Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Carl Walters, a prisoner at HMP Exeter, on 30 March 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 Carl Walters died of a ruptured spleen on 30 March 2019, having been found unresponsive in his cell at HMP Exeter. Post-mortem tests showed the presence of drugs in his system. Mr Walters was 34 years old. I offer my condolences to Mr Walters' family and friends.

Mr Walters was only in Exeter for 10 days. He complained of stomach pain on the morning of his death. That afternoon, staff found him unresponsive on the floor of his cell. The pathologist was unable to determine when Mr Walters sustained the damage to his spleen – it could have been days or months earlier - but the post-mortem examination found there were no injuries to suggest that it was in the days leading up to his death.

The clinical reviewer found that Mr Walters received health care equivalent to that he could have expected in the community. His condition was a very rare one and the clinical reviewer was satisfied that, given Mr Walters' presentation on 30 March, healthcare staff responded appropriately.

We are concerned that Mr Walters was able to locate drugs with apparent ease at Exeter and that an emergency radio code was not used when staff found Mr Walters unresponsive. We are also concerned about the failure to preserve evidence adequately after Mr Walters' death, contravening national guidelines.

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 **January 2021**

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Summary

Events

1. Mr Carl Walters was sentenced to 28 days imprisonment and taken to HMP Exeter on 20 March 2019. It was his first time in prison. His reception health screen noted his history of substance misuse and he was put on a detoxification programme with a prescription of methadone. Healthcare staff monitored his withdrawal for five days, without any concerns. He told substance misuse workers that he wanted to carry on using drugs when he was released from prison so he did not engage with their programmes.

2. On the morning of 30 March, Mr Walters complained of stomach pain. He told a nurse that he had taken psychoactive substances (PS), but she did not think he seemed to be under the influence of anything. His medical observations were within normal limits.

3. Later that morning, Mr Walters said he was having a panic attack. A nurse assessed that he had taken drugs but she could not examine him properly because of his erratic behaviour. His blood oxygen level and temperature were normal. She told him to sleep off the effects of the drugs and scheduled a further check-up later that afternoon. A prison officer checked Mr Walters' several times, but Mr Walters was aggressive.

4. At approximately 1.20pm, a charity worker heard movement and a voice from Mr Walters' cell (which he shared with another prisoner). He called an officer, who opened the door and found Mr Walters unresponsive. He called to a nearby nurse for help and radioed for medical assistance at 1.24pm. Nurses and prison officers tried to resuscitate Mr Walters. One of the nurses asked for an ambulance, and one was requested at 1.25pm. Paramedics joined the efforts to save Mr Walters until, at 2.14pm, it was agreed that he had died.

5. Mr Walters had several bruises on his body when he died. The prison had no evidence that he was being bullied or had problems with other prisoners during his short time at Exeter. Our investigator spoke to Mr Walters' cellmate, who could not explain how Mr Walters sustained his injuries and said he got on well with other prisoners. The police investigated Mr Walters' death but no criminal charges were brought.

Findings

6. The post-mortem examination found some unexplained injuries to Mr Walters' head and nose that staff had not noticed earlier in the day.

7. The pathologist was unable to establish when Mr Walters sustained the damage to his spleen that caused his death but noted that there were no injuries to suggest that it had been recent.

Mr Walters' healthcare

8. The clinical reviewer was satisfied that the care provided to Mr Walters was equivalent to that which he could have expected in the community.

Substance misuse

9. Mr Walters had a history of substance misuse and he was on a detoxification programme. He was monitored for the effects of drug withdrawal but refused substance misuse interventions.

10. Post-mortem tests on Mr Walters showed the presence of higher levels of methadone than were expected from his prescription. There were also traces of synthetic cannabinoids (PS).

11. There were no intelligence reports before 30 March to suggest that Mr Walters was taking drugs. When the nurse saw him under the influence that morning, she assessed him as best she was able and arranged for someone to assess him again once the effects had worn off.

12. We are concerned that Mr Walters could get hold of drugs at Exeter with apparent ease. We hope that the prison's new drug strategy will be effective in reducing the supply and demand of illicit substances in the prison.

Emergency response

13. Although staff responded swiftly when Mr Walters was found unresponsive, the correct emergency code was not used. We note that the control room called an ambulance within a minute of the radio call for medical assistance. In this instance, the failure to use a code did not cause a significant delay but it could be crucial in future medical emergencies.

