Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Raymond Boyle, a prisoner at HMP Northumberland, on 19 May 2017

**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.

The Ombudsman's 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 Raymond Boyle died on 19 May 2017 at HMP Northumberland. The cause of his death is unknown. He was 30 years old. I offer my condolences to Mr Boyle's family and friends.

Although the cause of Mr Boyle's death has not been established, the pathologist thought it was likely that illicit drug use played a part. The day before Mr Boyle was found dead, he told a nurse that he had been drinking illicitly brewed alcohol. In addition, a low level of buprenorphine (an opioid drug that Mr Boyle had not been prescribed) was found in his system after his death.

The clinical reviewer found that the standard of healthcare provided to Mr Boyle was equivalent to that which he could have expected to receive in the community.

I am concerned that the emergency response was not carried out in line with national policy. I am satisfied, however, that this had no effect on the outcome for Mr Boyle.

I am also concerned about the ready availability of illicit drugs at the prison.

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** **May 2021**

## Contents

# Summary

## Events

1. On 23 January 2017, Mr Raymond Boyle was recalled to prison after failing to comply with his licence conditions. He was sent to HMP Durham. On 5 May 2017, Mr Boyle was transferred to HMP Northumberland.

2. Mr Boyle consistently told prison staff that, although he had been a drug user in the past, he did not have an issue with drugs in prison.

3. On 18 May, Mr Boyle was found outside his houseblock without permission. Staff considered he was under the influence of an unknown substance and asked a nurse to review him. Mr Boyle refused to let the nurse examine him but told her that he had been drinking 'hooch' (illicitly brewed alcohol). The nurse saw him at about 2.30pm and concluded that, although Mr Boyle was a little unsteady on his feet, he was not suffering any serious ill effects from the substance he had consumed. Mr Boyle was left to recover in his cell and later collected his evening meal from the servery at about 4.45pm.

4. The night patrol officer conducted a roll check at about 8.00pm that evening and said that she gained a response from all the prisoners on the wing, including Mr Boyle.

5. When the night patrol officer conducted the morning roll check at about 5.30am the next day, she saw Mr Boyle lying fully dressed on his bed. She knocked on the door and called his name, but he did not respond. She used her radio to call for assistance from other staff. She did not use an emergency code.

6. Other staff arrived and found Mr Boyle was unresponsive. They did not attempt to resuscitate him as he appeared to have been dead for some time.

7. The post-mortem was unable to establish the cause of Mr Boyle's death, although the pathologist considered that it was likely that illicit drugs had played a part.

## Findings

8. Mr Boyle was found dead in his single cell. The post-mortem did not find any evidence that he had been assaulted before his death or any evidence of third-party involvement. Toxicology tests showed that Mr Boyle had taken buprenorphine (Subutex) before his death, but this would not normally have been sufficient to have killed him.

9. The clinical reviewer noted that Mr Boyle had little significant contact with healthcare staff at Northumberland. When he arrived at Northumberland two weeks before his death, did not report any serious health problems and said he did not have any issues with drugs or alcohol.

10. The day before he was found dead, Mr Boyle was found under the influence of an unknown substance, which he said was illicit alcohol. He was seen by a nurse, but the clinical reviewer was satisfied he did not need medical treatment.

We are, however, concerned that the nurse did not make a record of this interaction until after Mr Boyle had died.

11. After Mr Boyle's death, a prisoner alleged an officer had seen Mr Boyle using an illicit drug during the evening. He claimed that although the officer had witnessed the incident, he had not challenged Mr Boyle. The prisoner submitted his concerns via the confidential request and complaint form system.

12. However, we were concerned that there was no evidence that the prisoner's complaint had been investigated correctly. We made two recommendations in respect of this issue in the initial report.

13. After the initial report into Mr Boyle's death was issued, the prison was able to provide evidence that the confidential request and complaint form had in fact been received and processed correctly. The prison also confirmed that no evidence was found to substantiate the prisoner's claims.

