Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tyrone Quinn a prisoner at HMP Northumberland on 14 May 2018

A report by the Prisons and Probation Ombudsman

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Our Vision

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

Our Values

We are:

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

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

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Tyrone Quinn died on 14 May 2018 from a combination of prescription drugs at HMP Northumberland. Mr Quinn was 22 years old. I offer my condolences to Mr Quinn's family and friends.

None of the drugs that caused Mr Quinn's death had been prescribed to him. I am concerned that despite Northumberland's attempts to reduce the supply of drugs into the prison, Mr Quinn was still able to obtain a range of prescription drugs. The prison will need to reassess their approach in line with the Prison Service's recently published Prison Drugs Strategy.

There was potentially a delay in staff discovering Mr Quinn because the member of staff who carried out the morning roll check did not adequately check on his wellbeing. Mr Quinn was dead when his cell was unlocked two hours later, but I cannot say for certain whether he was dead at the time of the roll check.

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 **February 2020**

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Summary

Events

1. On 30 July 2016, Mr Tyrone Quinn was recalled to prison on suspicion of causing death by dangerous driving and was sent to HMP Durham. On 18 October, he was sentenced to six years and eight months imprisonment. He had a history of substance misuse.

2. Mr Quinn was moved to HMP Northumberland on 7 November. On 7 March 2017, prison staff tested Mr Quinn's urine as part of a mandatory drug test. It tested positive for buprenorphine (an opioid drug) and cocaine.

3. On 17 March, Mr Quinn was moved to Durham but was returned to Northumberland on 28 July.

4. Between 2 February and 3 April 2018, prison staff submitted three intelligence reports that alleged that the smell of drugs was coming from Mr Quinn's cell; that he was associating with another prisoner, thought to be dealing drugs; and that he was dealing drugs on Houseblock One. On 19 March and 4 April, prison staff searched Mr Quinn's cell, but found no illicit items.

5. At approximately 5.30am on 14 May, an operational support grade (OSG) performed a roll check on Houseblock One. CCTV footage shows that the OSG stopped for a few seconds outside Mr Quinn's cell and shone a torch through the observation panel. The OSG told the investigator that he thought Mr Quinn was asleep. He said that he would normally check that he could see the prisoner breathing but he was not 100% certain that he saw Mr Quinn breathing because he was under a quilt and it was difficult to tell.

6. At approximately 7.45am, an officer unlocked Mr Quinn's cell door and found him unresponsive on his bed. At 7.49am, the officer called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) and started cardiopulmonary resuscitation (CPR). Three officers and two nurses responded and continued CPR.

7. Control room staff called an ambulance at 7.56am and paramedics reached Mr Quinn at 8.12am. They found that Mr Quinn showed signs of rigor mortis (stiffening of the body that appears around two hours after death) and lividity (pooling of blood). At 8.25am, a paramedic declared that Mr Quinn had died.

8. The post-mortem report concluded that Mr Quinn's death was caused by the combined effects of buprenorphine, diazepam, zopiclone and pregabalin, all prescription drugs. None of these drugs had been prescribed to Mr Quinn. Psychoactive substances (PS) were also found in Mr Quinn's system, but the pathologist considered these did not contribute to his death.

Findings

Substance misuse

9. Staff did not tell the Drug and Alcohol Recovery Team (DART) when Mr Quinn failed a mandatory drug test in March 2017, or when he was suspected of

dealing and using drugs in early 2018. This meant that DART did not have the opportunity to offer Mr Quinn support with his substance misuse.

10. Despite Northumberland's attempts to reduce the supply of drugs into the prison, we are concerned that Mr Quinn was able to obtain a range of prescription drugs and PS. The prison needs to do more to reduce the supply and demand for drugs.

Roll checks

11. Mr Quinn was dead when he was found at 7.45am and the presence of rigor mortis indicated that he had been dead for some time. We are concerned that the OSG completed the roll check at 5.30am too quickly so failed to properly check on Mr Quinn's wellbeing.

Emergency response

12. We are concerned that the prison's control room did not call an ambulance for seven minutes after the code blue emergency was called.

13. We are also concerned that two nurses continued CPR, when Mr Quinn showed signs of rigor mortis and lividity, and that they were unaware of various policies that explain when it is inappropriate to attempt resuscitation.