Evidence after a death in custody

14. The prison was unable to provide the PPO with electronic evidence, including staff statements and CCTV footage. This adversely affected our investigation and we have made a recommendation that all evidence must be preserved.

Recommendations

- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including using the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.
- The Governor should ensure that all evidence including electronic evidence relevant to a death in custody is retained and made available to the PPO, in line with PSI 58/2010.

The Investigation Process

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

16. The investigator obtained copies of relevant extracts from Mr Walters' prison and medical records. He contacted the police officer in charge of the police investigation and exchanged information. HMP Exeter were unable to provide CCTV footage, or recordings of radio traffic from the emergency response

17. The investigator interviewed five members of staff at Exeter in November 2019.

18. NHS England commissioned a clinical reviewer to review Mr Walters' clinical care at the prison. He joined the investigator for interviews of healthcare staff

19. We informed HM Coroner for Exeter and Greater Devon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

20. One of our office's family liaison officers contacted Mr Walters' mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked about the healthcare her son received. We cover this in the report, but more detailed information can be found in the clinical review, the first annex to this report.

Background Information

HMP Exeter

21. HMP Exeter is a Victorian city-centre prison which covers the courts of Devon, Cornwall and Somerset. It holds up to 561 adult men and young offenders. Care UK provide primary healthcare and commission Devon Partnership NHS Trust to provide mental health care.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Exeter was conducted in May 2018. Inspectors found that, despite a significant increase in staffing since the last inspection in August 2016, there had been a sharp deterioration in the outcomes for prisoners. They noted that many of their previous recommendations had been ignored. They were particularly concerned to find that the key area of prisoner safety attracted their lowest possible grading of 'poor'. Inspectors reported that two-thirds of prisoners did not feel safe, prisoner on prisoner assaults were at the highest levels seen in the past three years, and illicit drugs continued to be prevalent. The inspectors were also concerned about poor living conditions.

23. Following the inspection, HM Chief Inspector of Prisons invoked the Urgent Notification protocol and wrote to the Secretary of State on 30 May 2018 setting out his significant concerns about the treatment of prisoners and the conditions in which they were held.

24. In April 2019, HMIP carried out an Independent Review of Progress which followed up 13 of the 47 recommendations they had made after their 2018 inspection. Inspectors found that there had been good progress on three recommendations, reasonable progress on three recommendations, insufficient progress on four recommendations and no meaningful progress on three recommendations.

Independent Monitoring Board

25. 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 Exeter for the year to December 2019, the IMB reported that living conditions in the prison were poor, although relations between staff and prisoners were positive. Healthcare was comparable with the wider community.

Previous deaths at HMP Exeter

26. Mr Walters was the 15th prisoner at HMP Exeter to die since the beginning of 2017. Seven of those prisoners died of natural causes. There have since been a further eleven deaths, seven of which were due to natural causes. The circumstances of Mr Walters' death are not comparable to those of previous investigations. We have previously made recommendations about using emergency codes, a recommendation we repeat in this report.

Psychoactive Substances (PS)

27. Psychoactive substances (formerly known as ‘new psychoactive substances’ or ‘legal highs’) are a significant problem across the prison estate. They are difficult to detect and can affect people in several 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.

28. 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.

29. 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.

Key Events

30. Mr Carl Walters was sentenced to 28 days imprisonment for assault on a police officer. He was taken to HMP Exeter on 20 March 2019. It was Mr Walters' first time in prison. He was due to be released on 2 April.

31. Mr Walters had a history of alcohol and drug dependency. In 2017, he had broken his right ankle in three places, and was awaiting a further operation. When he got to prison, his leg was swollen due to a severe infection in his foot as a result of intravenous drug use. He had been working with community drug workers to address his drug problems, and was on a methadone programme, but he continued to use drugs.

32. An initial health screen noted Mr Walters' drug issues and urine tests confirmed recent drug use. Mr Walters declined a referral to substance misuse support. He said he had a history of depression so was referred to the mental health team. The nurse said in interview that Mr Walters did not complain of any pain, nor did he have any visible injuries.

33. The following day, 21 March, a nurse completed a secondary health screen. Mr Walters' methadone prescription was confirmed and re-prescribed. He said that he used heroin and crack cocaine daily and Valium weekly and injected the drugs. Mr Walters was experiencing symptoms of drug withdrawal, but generally appeared to be well. The nurse planned for staff to check him regularly for the first five days in prison as part of his detoxification programme and referred him to a recovery worker. Mr Walters said that he had depression but did not want to be referred to the mental health team. He said his foot was painful but did not mention any other pain.