14. The officers who found Mr Boyle unresponsive did not immediately call an emergency code or enter the cell to check for signs of life. The Night Orderly Officer told them to wait for her to arrive before they entered the cell. This led to a delay before an ambulance was called. Although this did not affect the outcome for Mr Boyle, as he had been dead for some time, it could make a critical difference in future cases.

15. Mr Boyle was not prescribed buprenorphine and must, therefore, have obtained it illicitly in prison. We are concerned about the easy availability of drugs at Northumberland. Although the prison has a substance misuse strategy, more needs to be done to reduce supply and demand.

## Recommendations

- The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:
    - staff know when to enter a cell; and
    - staff promptly use an emergency code to effectively communicate the nature of an emergency so there are no delays in calling an ambulance.
- The Head of Healthcare should:
    - ensure that healthcare staff record any interventions in a prisoner's medical record in line with the Nursing and Midwifery Council's guidance on record keeping; and
    - speak to Nurse A to remind her of this.
- The Director should ensure that the key drug issues at Northumberland are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

## The Investigation Process

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

17. The investigator visited HMP Northumberland on 28 June 2017. He obtained copies of relevant extracts from Mr Boyle's prison and medical records and interviewed one prisoner. The investigator returned to Northumberland on 15 January 2019 and interviewed four members of staff.

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

19. We informed HM Coroner for Northumberland North District 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. Mr Boyle's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

# Background Information

22. HMP Northumberland holds up to 1,348 men. Sodexo Justice Services manage the prison and G4S provide the healthcare services. Healthcare staff are on duty on Monday - Thursday from 7.30am to 7.30pm and on Fridays from 7.30am to 6.00pm. They are also on duty at weekends and on Bank Holidays from 8.00am to 6.00pm. Northern Doctors Urgent Care provide an out-of-hours service at other times.

### HM Inspectorate of Prisons

23. The most recent inspection of HMP Northumberland was in August 2017. Inspectors criticised many aspects of the prison but noted the Director's determination and leadership in making improvements. The inspectors found that agency staff were regularly used in the healthcare department to cover vacancies and the nursing team struggled to achieve their core functions. Despite this, most healthcare needs were met. Most prison officers had received appropriate first aid training and had access to defibrillators.

24. However, inspectors noted there was a significant issue at the prison with the availability of illicit drugs. When questioned, 61% of prisoners said it was easy to obtain illicit drugs in the prison, and 21% of prisoners said they had developed a drug habit since arriving at the prison. 17% of all mandatory drug testing carried out at Northumberland resulted in a positive test. When that figure was combined with positive test results for psychoactive substances (synthetic cannabinoids) that figure rose to 34%.

25. Inspectors considered that although there was a drug supply reduction strategy in place at Northumberland, it seemed to be having little impact on the availability of illicit substances.

### Independent Monitoring Board

26. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to December 2018, the IMB noted that changes made to the roles of other prisons in the region had resulted in a higher turnover of prisoners than normal in Northumberland, which had had an impact on the healthcare resources at the prison. However, despite that extra strain on resources, the IMB noted the overall quality of health services at Northumberland was of a reasonable standard.

27. The IMB also noted a concerning rise in the use of illicit substances at the prison. However, they considered the more stringent search procedures for visitors and items being sent into the prison, could have a positive impact on the level of drugs available in the prison. They also noted that the use of family engagement, and the range of services available to those prisoners with substance misuse issues, could also yield positive results.

## Previous deaths at HMP Northumberland

28. Mr Boyle was the 16th prisoner to die at HMP Northumberland since May 2014. Ten of the previous deaths were from natural causes, five were self-inflicted deaths and one from a drug overdose. There have been six further deaths since, four from natural causes, one self-inflicted. There has also been one death suspected to be drug related. We have made recommendations about the emergency response in two previous cases, one in 2014 and again in 2016.

# Key Events

29. On 23 January 2017, Mr Raymond Boyle was recalled to prison after failing to comply with his licence conditions. He was sent to HMP Durham.

