Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Raymond Fisher a prisoner at HMP Coldingley on 18 August 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

I carry out investigations to understand what happened and identify how the organisations whose actions I oversee can improve their work in the future.

Mr Raymond Fisher died of psychoactive substance (PS) toxicity on 18 August 2018 at HMP Coldingley. He was 56 years old. I offer my condolences to Mr Fisher's family and friends.

Mr Fisher had a significant history of illicit drug use. Despite receiving appropriate advice and support to help address his drug misuse problems, he continued using drugs at Coldingley and was regularly found under the influence of PS. On one occasion in, May 2108, he was taken to hospital after having to be resuscitated.

During Mr Fisher's time at Coldingley he was also monitored under Prison Service suicide and self-harm monitoring procedures (known as ACCT) on a number of occasions, with the last period of monitoring ending on 3 August. The investigation found no deficiencies in the way the ACCT procedures were carried out and I am satisfied that it was appropriate for them to have ended when they did. Mr Fisher was due to be released from prison two weeks after he died and there is no reason to believe that his death was anything but accidental.

I remain concerned, however, that, despite wide-ranging local policies and the efforts of staff to prevent the supply of and demand for illicit substances, Mr Fisher was able to obtain drugs at Coldingley with apparent ease.

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 **August 2019**

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Summary

Events

1. In January 2015, Mr Raymond Fisher was convicted of blackmail and remanded to HMP Winchester. In February 2015, he was sentenced to seven years imprisonment. On 1 December 2016, Mr Fisher was transferred to HMP Coldingley. He had been in prison before.

2. Mr Fisher had a significant history of illicit drug use which continued in prison. Between 6 February 2017 and 9 August 2018, despite receiving support and advice from the drug rehabilitation service, Mr Fisher was found to be under the influence of a psychoactive substance (PS) on 24 separate occasions. On six of these occasions, paramedics were called and on one occasion, in May 2018, he was taken to hospital after having to be resuscitated.

3. During the same period, Mr Fisher was monitored by staff under Prison Service suicide and self-harm prevention procedures (known as ACCT) on five separate occasions. The last ACCT was closed on 3 August 2018.

4. On 14 August, Mr Fisher met with housing association staff to discuss where he would live on his release on 25 August 2018.

5. On 18 August, at 4.50pm, staff found Mr Fisher unconscious in his cell. Staff requested an ambulance and started cardiopulmonary resuscitation. The paramedics arrived at 5.07pm and pronounced Mr Fisher dead at 5.39pm.

6. The post-mortem found that he died of PS toxicity.

Findings

Psychoactive Substances

7. We are satisfied that Mr Fisher received appropriate advice and support to help address his drug misuse problems.

8. Coldingley has comprehensive policies to minimise and treat illicit substance misuse. Despite this, Mr Fisher was able access drugs with apparent ease.

Management of risk of suicide and self-harm

9. We found that ACCT procedures at Coldingley were conducted to a good standard in line with mandatory national instructions, case reviews were multidisciplinary and there were appropriate assessments of Mr Fisher's risk of self-harm.

10. We are satisfied that it was appropriate to close the ACCT on 3 August, and that Mr Fisher gave staff no indication that he had further thoughts of self-harm after that date.

Clinical care

11. The clinical review concluded that the care provided to Mr Fisher was equivalent to that which he could have expected to receive in the community. Mr Fisher

was assessed by mental health staff and there was no evidence that he had a significant mental health issue. Mr Fisher had good access to the drug rehabilitation service.

12. We are, however, concerned that the prison's substance misuse provider did not make entries in Mr Fisher's electronic medical records system. Although this caused no specific problems in this case, it meant that there was no single comprehensive record of his clinical history.

Recommendations

- The Governor should ensure that the key drug issues at Coldingley 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 Head of Healthcare should ensure all healthcare providers record all interventions in a prisoner's primary medical records (SystmOne) so all information is documented, enabling appropriate continuity of care for each prisoner.

The Investigation Process

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

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

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

16. On 17 April 2019, the investigation was reallocated to senior investigator. He interviewed three members of staff at Coldingley in May.

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

18. The investigator contacted Mr Fisher's sister to explain the investigation and to ask whether there were any matters she wanted the investigation to consider. Mr Fisher's sister had no questions or concerns and did not request a copy of the report.

Background Information

HMP Coldingley

19. HMP Coldingley is a Category C prison in Surrey, holding just over 500 adult male prisoners. Its primary purpose is to provide prisoners with the opportunity to experience a typical working day to prepare them for a purposeful life on release. Central and North-West London Foundation Trust provides primary and mental healthcare services.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Coldingley in February and March 2017. Inspectors found a ready availability of illicit drugs but also found that the levels of violence were not high and vulnerable prisoners were supported by staff. Inspectors found Coldingley provided a good range of substance misuse psychosocial interventions, including a four-week programme, and active peer support. Clinical management of substance misuse problems was good and prescribing flexible, with this care well-coordinated with other areas of healthcare.