Recommendations

- The Director and Head of Healthcare should ensure that staff inform the substance misuse team when prisoners fail drug tests or are suspected of using drugs so that it can provide prompt substance misuse support.
- The Director should ensure that the key drug issues at Northumberland 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 Director should ensure that staff completing roll checks satisfy themselves that there are no immediate causes for concern.
- The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.
- The Director and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.
- The Head of Healthcare should ensure that all staff are aware of the Decision Relating to Cardiopulmonary Resuscitation guidance and the G4S Resuscitation Policy and that appropriate training is put in place to implement the guidance.

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Northumberland informing them of the investigation and asking anyone with relevant information to contact her. A REFORM restorative justice coordinator contacted the investigator.

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

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

17. The investigator interviewed four members of staff by video link on 2 and 18 July. The clinical reviewer accompanied the investigator for one of the interviews on 2 July.

18. We informed HM Coroner for Northumberland North District of the investigation. The coroner gave us the results of the post-mortem examination. Our investigation was suspended for over eight months until we received the post-mortem and toxicology reports from the coroner. We have sent the coroner a copy of this report.

19. The investigator contacted Mr Quinn's mother to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised no issues.

20. 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.

21. The initial report was shared with the Independent Monitoring Board (IMB). The IMB pointed out some factual inaccuracies and this report has been amended accordingly.

22. Mr Quinn's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Northumberland

23. HMP Northumberland is a training prison holding up to 1,348 men, predominately from the North East of England. Sodexo Justice Services manage the prison, G4S provide the primary healthcare services and Tees, Esk and Wear Valley NHS Foundation Trust provide mental health services.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Northumberland was in August 2017. Inspectors found that the prison was suffering from the impact of drugs more severely than many other prisons. Prisoners admitted that it was easy to obtain illicit drugs and over a fifth said they had developed a drug habit since entering the prison. Inspectors also found that a drug and alcohol strategy committee discussed supply and demand reduction initiatives but that attempts to address the widespread drug problem were not effective.

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 the year to December 2018, the IMB found that problems with drugs persisted, though the prison had made efforts to curtail drug demand and supply. The IMB reported that these steps included withholding mail believed to have been impregnated with psychoactive substances, the arrival of two drug detection dogs and the use of body scanners to detect drugs. Despite these efforts, the IMB found that the impact on drug use was happening slowly.

Previous deaths at HMP Northumberland

26. Mr Quinn was the 13th prisoner to die at Northumberland since May 2015. Of the previous deaths, five were due to natural causes, five were self-inflicted and two were unascertained but suspected to be drug-related. There have been two deaths since, both from natural causes. We have made previous recommendations about reducing the supply and demand for drugs, ensuring that a prisoner's wellbeing is checked during a roll check, and about immediately calling an ambulance when an emergency code is called.

Key Events

27. On 30 July 2016, Mr Tyrone Quinn was recalled to prison on suspicion of causing death by dangerous driving and was sent to HMP Durham. On 18 October, he was sentenced to six years and eight months imprisonment.

28. When he arrived at Durham, a nurse saw Mr Quinn for an initial health assessment. Mr Quinn said that he did not have any history of substance misuse and had no health concerns.

29. On 1 August, a prisoner working on the Peer Information Desk (PID) saw Mr Quinn and gave him information about minimising the risks from using drugs. The prisoner also gave Mr Quinn a leaflet warning him of the dangers of using psychoactive substances (PS). Mr Quinn declined to work with the Drug and Alcohol Recovery Team (DART). Despite his refusal, on 24 August, a DART support worker saw Mr Quinn, who did not raise any substance misuse concerns.

30. On 1 September, prison staff tested Mr Quinn's urine as part of a mandatory drug test and it produced a negative result.

31. On 7 November, Mr Quinn was moved to HMP Northumberland. A nurse saw Mr Quinn for an initial health assessment and he said that he did not have any history of substance misuse.

32. Two weeks later, a DART support worker saw Mr Quinn, who said he had been drinking alcohol and had used cocaine when he had committed his offence, and that he used cocaine on a monthly basis in the community. The DART worker started a substance misuse recovery map for Mr Quinn and gave him information on the dangers of using cocaine and alcohol.