### HMP Durham

30. At his reception health screen, Mr Boyle told a nurse that he was experiencing minor muscular pain from injuries he had suffered in a motorcycle accident two days earlier. The nurse referred Mr Boyle to a Nurse Practitioner for review. Mr Boyle said he had no history of illicit drug use.

31. Soon after his arrival at Durham, prison staff noted Mr Boyle appeared to be attempting to become involved in the drug culture at the prison, and considered he was attempting to take over the supply of illicit drugs and mobile telephones on his wing. They also noted he had started to receive payments in his prison account from the families of other prisoners. It was suspected those payments were for illicit drugs.

32. On 23 February, Mr Boyle was sentenced to nine years and six months in prison for burglary and drugs offences.

33. On 6 March, a nurse reviewed Mr Boyle. He had access to Mr Boyle's hospital notes about the accident. No lasting issues had been identified as a result of the accident. The nurse also recorded that Mr Boyle did not report any pain or illness.

34. In April, Mr Boyle reported episodes of vomiting and chest palpitations. Healthcare staff arranged for blood tests and an electrocardiogram (ECG, which is carried out to check the rhythm and electrical output of the heart) to try to identify the cause of his condition. The results showed nothing of concern.

35. Following further reviews on 5 and 7 April, healthcare staff took his observations, and again, noted nothing of concern. However, a nurse noted the level of serum aminotransferase in his blood test results was slightly raised (an indicator of possible liver disease) and referred Mr Boyle for a GP review. There is no record of Mr Boyle reporting any further vomiting or issues with his chest.

36. On 24 April, Mr Boyle told healthcare staff he had slipped in his cell and aggravated his back injury. A nurse reviewed Mr Boyle and noted he could stand, walk normally and was able to support his own weight unaided, and prescribed ibuprofen gel (a non-steroid based anti-inflammatory). The nurse told Mr Boyle to inform staff if he had any further issues.

### HMP Northumberland

37. On 5 May, Mr Boyle was transferred to HMP Northumberland as a progressive move.

38. Before his transfer, Mr Boyle told staff that he could not move to Northumberland because he was under threat from other prisoners at the prison. However, prison staff suspected he did not want to transfer there because it would disrupt his ability to supply illicit articles at Durham. Soon after his arrival at Northumberland,

prison staff suspected that Mr Boyle was attempting to become involved in the supply of illicit drugs there. Prison staff continued to monitor Mr Boyle's behaviour and submitted intelligence reports where appropriate.

39. A nurse carried out a reception health screen and noted Mr Boyle's ongoing back pain and his prescribed pain relief. She also noted that his community GP notes recorded incidents of alcohol misuse. When questioned, Mr Boyle told her he did not drink alcohol, but had used cocaine in the past, although not since being in prison. The nurse did not note any other medical issues.

### Events of 18 May 2017

40. On the afternoon of 18 May, prison custody officers (PCOs) unlocked prisoners to attend work or education. Mr Boyle was not employed but his cell was unlocked by mistake and he left the wing unescorted and without permission. A workshop instructor noted that Mr Boyle was unaccompanied and walking around the prison works department compound. He radioed for assistance from prison staff.

41. A PCO responded and went to collect Mr Boyle to return him to his houseblock. The PCO noted that Mr Boyle appeared to be under the influence of an unknown substance as he was unsteady on his feet and his speech was slurred. When he returned Mr Boyle to his cell, the PCO and another PCO gave Mr Boyle a full (strip) search. Nothing was found. A PCO asked a nurse to review Mr Boyle and he completed an intelligence report.

42. Nurse A saw Mr Boyle at about 2.30pm and noted that his speech was slurred and that he was unsteady on his feet. To enable her to assess his condition, she attempted to record his observations (blood pressure, heart rate, respiratory rate and blood oxygen saturation levels) but he refused. Nurse A did however check his pupils (as pinpoint pupils are a symptom of opioid intoxication) and recorded them as normal and reactive. She also considered he had a normal level of coordination and consciousness.

