ormond's death and traces of synthetic cannabinoids were present in his blood and urine. He explained that synthetic cannabinoids can cause several serious adverse health effects; the onset of symptoms can occur within minutes of smoking; and intoxication might last for two to five hours; and that the effects can be fatal. The toxicology tests had also

detected traces of mirtazapine, an antidepressant, which had not been prescribed to Mr Ormond.

# Findings

### Drug strategy at HMP Long Lartin

77. Following an inspection in January 2018, HM Chief Inspector of Prisons concluded that Long Lartin had a less significant problem with drugs than at other prisons because of robust physical and procedural security arrangements. Intelligence reports were processed and analysed quickly, with feedback given on those of poor quality; and the prison's corruption prevention unit worked closely with the police to protect prisoners from illegal activities by staff. Most of the security processes were described as sound and supply reduction was considered to be reasonably thorough.

78. Our investigation found that Long Lartin has an up to date, clear and comprehensive '*Substance Intoxication Strategy'* to reduce the demand for and supply of illicit drugs. The strategy focusses mainly on PS, with key strands of informing prisoners of the risk, reducing access, implementing sanctions, and support for those involved in substance misuse.

79. The Head of Security said that there had been a problem with PS at Long Lartin for several years and this had increased in the previous 18 months. In response to this, all personal correspondence is now screened for traces of illicit substances, using the Rapiscan Itemiser machine. Personal letters for prisoners in the segregation unit are photocopied. Mail is also X-rayed and checked by the prison's drugs dogs.

80. The Head of Security said that the movement of men during the upgrade of the prison's fire alarm system had worsened the problems with drugs. Wings had been cleared and, since December 2018, after the work was completed, a high number of prisoners (around 70) had transferred in. A large amount of property had been sent in for these prisoners which had not been searched at the other prisons and a quantity of drugs had been found.

81. 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 recent guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

82. 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."

83. We acknowledge that Long Lartin has a detailed strategy and robust processes to help combat the flow of drugs and manage prisoners with substance misuse problems. However, it is clear that Mr Ormond had easy access to PS and this suggests that much more needs to be done to reduce this problem at Long Lartin. We make the following recommendation:

**The Governor should identify and address the key weaknesses in reducing the supply of drugs and revise the Substance Intoxication Strategy in light of the findings.**

### Support for substance misuse

84. Mr Ormond had a long history of substance misuse in the community. He continued to take illicit substances, including PS, in prison. He was prescribed methadone to treat his opiate addiction, but this was stopped for safety reasons due to his persistent drug taking. Mr Ormond attended courses and engaged well with the substance misuse teams in several prisons.

85. Mr Ormond transferred to Long Lartin for psychosocial substance misuse treatment. Shortly after he arrived, he was fully inducted by the Inclusion psychosocial team, including advice on harm minimisation and the offer of support. Just over a week later, on 25 July, Mr Ormond had a detailed mental health assessment with a senior mental health nurse and a drug recovery worker, as part of the integrated mental health and substance misuse service.

86. In August 2018, after a medical emergency due to suspected PS use, Mr Ormond was referred to Inclusion. A full assessment was conducted and he had monthly meetings with a member of the psychosocial team. Mr Ormond was sometimes open about his use of PS. On other occasions, he contradicted himself and denied taking it, although events suggested otherwise. Drug tests in August and November 2018 were negative, but the clinical reviewer pointed out that such tests are unreliable as some substances can be undetectable within a short time after ingestion.

87. We are satisfied that Mr Ormond was well supported by the substance misuse service and that when he was suspected of drug use, or possession, the action taken was consistent with the prison's substance misuse strategy.

### Possible bullying

88. In late December 2018, Mr Ormond reported threats from other prisoners. Although he refused to give specific details of the problems, staff monitored him under the prison's violence reduction strategy. Mr Ormond moved to F wing three days before he died and it was thought that this had resolved the problem.

89. Mr Ormond's father said that two or three weeks before Mr Ormond's death, his mother had received three telephone calls demanding payment for an X-box games console and she had refused to pay. He was concerned that other prisoners might have interfered with the drugs used by Mr Ormond as an example to other prisoners in debt. Without evidence of the nature of the threats to Mr Ormond, we were unable to explore whether these were linked to the concerns raised by his father.

90. What we can say, however, is that the contents and effects of synthetic cannabinoids are unpredictable because of the variety of chemicals they contain and that they are known to have potentially fatal consequences.

## Clinical care

### *Mental health*

91. Mr Ormond had a significant amount of mental health input at previous prisons. Following his initial health screen at Long Lartin, he was referred to the mental health team and had a detailed assessment with a senior mental health nurse within two weeks. Mr Ormond frequently requested pregabalin for anxiety, but sometimes claimed it was for hip pain. Prison GPs found no clinical reasons to prescribe it and he declined alternatives. He made numerous formal complaints about the refusal to prescribe his choice of painkillers.

92. At interview, the senior mental health nurse said that Mr Ormond felt that medication for anxiety had been unjustly withdrawn at previous prisons and he wanted it to be reinstated. He was particularly keen to be prescribed pregabalin. The nurse concluded that Mr Ormond had no severe mental health conditions and that substance misuse was the predominant problem. However, after a review in September, she referred him to the prison psychiatrist, who assessed him on 15 November. He found no mental illness and agreed with the opinions of previous psychiatrists that Mr Ormond had a personality disorder. There were no further mental health assessments before Mr Ormond's death.

### *Physical health*

93. At Long Lartin, Mr Ormond was promptly tested to find out the extent of his hepatitis C. He received effective treatment and blood tests confirmed that the virus had been cleared.

94. We agree with the clinical reviewer that the care Mr Ormond received at Long Lartin for both his mental and physical health was at least the equivalent of that which he could have expected to receive in the community.

## Emergency response

95. When Mr Ormond was found in his cell, prison and healthcare staff responded quickly and followed the emergency response procedures. Although the officer who found him did not have a radio, his colleague on the other side of the landing was alerted immediately and called a code blue. An ambulance was requested at 4.38pm and the first one arrived at the prison at 5.09pm. The timings in the Ambulance Service records accord with those in the prison's incident log. There is no record of exactly when the crew arrived at the cell, but the paramedics' records show that complex intravenous treatment had begun by 5.18pm.

96. There was no evidence of any avoidable delay in the emergency procedures on the part of prison staff. However, the clinical reviewer had concerns about possible delays in the paramedics arriving at the prison, as well as a lack of equipment and has recommended that the prison follows this up with the Ambulance Service.

97. The clinical reviewer concluded that the resuscitation attempts were efficient and compliant with Resuscitation Council UK guidelines and we agree.

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