34. On 22 March, healthcare staff recorded that Mr Walters did not have serious withdrawal symptoms. This monitoring and outcome were repeated on 23 March. On 24 March, he told a nurse that he sometimes felt anxious and depressed, and she referred him for a mental health assessment.

35. Healthcare staff checked Mr Walters during the night. There were no problems, and, on 25 March, it was agreed that he no longer needed night time welfare checks.

36. On 26 March, Mr Walters had a mental health assessment. He said he had long-term depression and had misused opiates since the age of 18. He was not taking medication for his mental health, and it was assessed that he did not need support from secondary mental health services.

37. On 27 March, Mr Walters saw a substance misuse caseworker. Mr Walters said that he was intending to continue drug use after release from prison, so did not want support from the substance misuse team. The caseworker told him that his tolerance to drugs might have reduced while he was in prison.

38. On 29 March, Mr Walters saw a member of the resettlement team. He said he had no medical problems other than his ankle. He said he was working with community agencies to help his drug addiction.

39. At a medical appointment that afternoon, Mr Walters told a prison GP that he was suffering a good deal of pain from his foot, as well as his teeth. He was awaiting an operation to have some teeth removed. He asked for codeine. The doctor examined Mr Walters' foot and agreed to prescribe codeine for three days. Mr Walters did not complain of stomach pain.

Saturday 30 March

40. On the morning of 30 March, Mr Walters told an officer in the wing office that he was in pain, pointing to his stomach. The officer took Mr Walters to the healthcare unit, where he saw a nurse. He told her that he had severe pain in the left side of his abdomen and had been sick. He asked to go to hospital.

41. The nurse noted that he did not seem in pain, said he had no chest pain and that he had used the toilet normally that morning. Mr Walters told the nurse that he had smoked teabags and 'spice' (a type of PS) and asked to stay in the healthcare centre. She told him that she could not admit him to the healthcare centre. She did not think he seemed under the influence of drugs during her assessment. The nurse noted on Mr Walters' medical record that the pain may have been due to cramp or excessive gas, but if he continued to complain of pain that afternoon, he should be examined.

42. Just after the nurse left, Mr Walters was sick. He admitted that he had smoked some of a cigarette his cellmate had been smoking earlier that morning and said he did not know what was in it. Another nurse took Mr Walters' medical observations, which were all normal. The officer took Mr Walters back to the wing.

43. At approximately 10.22am, Mr Walters went to collect his methadone prescription. A nurse was the dispensing nurse. In interview, she said that if prisoners appeared to be under the influence of anything, she would not dispense methadone without further assessments. That morning, she and Mr Walters spoke briefly while she was dispensing the methadone. He did not complain of any pain and appeared fine, so she dispensed his methadone. She did not notice any bruising or grazes on him.

44. Mr Walters pressed his cell bell at 11.15am and an officer responded. Mr Walters was sitting on the toilet. Mr Walters asked to see somebody from the healthcare team but would not say why. The officer asked if he had a stomach problem, and Mr Walters said that he did not, but said he was having a panic attack. The officer called the healthcare team and asked for someone to come to see him. While waiting, Mr Walters was talking incoherently to the officer who suspected that he was under the influence of drugs. He asked Mr Walters' cellmate if Mr Walters had taken anything, but he just shrugged his shoulders. The officer said that he did not notice any marks on Mr Walters' face at that time.

45. When a got to Mr Walters' cell, he was still sitting on the toilet and said that he needed to go to hospital. Mr Walters told the nurse that he had been smoking teabags and spice, and she noticed that the sink was blocked with teabags, nicotine patches and cigarette butts. She noted that Mr Walters was pale and sweaty, appeared drowsy and had slurred speech. He could not keep his eyes open long enough for her to check his pupils. The nurse could not take full

medical observations because Mr Walters would not get off the toilet. She checked his blood oxygen level and temperature, and they were normal. She considered that he was under the influence of drugs and told him to sleep off the effects of whatever he had taken. She noted on Mr Walters' medical record that it may have been a panic attack. He did not mention any abdominal pain.