43. Nurse A asked Mr Boyle what he had taken. Mr Boyle said he had been drinking 'hooch' (illicit prison-brewed alcohol). She considered that he did not need any further input from healthcare staff but told prison staff that Mr Boyle had told her that he had been drinking alcohol. (Nurse A did not record her examination of Mr Boyle until 7.07am on 19 May, after Mr Boyle's death.)

44. At 4.10pm, a PCO unlocked the prisoners for their evening meal. He opened Mr Boyle's cell and saw he was asleep. He called Mr Boyle's name twice but he did not get a response. He went into the cell to check on Mr Boyle and noted he was breathing heavily and was in a deep sleep. He closed Mr Boyle's cell door and moved onto the next cell.

45. At 4.45pm, Mr Boyle went to the servery to collect his evening meal. A PCO noted that Mr Boyle appeared 'dishevelled', as if he was suffering from a hangover. After collecting his meal, Mr Boyle returned to his cell.

46. At 8.00pm, an Operational Support Officer (OSO) arrived on Mr Boyle's houseblock to start her night duties. A PCO told her that there were a number of

prisoners on the wing who appeared to be under the influence of illicit substances. He did not give her a list of names.

47. The PCO said in his statement to the police that the majority of prisoners on the wings 3 and 4 landings were displaying signs of illicit substance use that evening and that he stayed about an hour after his finish time to document his concerns in an intelligence report.

48. The OSO conducted a roll check (a count of prisoners, which is also an opportunity to check on prisoners' wellbeing). She told the investigator that she gained a response from all the prisoners on the wing, including Mr Boyle.

49. While carrying out her duties through the night, the OSO noted Mr Boyle's in-cell light was always on. However, it was not unusual for prisoners to be awake late into the night reading or watching television, so it did not strike her as out of the ordinary. The OSO told the investigator that Mr Boyle did not press his cell bell for assistance, so she had no reason to return to his cell during the night.

### Events of 19 May

50. At about 5.30am, the OSO began conducting the morning roll check. When she arrived at Mr Boyle's cell, she opened the observation panel and noticed he was lying fully dressed on top of his bed. The bed was still made and the bedding was neat. He had one arm behind his head and the other across his chest. His legs were crossed and were resting on the radiator in the cell.

51. The OSO told the investigator that she had a 'gut feeling' that something was not right and looked into Mr Boyle's cell again. She checked to see if Mr Boyle was breathing, and she thought he was, but she could not be sure. She also thought he had a yellow complexion. The OSO tried to get a response from Mr Boyle by calling his name and knocking on his cell door, but there were no signs of any movement.

52. The OSO remained at the cell door and used her radio to ask the PCOs on duty to attend the cell. She did not use an emergency code. She told the investigator that she did not use an emergency code to summon help because she was unsure if Mr Boyle was asleep or not.

53. A PCO arrived at the cell from Houseblock 6, situated next to Houseblock 7, the houseblock on which Mr Boyle lived, and looked through the observation panel. He was also unsure if Mr Boyle was breathing. The PCO called the Night Orderly Officer, a Custodial Operations Manager (COM), and asked for permission to break the seal on his key pack and enter the cell. The COM said she was just arriving and that they should wait for her.

54. The COM arrived, together with a PCO, and immediately went inside the cell. The other staff remained outside. The COM noted that Mr Boyle was lying on his bed as if he was asleep and that there were no signs that he had been in any distress during the night. She felt his neck for any signs of a pulse, and there were none. She noted he was very cold to the touch. She felt under his nose for any signs of breathing and observed his chest for any signs of movement. To double check for signs of a pulse she took hold of his left arm to check his wrist. However, as she did so she noted it was stiff with little or no movement, and she

considered rigor mortis had set in. The COM decided cardiopulmonary resuscitation (CPR) was not necessary as it was clear Mr Boyle had been dead for some time.

55. The COM used her radio to inform communications room staff of Mr Boyle's death. She instructed them to initiate the contingency plans for a death in custody, including contacting the ambulance service, police and Duty Director.