Independent Monitoring Board

21. 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 annual report, published in October 2018, the IMB was concerned about the availability of drugs in the prison and the serious consequences of drug taking. The IMB commented that the number of occasions on which healthcare staff and paramedic services were called to prisoners under the influence of psychoactive substances (PS) was significant. In addition to the serious health implications for prisoners, the IMB was concerned that staff had suffered from the effects of drug fumes which, in some instances, rendered them unfit for duty.

Previous deaths at HMP Coldingley

22. Mr Fisher's was the second death to occur at Coldingley since January 2017. Another prisoner has died since. The two other deaths were both self-inflicted. Mr Fisher's death was the first death at Coldingley from PS toxicity.

Psychoactive Substances (PS)

23. 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.

24. 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.

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

Assessment, Care in Custody and Teamwork (ACCT)

26. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the 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.

27. 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 (Safer Custody)*.

Key Events

28. On 9 January 2015, Mr Fisher appeared at Bournemouth Crown Court and was convicted of blackmail. He was remanded into custody at HMP Winchester. On 26 February 2015, Mr Fisher was sentenced to seven years imprisonment. Mr Fisher was transferred to HMP Bullingdon on 9 March, then to HMP Ranby on 13 March, and finally to HMP Coldingley on 1 December 2016.

29. When Mr Fisher arrived at Coldingley, he saw a nurse in reception. She recorded that Mr Fisher was not prescribed any medication and had no thoughts of self-harm or suicide.

30. Between 6 February 2017 and 9 August 2018, despite receiving advice and having 21 one-to-one interventions with a member of the drug rehabilitation service, Mr Fisher was found to be under the influence of PS on 24 separate occasions. On six of these occasions paramedics were called and on 20 May 2018, cardiopulmonary resuscitation (CPR) was administered by healthcare staff when he was found unresponsive and he was taken to hospital. Mr Fisher also failed two mandatory drug tests and on 14 June 2018, he was placed on a disciplinary charge for refusing to take a mandatory drug test.

31. The drug rehabilitation service manager said Mr Fisher was a regular user of PS and that he became aggressive and abusive while under the influence of PS. She said that the drug rehabilitation service at Coldingley used trained prisoners to act as peer support workers, in addition to the employed staff. She said some prisoners would not engage with staff but would engage with the peer support workers.

32. While at Coldingley, Mr Fisher was also monitored by staff under Prison Service suicide and self-harm prevention procedures (known as ACCT) on five separate occasions. This was due to his pattern of substance misuse (when staff thought he might be using PS to cope with his emotions about the deaths of his brother, mother and partner) and two incidents of self-harm by making superficial cuts to his arms.

33. An ACCT was opened on 20 May 2018 after Mr Fisher was taken to hospital as a result of using PS a few days after the death of his partner. He was adamant, however, that this had not been deliberate self-harm and the ACCT was closed the following day.

34. His last ACCT was opened on 14 June 2018, after Mr Fisher self-harmed by making cuts to his arms. At an ACCT review on 4 July, Mr Fisher said he had not touched drugs for the last three weeks. At a review on 11 July, he said he was using work as a way of keeping busy and was due to start bereavement counselling on 24 July. At a review on 28 July, he said he had found the bereavement counselling helpful and was looking forward to his next session on 3 August. He said that he was no longer using drugs as “it’s not worth the money and it’s not worth dying for”. He said his main focus was on finding somewhere to live and reconnecting with his children when he was released in four weeks’ time. The ACCT was closed on 3 August after a multi-disciplinary review, and a post closure interview took place on 9 August.

35. During his time at Coldingley, Mr Fisher worked in the workshops. There were several positive comments recorded in his prison computer record about his work ethic and his willingness to undertake additional duties.

36. On 14 August, a resettlement officer saw Mr Fisher to discuss organising his accommodation after his release on 25 August.

37. On 15 August, a substance misuse peer support worker saw Mr Fisher to discuss support after his forthcoming release. Mr Fisher said he would not use PS after his release and that he was aware of the community services available and how to access them.

Events of 18 August 2018

38. On 18 August, at 4.50pm, an officer went to unlock Mr Fisher's cell to allow him to collect his evening meal. The officer found Mr Fisher unconscious in his cell and immediately radioed a medical emergency code blue. This indicates a prisoner is unconscious or having breathing difficulties and an ambulance was called immediately.