46. While the nurse was trying to examine Mr Walters, an officer found a homemade pipe (used to smoke drugs) on the floor of the cell, which had been recently used. He removed the pipe and made a note about it in the wing observation book. The nurse told the officer that she was not concerned about Mr Walters' physical health and guessed that he had taken a substance that had nearly worn off. She said that she would task someone from the healthcare department to check Mr Walters' wellbeing later that afternoon.

47. Shortly after the nurse left, the officer checked Mr Walters. He had moved his bedding off his bunk and was folding it on the floor. The officer said he asked if he was alright, and Mr Walters replied, "Fuck off." A while later, the officer checked him again, and Mr Walters had put his bedding back onto his mattress and got into bed. The officer asked if he was alright, and Mr Walters told him to shut the door. The officer asked if he needed to see a nurse, and Mr Walters replied, "Fuck off." When his cellmate returned to the cell, the officer again asked Mr Walters if he was alright and if he wanted to see a nurse, and again Mr Walters said, "Fuck off." This was at about 12.30pm.

48. Mr Walters' cellmate said that he was not happy sharing a cell with Mr Walters at that time because he seemed quite ill. He said he pressed the cell bell over lunch to get officers' attention because he was worried about Mr Walters. He said that officers did not respond for a long time. Cell bell records indicate that the bell in that cell was not activated in the twenty-minute period before Mr Walters was found unresponsive.

49. At 1.20pm, a volunteer working with prisoners, was near Mr Walters' cell and heard movement and someone shouting, "Get off me." The volunteer called an officer, who went to the cell and looked through the observation panel. Mr Walters was leaning across the door and his cellmate was sitting rolling a cigarette. The officer was concerned about Mr Walters and told the cellmate to move him away from the door so he could go in (the cell door opens inwards). He said the cellmate was slow to react, but eventually moved Mr Walters enough for the officer to open the door. The officer shouted for assistance to a nurse who was on the wing, then went into the cell.

50. Another officer had heard the officer's shout and gone to the cell, and she helped the officer to move Mr Walters to the middle of the cell. The officer could not find a pulse, so the other officer began cardiopulmonary resuscitation (CPR). The nurse arrived and asked for an ambulance to be called. Exeter did not provide us with the radio recordings, but the incident log showed that a radio call for medical assistance was made at 1.24pm, and a further radio message asked for an ambulance within a minute. Ambulance Service records show that the prison control room requested an ambulance at 1.25pm.

51. Other nurses arrived at the cell with medical equipment, including a defibrillator (a machine that can restart the heart in certain circumstances) and joined the

efforts to resuscitate Mr Walters. The nurses and prison officers continued to do so until paramedics arrived at about 1.40pm. Paramedics treated Mr Walters until 2.14pm, when they confirmed that Mr Walters had died.

Contact with Mr Walters' family

52. A Supervising Officer (SO), the prison's family liaison officer (FLO), identified Mr Walters' mother as his next of kin, and went to her address with senior prison managers to inform her of her son's death. In line with Prison Service guidance, Exeter offered a contribution to the costs of Mr Walters' funeral.

Support for prisoners and staff

53. After Mr Walters' death, one of the prison's senior managers 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.

54. The prison posted notices informing other prisoners of Mr Walters' 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 Walters' death.

After Mr Walters' death

55. After Mr Walters died, the prison received intelligence that Mr Walters had been given a quantity of tablets by another prisoner. It was alleged that he had taken them on the morning of the day he died.

Post-mortem report

56. The post-mortem examination found that that Mr Walters died as a result of an intraperitoneal haemorrhage (bleeding into the abdomen), caused by a ruptured splenic pseudoaneurysm.

57. A pseudoaneurysm occurs when a blood vessel wall is injured and the leaking blood collects in the surrounding tissue causing a swelling. In Mr Walters' case the pseudoaneurysm was in the artery supplying the spleen and had ruptured, causing significant blood loss. The pathologist said that this is a very rare diagnosis.

58. The pathologist noted that there are a number of possible causes for a splenic pseudoaneurysm, including disease (such as pancreatitis) or blunt force trauma to the abdomen. Mr Walters had no history of pancreatitis and the pathologist concluded that in Mr Walters' case the most likely cause was trauma, although she could not say whether that trauma was the result of a fall onto a hard surface or whether it was the result of assault by a third party. There were no injuries to suggest the damage had been sustained in the days leading to Mr Walters' death.