56. An emergency ambulance arrived at the prison at 6:15am. Paramedics confirmed the COM's decision not to carry out CPR. At 6:30am, the paramedics confirmed that Mr Boyle had died.

### Contact with Mr Boyle's Family

57. At 7.40am, one of the Deputy Heads of Residence was appointed as family liaison officer (FLO) for the prison. At 7.58am, the FLO, accompanied by a PCO, also appointed to act as a family liaison officer, left the prison to visit Mr Boyle's parents, who he had named as his next of kin, to inform them of his death.

58. Mr Boyle's parents asked if anyone else had been involved, as Mr Boyle's death had been completely unexpected. The FLO assured them that was not the case and that he was in a cell on his own at the time of his death.

59. Mr Boyle's brother arrived shortly afterwards. He also asked if there had been any third-party involvement in his brother's death. The FLO reassured the family it was not possible for anyone to have caused Mr Boyle's death. She told them that prison staff had checked Mr Boyle the previous evening and there had not been any issues reported.

60. The FLO and PCO offered the family support and explained what they should expect to happen over the coming days. The FLO also told the family that the prison would offer to contribute towards the cost of the funeral.

61. On 21 May, Mr Boyle's mother telephoned the FLO to ask if she could visit her son's cell. The FLO said that the police had asked that the cell remain sealed and that she would confirm a visit once it had been released back to the prison. The FLO telephoned Mr Boyle's mother on 23 May, to tell her the police had finished their investigations and that the cell had been handed back to the prison. However, Mr Boyle's mother told the FLO she had changed her mind and no longer wished to see the cell.

62. On 31 May, the FLO arranged for Mr Boyle's property to be given to his mother. The FLO offered on-going support to Mr Boyle's family.

63. Mr Boyle's funeral was held on 2 June. In line with national instructions, the prison offered a financial contribution towards to cost of the funeral.

### Support for prisoners and staff

64. After Mr Boyle's death, a prison manager debriefed the staff who were involved in the incident giving them the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

65. The prison posted notices informing other prisoners of Mr Boyle'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 Boyle's death.

### Events after Mr Boyle's death

66. Prison staff searched Mr Boyle's cell after his death and found half of a white tablet in the drawer of a cabinet. It has not been established what the tablet contained. The post-mortem report also said that four tablets (thought to be Subutex) were found in the pocket of Mr Boyle's jeans.

67. On 20 May, a prisoner submitted a complaint under the confidential access arrangements about Mr Boyle's death. He said that at about 4.00pm on 18 May, he and another prisoner saw a PCO trying to get a response from Mr Boyle in his cell. He said Mr Boyle eventually responded and the PCO then left and locked Mr Boyle in the cell. The prisoner said he thought it was strange that a nurse was not called out.

68. The prisoner also said that at about 6.30pm, Mr Boyle was in his cell during association 'snorting' Subutex. The prisoner said that he had tried to stop Mr Boyle because he had been under the influence earlier and during association he had been in a 'state' and falling over. The prisoner said that a PCO came and spoke to them in the cell and watched what Mr Boyle was doing without trying to stop him. He said it was the PCO's job to have stopped Mr Boyle using drugs and that by not doing so, he was responsible for Mr Boyle's death.

69. We asked the PCO about the prisoner's allegation that he had seen Mr Boyle snorting drugs in the evening and had not challenged him. The PCO denied absolutely that this had ever happened. He said that he only had direct contact with Mr Boyle's cell on the evening of 18 May when he unlocked him at about 4.10pm and found him asleep. He said he was not concerned about him as he could see and hear that he was breathing and he knew he had been checked by a nurse earlier.

### Post-mortem report

70. The post-mortem was unable to establish Mr Boyle's cause of death.

71. Toxicology tests were carried out and showed a low level of buprenorphine (also known as Subutex, an opioid drug used to treat addiction to opioid drugs such as heroin).