39. Staff responded and started cardiopulmonary resuscitation (CPR) using an automated external defibrillator, which administers electrical shocks to restore a normal rhythm to the heart if any is found. Two nurses arrived within two minutes. The defibrillator found no shockable rhythm, so the nurses continued with CPR. The paramedics arrived at 5.07pm, and took over Mr Fisher's care. However, after a period of treatment, Mr Fisher was pronounced dead at 5.39pm.

Post-mortem report

40. Toxicology tests showed that Mr Fisher had taken 5F-ADB (a form of PS, known as 'Spice') before his death. A post-mortem examination, conducted by a Home Office Forensic Pathologist, who confirmed that the cause of Mr Fisher's death was 5F-ADB ('Spice') toxicity.

Contact with Mr Fisher's family

41. Mr Fisher had nominated his sister as his next of kin though they had not been in contact for many years. On 19 August, at 2.35am, the Deputy Governor and the family liaison officer from Coldingley, visited Mr Fisher's sister at her home address to break the news of her brother's death and offer condolences. In the days that followed, Coldingley maintained contact with Mr Fisher's sister and, in line with Prison Service instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

42. The Deputy Governor held a debrief for staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and for managers to offer support. The staff care team also offered support.

43. The prison posted notices informing staff and prisoners of Mr Fisher'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 Fisher's death.

Findings

Psychoactive Substances

44. Mr Fisher had a significant history of illicit drug use. Mr Fisher's security records show he was involved in the use of illicit drugs and used mobile phones in prison. After his arrival at Coldingley, staff received and acted on intelligence that Mr Fisher was involved in the use of illicit drugs, and he failed two mandatory drug tests.

45. Despite receiving support and advice from the substance misuse team, Mr Fisher clearly continued to use drugs and was regularly found under the influence of PS.

46. Toxicology results show that Mr Fisher had used PS before his death and the Home Office pathologist confirmed the cause of Mr Fisher's death was PS toxicity.

47. Coldingley has a strategy to address both the supply of and demand for PS and illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. Examples of this include photocopying mail to prevent paper soaked in PS entering the prison and providing additional staff resources to carry out mandatory drugs tests and cell searches. There are also measures to educate prisoners about the dangers of PS and support those known to use the drugs, plus additional disciplinary measures to deter drug use.

48. We are concerned that, despite this, Mr Fisher was able to obtain PS with apparent ease at Coldingley. Both HM Inspectorate of Prisons and the Independent Monitoring Board have expressed concern about the ready availability of drugs at Coldingley and it is obviously a cause for concern that Mr Fisher was able to obtain and use them.

49. 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, and we welcome the fact that such guidance was issued in April 2019, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

50. In relation to reducing the supply of drugs, we note that 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 Coldingley are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Management of risk of suicide and self-harm

51. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody),* which sets out the Prison Service's framework for delivering safer custody procedures, lists a number of risk factors and potential triggers for suicide and self-harm. All staff should be alert to the increased risk of self-harm or suicide posed by prisoners with these risk factors and should act appropriately to address any concerns, including opening an ACCT if necessary.

52. We found that ACCT procedures at Coldingley were correctly conducted in line with mandatory national instructions, case reviews were multidisciplinary and Mr Fisher received appropriate support from staff. ACCT reviews showed a good understanding of risk and were of a higher quality than we often see. After the ACCT was closed on 3 August, Mr Fisher gave no indication, either verbally or in terms of how he presented to staff or other prisoners, that he had thoughts of self-harm or suicide.

53. We are satisfied that it was appropriate to have closed the ACCT on 3 August and that there is nothing to suggest that Mr Fisher's death was anything other than accidental.

Clinical care

54. The clinical reviewer judged that the care that Mr Fisher received from healthcare staff at HMP Coldingley was equivalent to the care he could have expected to receive in the community.

55. A prison GP commented that Mr Fisher had good access to the mental health team and was assessed promptly and thoroughly. Mr Fisher also had good access to the drug rehabilitation service, and it was his personal decision and choice as to whether and when he engaged with the team, whose members were always available to him.

56. We are concerned, however, that the prison's drug rehabilitation service did not record entries on SystmOne (the electronic system for prisoners 'medical records). This reduced the opportunity for comprehensive oversight of his clinical history and therefore for a coordinated approach to his care by all health providers at Coldingley. Although no actual failing arose in respect of Mr Fisher, Coldingley's record-keeping does not comply with General Medical Council and Nursing and Midwifery Council standards. We make the following recommendation:

The Head of Healthcare should ensure all healthcare providers record all interventions in a prisoner's primary medical records (SystmOne) so all information is documented enabling appropriate continuity of care for each prisoner.

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