59. The pathologist also noted that a splenic pseudoaneurysm may rupture at any time from days to months after its formation and there may be no obvious reason for the rupture.

60. As well as therapeutic amounts of prescribed medication, toxicology tests showed levels of methadone higher than expected from Mr Walters' prescribed daily dose. Traces of synthetic cannabinoids (PS) were also found.

Findings

61. Mr Walters made no phone calls during his time in Exeter. There was no evidence or intelligence suggesting that Mr Walters had been bullied or suffered any incidents of violence during his time at the prison. The investigator interviewed Mr Walters' cellmate who said that Mr Walters got on well with other prisoners and he did not know of any issues.

62. A nurse said that during the emergency response, she noticed a graze on Mr Walters' nose and bruising to his head and a mark on his stomach that she had not noticed earlier that day. The post-mortem examination found a graze on his nose. In the absence of any further information we are unable to comment on how he might have come by these injuries. The police investigated the circumstances of Mr Walters' death. No criminal charges were brought.

Mr Walters' clinical care

63. The clinical reviewer found that the healthcare provided to Mr Walters was equivalent to that which he could have expected to receive in the community. Mr Walters' detoxification programme meant that he was regularly checked by healthcare staff and he did not complain of stomach pain during these checks. Healthcare staff took basic observations, which were all normal through his brief time at Exeter.

64. On the day he died, Mr Walters was assessed by a nurse, who thought the pain he described could have been trapped wind. Later that morning, Mr Walters appeared to be under the influence of drugs and there was a homemade pipe in the cell. The same nurse took some observations, which were normal and arranged for another nurse to check him that afternoon. The clinical reviewer considered that the nurse's actions were reasonable, given Mr Walters' presentation.

65. The clinical reviewer noted that the emergency response was timely, and the resuscitation efforts were in keeping with established resuscitation guidelines. The use of prison emergency equipment was prompt and appropriate.

Substance misuse

66. The clinical reviewer considered the treatment of Mr Walters' substance misuse was appropriate. He was put onto a detoxification programme and monitored for the effects of drug withdrawal. He was referred to a substance misuse worker but did not want substance misuse support in prison.

67. Post-mortem tests on Mr Walters showed the presence of higher levels of methadone than were expected from his prescription. There were also traces of synthetic cannabinoids. An intelligence report submitted the day after Mr Walters died stated that he had taken a quantity of tablets. The clinical reviewer noted that, in his experience, damage such as that to Mr Walters' spleen could not be caused or exacerbated by drug use.

68. Drug taking and trading is a serious problem across much of the prison estate. In April 2019, HMPPS issued national guidance to prisons on developing local

drugs strategies, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

69. In their report on Exeter in May 2019, Her Majesty's Inspectorate of Prisons commented on the availability of drugs in the prison. We are concerned that Mr Walters was able to obtain PS in Exeter with apparent ease. We note that since Mr Walters' death, Exeter have reissued their Substance Misuse Reduction Strategy. We do not therefore make a recommendation, but we hope that the new measures prove to be effective in reducing the supply of drugs in the prison.

Emergency response

70. Prison Service Instruction (PSI) 03/2013 requires prisons to have a two-code medical emergency response system based on the instruction. As is usual, Exeter use code blue to indicate an emergency when a prisoner is unconscious or having breathing difficulties, and code red when a prisoner is bleeding. Calling an emergency code should automatically trigger the control room to call an ambulance.

71. Exeter could not provide recordings of radio traffic around the time of the emergency response. It appears, however, that nobody used a radio to call a code blue emergency. As a result, there may have been a delay before an ambulance was called. It is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found unresponsive might save their life. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including using the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

Preservation of evidence after a death in custody

72. Prison Service Instruction (PSI) 58/2010 makes it mandatory for prisons to provide evidence to the Ombudsman's office for the purpose of our investigations. Prison officers involved in the emergency response for Mr Walters did not make written statements. We are concerned that the prison was unable to provide the PPO with recordings of the radio traffic or CCTV footage of the emergency response, despite being asked to do so. These can provide crucial evidence for investigations, and we would expect the prison to ensure that electronic evidence is preserved following a death in custody to ensure appropriate scrutiny and accountability. We make the following recommendation:

The Governor should ensure that all evidence including electronic evidence relevant to a death in custody is retained and that evidence is made available to the PPO, in line with PSI 58/2010.

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