72. The toxicology tests did not find any presence of alcohol or psychoactive substances (PS) in Mr Boyle's system (although the pathologist noted that PS are difficult to detect after death and the fact that they had not been detected did not necessarily mean that Mr Boyle had not used PS before his death).

73. It was not possible for the pathologist to say confidently that the level of buprenorphine in Mr Boyle's system was responsible for his death. However, the pathologist considered that the circumstances of Mr Boyle's death were 'highly suggestive of a death related to the use of an illicit substance'.

# Findings

## Clinical care

74. The clinical reviewer concluded that the clinical care Mr Boyle received at Durham was equivalent to that which he could have expected to receive in the community. Healthcare staff appropriately investigated Mr Boyle's healthcare issues and made timely referrals to the GP for further review. Mr Boyle was only at Northumberland for two weeks before he died and had little significant contact with healthcare staff.

## Emergency Response

75. Prison Service Instruction (PSI) 24/2011, which sets out the procedures for management and security in prisons at night, says that under normal circumstances prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two staff being present. However, it goes on to say that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over the usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff can enter the cell on their own. Northumberland's local policy reflects these provisions.

76. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency is called. Its provisions are mirrored in local policies at Northumberland.

77. We are concerned that when the OSO could not get a response from Mr Boyle (on 18 May), she did not call an emergency code over her radio or enter Mr Boyle's cell, but she called for assistance over her radio. When a PCO arrived, and could not get a response from Mr Boyle, he also did not call an emergency code. Because they did not call a code blue, the control room did not know if an emergency ambulance was needed. This caused a delay in calling the emergency ambulance.

78. We also consider that the OSO and PCO should have entered Mr Boyle's cell when they could not get a response from him. The OSO told the investigator that Mr Boyle had a yellow complexion and that she had a 'gut feeling' that something was wrong. Both officers were also concerned enough to summon help from a senior manager. We consider that they had sufficient concerns about his wellbeing to have warranted them entering the cell.

79. We are also concerned that the COM told the officers to wait for her before they entered the cell. We recognise that there was not a long wait before the COM arrived and that it did not affect the outcome for Mr Boyle, as he had been dead for some time. However, the COM did not know this at the time and it is essential to begin CPR as quickly as possible in an emergency situation as seconds can make the difference between life and death.

80. This is the third time we have made a recommendation about the emergency response at Northumberland. In our investigation into a death in 2016, we recommended that all prison staff are made aware of and understand PSI 03/2013, Medical Emergency Response Codes and their responsibilities during medical emergencies, which ensures staff immediately call for an emergency ambulance when a medical emergency code is used. In July 2017, Northumberland accepted our recommendation and said that they had recirculated PSI 03/2013 as a Director's Order and that the notice would be reissued on an annual basis in order to refresh staff and capture new recruits. Those staff deployed to work in the communications room were reminded that there should be no delay in contacting the ambulance service in the event of a code red of code blue being initiated.

81. Although the delay in entering the cell and calling an emergency code had no impact on the outcome for Mr Boyle, any delay could be critical in future cases. We make the following recommendation:

**The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that:**

- **staff know when to enter a cell;**
- **staff promptly use an emergency code to effectively communicate the nature of an emergency so there are no delays in calling an ambulance.**

### Substance misuse

82. Mr Boyle was a 30-year old man with no record of serious health problems. Although the cause of his death is not known, the pathologist thought his death was likely to be drug-related.

83. Mr Boyle had a history of crack cocaine use in 2011. However, there was no documented history of any drug misuse after that and he denied any drug issues at his reception screens at Durham and Northumberland. Mr Boyle also had a history of alcohol misuse in the community, but he denied any ongoing alcohol problems at the reception screens. Intelligence suggested that Mr Boyle was involved in the illicit supply of drugs at both Durham and Northumberland. There was intelligence that he was suspected of using cannabis at Durham, but there were no reports of him using drugs at Northumberland until the day before his death.