33. On 1 December, Mr Quinn met with his offender supervisor for a sentence planning meeting. Mr Quinn said that he was working with DART to address his use of cocaine and alcohol. The offender supervisor set Mr Quinn four sentence plan objectives, which included continuing to work with DART and attending the Thinking Skills Programme.

34. On 14 December, a DART support worker saw Mr Quinn, who said that he was grateful for the support that DART had offered him.

35. Two weeks later, Mr Quinn told the DART worker that he was "drug-free". The DART worker reiterated the importance of maintaining this in the short and long-term.

36. On 23 January 2017, Mr Quinn told a DART support worker that he did not need any support from DART at that time and that he wanted his file to be closed. The DART worker gave Mr Quinn a leaflet on reducing the risks from drugs.

37. On 7 March, prison staff tested Mr Quinn's urine as part of a mandatory drug test. It tested positive for buprenorphine (an opioid drug, used to treat heroin addiction) and cocaine. An officer placed Mr Quinn on report for the failed drug test and recorded this information on his electronic prison record. There is no record that this information was given to DART.

38. On 17 March, Mr Quinn was moved from Northumberland to Durham, after appearing in court. A nurse reviewed Mr Quinn, who said that he did not have any drug or alcohol problems.

39. Three days later, a prisoner working on the Peer Information Desk (PID) saw Mr Quinn and gave him information about minimising the risks from using drugs. The prisoner also gave Mr Quinn a leaflet warning him of the dangers from using PS. Again, Mr Quinn declined to work with DART.

40. On 28 July, Mr Quinn was moved from Durham to Northumberland. When he arrived at Northumberland, Mr Quinn refused a new patient screening, although a nurse noted that Mr Quinn had not used drugs in the last month and did not have any history of substance misuse.

41. On 15 August, a sexual health outreach worker saw Mr Quinn in the genitourinary clinic. Mr Quinn told the outreach worker that he had snorted drugs in the past but did not share his equipment. The outreach worker recorded in Mr Quinn's electronic medical record that he was "educated around risks".

42. On 19 December, a DART administrator recorded on Mr Quinn's DART record that he had been working with a DART mentor and that he was "drug-free".

43. On 2 February 2018, an unidentified member of staff submitted an intelligence report that alleged that a strong smell of cannabis was coming from Mr Quinn's cell.

44. A week later, an unidentified member of staff submitted an intelligence report that alleged that Mr Quinn was associating with another prisoner, who was thought to be dealing drugs.

45. On 19 March, two prison staff searched Mr Quinn's cell but they did not find any illicit items.

46. On 3 April, an unidentified member of staff submitted an intelligence report that alleged that Mr Quinn was dealing drugs on Houseblock One.

47. The following day, two prison staff searched Mr Quinn's cell but they did not find any illicit items.

48. Later that day, an officer spoke to Mr Quinn about his sentence progression. Mr Quinn said that he felt paranoid about how often his cell had been searched and the officer suggested that this was due to who he associated with on the houseblock.

49. On 11 and 24 April, an officer spoke to Mr Quinn about being on Houseblock One. On both occasions, Mr Quinn said that he was happy on the houseblock but he was annoyed by the "spice heads" (that is, prisoners who used PS).

50. On 26 April, a treatment manager held a post programme review of Mr Quinn's attendance at his Thinking Skills Programme, which he had started on 19 February. During the programme, Mr Quinn identified that the use of illicit substance was one of his risk factors for offending but that he had learnt some

distraction techniques to avoid drug use. Mr Quinn said he had set himself the goal of remaining drug free in custody.

51. At 2.10pm on 13 May, an officer spoke to Mr Quinn, who said that he was in high spirits and doing well on the wing.

52. At 11.06pm, Mr Quinn used his in-cell telephone and called his mother's telephone number. Mr Quinn was on the call for just over two minutes before he hung up.

Events on 14 May 2018

53. At approximately 5.30am on 14 May, an OSG performed a roll check on Houseblock One. The CCTV footage shows that the OSG stopped for a few seconds outside Mr Quinn's cell and that he shone a torch through the observation panel. The OSG told the investigator that he thought Mr Quinn was asleep but he could not be 100% certain that he was breathing.