84. There were, therefore, no reasons for staff to have referred Mr Boyle to the prison's substance misuse services.

85. On 18 May, the day before he was found dead, Mr Boyle was found under the influence of an unknown substance. We are satisfied that staff responded promptly and appropriately in referring him to a nurse.

86. Nurse A recorded that when she saw Mr Boyle at about 2.30pm, he told her he had been drinking alcohol, and that although he refused to let her examine him, she was satisfied that he had a normal level of coordination and consciousness. The clinical reviewer is satisfied that, in these circumstances, it was appropriate for Mr Boyle to be left in his cell to sleep it off and that no medical intervention was required.

87. While we have no reason to doubt that, we are concerned that Nurse A did not record this interaction with Mr Boyle until the following morning, nearly 15 hours later, by which time she knew Mr Boyle had died.

88. The Nursing and Midwifery Council's guidance (NMC 2002c) says that effective record keeping is necessary to ensure that medication is properly prescribed and treatment properly administered. The guidance requires that records are written up at the same time or as close to events as possible. In this case Nurse A made her entry so long after the event, that we have to question whether she would have made an entry at all if she had not known that Mr Boyle had died. In addition, retrospective entries of this kind, written with the benefit of hindsight, cannot be relied upon as evidence. We, therefore, recommend:

**The Head of Healthcare should:**

- **ensure that healthcare staff record any interventions in a prisoner's medical record in line with the Nursing and Midwifery Council's guidance on record keeping; and**
- **speak to Nurse A to remind her of this.**

### Confidential access complaint

89. Another prisoner submitted a 'confidential access' complaint alleging that the evening before Mr Boyle was found dead, a PCO watched Mr Boyle 'snorting' Subutex (buprenorphine) without challenging him. If true, this would amount to a serious dereliction of duty by the PCO.

90. The PCO told the investigator the allegations made against him were untrue, and that he had not seen Mr Boyle taking any illicit substances. This is, therefore, a case of one person's word against another's. In addition, after reviewing CCTV footage subsequently provided by the prison, the investigator found no evidence to substantiate the allegations made against the PCO.

91. We note that although the post-mortem found that Mr Boyle had used buprenorphine before his death, this would not have been sufficient to have caused his death.

92. PSI 2/2012, *Prisoner Complaints*, provides that prisoners have the right to make complaints confidentially direct to the Governor in certain circumstances (such as when they are making a complaint about a member of staff). The PSI sets out the procedures for handling such complaints and says they should be recorded and given a serial number by the Complaints Clerk, but only opened by the person they are addressed to. In this way, the prison is able to keep track of

confidential access complaints and ensure that the complainant receives a reply, without compromising the confidentiality.

93. In this case, although the complaint had been logged and assigned a serial number, we were concerned that the prison had no record of the complaint.

94. However, following the initial report, the prison evidenced that the complaint had in fact been investigated and that no evidence had been found to support the prisoner's allegations against the PCO.

95. We cannot say whether Mr Boyle regularly used alcohol or illicit drugs during his time at Northumberland. However, it is clear that Mr Boyle had used illicit substances on the day before he was found dead. He was found under the influence of an unknown substance during the afternoon. He said this was alcohol, although toxicology tests found no traces of alcohol in his system after his death. Another prisoner said that Mr Boyle took buprenorphine later that evening and a low level of this opioid drug was found in his system after his death. In addition, tablets, thought to be buprenorphine, were found in his cell and his pocket after his death.

96. Mr Boyle was not prescribed buprenorphine in prison, and must therefore have obtained it illicitly. We are very concerned that a PCO said that the majority of prisoners on two landings of Mr Boyle's wing appeared to be under the influence of illicit substances the evening before Mr Boyle's death. We also note that following its inspection of Northumberland three months after Mr Boyle's death, HM Inspectorate of Prisons raised serious concerns at the apparent easy availability and level of illicit drug use at Northumberland. We share that concern and consider that although the prison has a substance misuse strategy, more needs to be done to reduce supply and demand. We recommend:

**The Director should ensure that the key drug issues at Northumberland are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.**

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