54. At approximately 7.45am, an officer started unlocking cells on Houseblock One. The officer unlocked Mr Quinn's cell door and called out his name but there was no response. The officer called out Mr Quinn's name again, entered the cell and found him unresponsive on his bed. The officer shook Mr Quinn and saw that his face was pale grey with yellow and white foam coming from his mouth. At 7.49am, the officer called a code blue emergency (which indicates that a prisoner is unconscious or having difficulty breathing) then started cardiopulmonary resuscitation (CPR). The officer told the investigator that, when he started CPR, he noticed that Mr Quinn was "freezing cold".

55. A senior officer and two officers quickly responded to the code blue emergency. They continued CPR and attached a defibrillator but it did not detect a shockable heart rhythm and advised to continue CPR.

56. Two nurses then arrived at Mr Quinn's cell. A nurse noted that Mr Quinn was warm to the touch and that his pupils were unreactive. They inserted an airway, gave Mr Quinn oxygen and continued CPR.

57. The North East Ambulance Service log shows they received the call for an emergency ambulance at 7.56am. Paramedics reached Mr Quinn at 8.12am and took his clinical observations. They decided that Mr Quinn showed signs of rigor mortis (stiffening of the body that normally appears around two hours after death) and lividity (pooling of blood) so, at 8.25am, a paramedic declared that he had died.

Contact with Mr Quinn's family

58. At 8.25am on 14 May, the prison appointed an OSG as the family liaison officer and a senior officer as the deputy family liaison officer. At approximately 11.00am, the OSG and the senior officer visited the home address of Mr Quinn's mother to break the news of his death and to offer their condolences and support.

59. The OSG and the senior officer continued to support Mr Quinn's mother and other family members until his funeral. Mr Quinn's funeral took place on 30 May and the prison contributed to the funeral costs in line with national policy.

Support for prisoners and staff

60. After Mr Quinn's death, the then Director 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.

61. The prison posted notices informing other prisoners of Mr Quinn'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 Quinn's death.

Post-mortem report

62. The post-mortem report concluded that Mr Quinn's death was caused by the effects of a combination of buprenorphine, diazepam (a tranquilliser), zopiclone (also a tranquilliser) and pregabalin (used to treat epilepsy, anxiety and nerve pain but can be taken to enhance the euphoric effects of other drugs such as opioids). The post-mortem report explained that these drugs, which Mr Quinn was not prescribed, are often abused and have overlapping side effects, which include respiratory depression, coma and death.

63. The post-mortem report also showed the presence of PS in Mr Quinn's blood. However, given the likely respiratory cause of death, the pathologist decided that the PS could not have caused or contributed to Mr Quinn's death.

Findings

Substance misuse

64. During the first six months of Mr Quinn's sentence, he engaged with DART support workers at Durham and Northumberland. On 23 January 2017, Mr Quinn said that he was "drug-free" and that he no longer required support from DART. However, less than two months later, on 7 March, Mr Quinn failed a mandatory drug test for buprenorphine and cocaine. Additionally, between 2 February and 3 April 2018, three intelligence reports alleged that Mr Quinn was suspected of dealing and using drugs.

65. Despite these episodes demonstrating that Mr Quinn was using or suspected of using drugs, there is no record that this information was passed to DART, which would have enabled them to offer him their support. We are concerned that information about Mr Quinn's misuse of drugs was not provided to healthcare or DART staff and that this led to him not being properly supported following his relapse, despite continuing to work with DART being one of his four sentence plan objectives. We make the following recommendation:

    The Director and Head of Healthcare should ensure that staff inform the substance misuse team when prisoners fail drug tests or are suspected of using drugs so that it can provide prompt substance misuse support.

66. In the months before Mr Quinn's death, prison staff submitted three intelligence reports that alleged that he was involved in using and supplying drugs. On 19 March and 4 April, prison staff searched Mr Quinn's cell but they did not find any illicit items. While it is disappointing that the searches were unsuccessful, we are satisfied that the prison reacted appropriately to the intelligence reports and that they took steps to reduce the supply of drugs on Houseblock One.

67. However, following Mr Quinn's death, the prison received an allegation that Mr Quinn used drugs that visitors brought into the prison. We note that the prison's Drug Supply Reduction Strategy, dated January 2018, contained a number of actions, some complete and others incomplete, aimed at reducing the supply of drugs through social visits. These included introducing the use of a drug dog, purchasing an X-ray machine, installing a drug amnesty box and increasing the use of closed visits.

68. While we recognise that the prison has taken steps to try to reduce the supply of drugs during social visits, Mr Quinn's death demonstrates that further efforts are required. Northumberland is not alone in facing this problem, drug use is a serious problem across much of the prison estate. The PPO has called for HMPPS to publish national guidance to prisons providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a strategy to reduce the supply of and demand for drugs in prisons.

69. In relation to reducing the supply of drugs, the new 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."

70. We, therefore, make the following recommendation:

The Director should ensure that the key drug issues at Northumberland are identified and that the prison's local drugs strategy is revised by September 2019 to ensure that these key issues are being addressed.

Roll checks

71. The purpose of a roll check is to confirm that all prisoners are present and correctly accounted for, that they have not escaped, and are not ill or dead. CCTV footage shows that the OSG's roll check consisted of briefly shining a torch through the cell observation panel and that he spent a matter of seconds looking into Mr Quinn's cell.

72. The OSG told the investigator that when completing his roll checks, he would see whether the prisoner was breathing by checking whether their chest was rising and falling. The OSG said he thought he had checked whether Mr Quinn was breathing but, due to him being under a quilt, he was not 100% sure. The OSG said that he would not bang on the door to wake a prisoner because there would be an uproar.

73. When paramedics reached Mr Quinn at 8.12am, they found signs of rigor mortis and lividity, which indicated that he had been dead for some time. While we cannot be sure when Mr Quinn died, it is possible that he was dead at the time of the roll check. We are concerned that the speed of the check meant that the OSG did not adequately check on Mr Quinn's welfare and that his own uncertainty about whether Mr Quinn was breathing, increase the possibility that Mr Quinn was dead at the time of the roll check. We make the following recommendation:

The Director should ensure that staff completing roll checks satisfy themselves that there are no immediate causes for concern.

Emergency response

74. PSI 03/2013, 'Medical Emergency Response Codes', contains a mandatory instruction that on hearing the code blue, control room staff must call an ambulance immediately.

75. An officer called a code blue emergency at 7.49am but according to the North East Ambulance Service, the prison's control room did not call for the ambulance until 7.56am, a delay of seven minutes. We are concerned that the control room ignored the requirement in PSI 03/2013 as they failed to immediately call for an ambulance. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that control room staff call an ambulance as soon as an emergency code is called.

76. In September 2016, the National Medical Director at NHS England wrote to prison Heads of Healthcare introducing new guidance to support staff on when not to perform CPR. This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in prison and was taken from the European Resuscitation Council Guidelines 2015 which state: "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile." The guidelines say that resuscitation should not be attempted where rigor mortis or lividity is present.

77. G4S Health Services' Resuscitation Policy, dated January 2017, repeats the guidance from the National Medical Director, though it states that "staff who are not able to recognise rigor mortis should start resuscitation until advised otherwise by a competent member of staff".

78. A nurse told the investigator that she did not see any signs of lividity with Mr Quinn and that she did not check for rigor mortis. The nurse also said that she understood that she had to continue CPR once it had been started and that she had not seen the National Medical Director's guidance. A second nurse told the investigator that he was not aware of G4S's Resuscitation Policy or how to identify when rigor mortis had set in.

79. We recognise that making a decision about whether to start or continue resuscitation is difficult in a distressing and stressful situation. However, we agree with the clinical reviewer that staff need training, guidance and reassurance about the circumstances when it is acceptable not to perform CPR, to minimise the distress for them and lack of dignity for the deceased. We make the following recommendations:

The Director and Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.

The Head of Healthcare should ensure that all staff are aware of the Decision Relating to Cardiopulmonary Resuscitation guidance and the G4S Resuscitation Policy and that appropriate training is put in place to implement the guidance.

80. The hot debrief highlighted that, at the start of the incident, there was too much radio traffic that caused a slight delay in receiving information about Mr Quinn and updates on the ambulance. The attendees were told that work was underway to improve usage of the radio network.

81. On 9 May 2018, the prison issued an Information Notice saying that, from 21 May, the control room would lead the radio network and that radio to radio transmissions would not be allowed. The prison introduced this change to enable the control room to quickly clear radio traffic during an emergency. As the prison has taken positive steps to resolve this issue, we do not make a recommendation.

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