Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jacob Rhoden, a prisoner at HMP Warren Hill, on 1 May 2021

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.

Our 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 Jacob Rhoden was found dead in his cell at HMP Warren Hill on 1 May 2021. The post-mortem examination found that he died from toxic levels of nefopam, a painkiller he had been prescribed. He was 42 years old. I offer my condolences to Mr Rhoden's family and friends.

On 23 April, the day he collected his supply of nefopam tablets, Mr Rhoden was taken to hospital after suffering a seizure. He was discharged in the early hours of 24 April. Two days later, a medication spot check found that Mr Rhoden had no nefopam tablets left, when he should have had 26. Pharmacy staff stopped his nefopam. A few days later, he was found dead in his cell.

There is no indication that Mr Rhoden took a large quantity of nefopam with the intention of ending his life. (He had taken overdoses of nefopam in the past with no apparent suicidal intent.)

The clinical reviewer found that the clinical care Mr Rhoden received at Warren Hill was not of a good standard and was not equivalent to that he could have expected to receive in the community. Not only had Mr Rhoden been prescribed nefopam over a long period of time when it should be used for short-term pain relief, but there were also concerns about its use alongside Mr Rhoden's epilepsy and heart issues. There were also signs that Mr Rhoden was using nefopam inappropriately. Despite this, staff at Warren Hill never carried out a medication review. The clinical reviewer found the lack of monitoring very concerning.

The investigation found that the officer who unlocked Mr Rhoden's cell on the morning of 1 May, did not do a proper welfare check and therefore failed to realise that Mr Rhoden was dead. Although this did not affect the outcome for Mr Rhoden, it took another hour before staff discovered him.

This version of my report, published on my website, has been amended to remove the names of the staff and prisoners involved in my investigation.

Elizabeth Moody
Deputy Prisons and Probation Ombudsman **February 2022**

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Summary

Events

1. In April 2000, Mr Jacob Rhoden was sentenced to life imprisonment for murder. On 28 July 2020, he was moved to HMP Warren Hill.

2. Mr Rhoden had a number of chronic health conditions, including heart problems and epilepsy. He also had ongoing pain in his neck, back and shoulders. He was first prescribed nefopam (a painkiller) in 2010, and he continued to be prescribed pain relief, including nefopam, thereafter.

3. On 21 April 2021, Mr Rhoden obtained additional nefopam by taking other painkillers to the medications hatch and saying he had been given them in error. Pharmacy staff swapped them for nefopam. However, the pharmacy manager quickly realised what Mr Rhoden had done and retrieved the extra nefopam.

4. Two days later, Mr Rhoden collected his nefopam as prescribed. That evening, he had a seizure and was treated in hospital. He returned to Warren Hill in the early hours of 24 April.

5. On 26 April, Mr Rhoden failed a medication check as he was found to have no nefopam tablets left when he should have had 26. He said he had thrown his nefopam in the bin. The pharmacy manager stopped his nefopam.

6. Three days later, staff held a multi-disciplinary meeting with Mr Rhoden to discuss his medication compliance. He said he no longer wanted nefopam as it made him feel 'funny'. Staff referred him to the wellbeing team for support and for an assessment with the substance misuse team, but he died before this took place.

7. On 1 May, at around 9.15am, an officer unlocked Mr Rhoden's cell. Around an hour later, another officer went to Mr Rhoden's cell and saw him lying on his bed. He did not respond to her and then she realised she could not see him breathing. She called a medical emergency code. When staff arrived, they realised that Mr Rhoden was already dead and did not try to resuscitate him. Paramedics arrived and at 10.45am, confirmed that Mr Rhoden had died.

8. Toxicology tests found that Mr Rhoden's blood contained a very high level of nefopam. No other drugs were detected. The post-mortem report concluded that Mr Rhoden died of nefopam toxicity. Epilepsy was listed as a contributory factor.

Findings

9. There is no indication that Mr Rhoden took a large quantity of nefopam with the deliberate intention to end his life.

10. The clinical reviewer found that the clinical care Mr Rhoden received at Warren Hill was not of a good standard and not equivalent to that he could have expected to receive in the community.

11. The clinical reviewer noted that Mr Rhoden had been prescribed nefopam for a long time despite it not being suitable for treatment of long-term chronic pain. She also had concerns about prescribing nefopam to Mr Rhoden was appropriate given his epilepsy and heart problems. In addition, there were signs that Mr Rhoden was using nefopam inappropriately. Despite this, no medication review was ever carried out at Warren Hill. The clinical reviewer found the lack of monitoring very concerning.

12. At morning unlock, prison staff are supposed to carry out a welfare check which involves getting a response from each prisoner to satisfy themselves that they have not escaped and are not ill or dead. In his statement, the officer who unlocked Mr Rhoden's cell said he thought Mr Rhoden responded when he said good morning. However, Mr Rhoden must have been dead at this time as when he was discovered an hour later, he had rigor mortis which indicates that he had been dead for at least two hours. Clearly the welfare check was not carried out properly at morning unlock, an issue we have previously identified at Warren Hill. The Governor has since issued a reminder to staff.

Recommendations

- The Head of Healthcare should ensure that medications are prescribed in line with safe prescribing guidelines and that:
    - all staff in the integrated healthcare teams can demonstrate they understand prescribing guidelines; and
    - prisoners have medication reviews according to their individual needs.

- The Head of Healthcare should share this report with the pharmacy manager and Dr A and discuss the Ombudsman's findings with them.

The Investigation Process

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

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

15. NHS England commissioned a clinical reviewer to review Mr Rhoden's clinical care at the prison. The investigator and clinical reviewer jointly interviewed nine prison and healthcare staff. The investigator also interviewed a prison manager and the clinical reviewer also had contact with the healthcare manager. Due to COVID-19 restrictions all interviews were conducted remotely.

16. We informed HM Coroner for Greater Suffolk of the investigation. The coroner gave us the post-mortem report. We have sent the coroner a copy of this report.

17. The Ombudsman's family liaison officer contacted Mr Rhoden's brother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Rhoden's brother asked about the state of Mr Rhoden's physical and mental health in the lead up to his death and how it was monitored; about his nefopam prescription, including the dose and whether Mr Rhoden kept it in his possession; and whether Mr Rhoden had ever overdosed or discussed death or suicide. His questions have been answered in this report and the clinical review report. (He also asked some questions that were not within the remit of this investigation about other deaths from nefopam toxicity and we have advised him how to request the information from the Prison Service.)

18. Mr Rhoden's family received a copy of the initial report. They identified a factual inaccuracy relating to Mr Rhoden's nominated next of kin, which we have amended.

19. The prison also received a copy of the report and did not identify any factual inaccuracies. An action plan for the recommendations is annexed to the report.

Background Information

HMP Warren Hill

20. HMP Warren Hill is a medium secure prison that holds nearly 258 men mostly serving life sentences and indeterminate sentences for public protection.

21. Practice Plus Group (formerly Care UK) provides healthcare services and Phoenix Futures provides the psychosocial aspect of substance misuse support. GP services are contracted via Leiston Surgery. Nurses are on duty between 7.30am and 7.30pm during the week, and 7.30am to 5.30pm on weekends and public holidays. Nurses provide regular clinics for chronic conditions, substance misuse and mental health. Doctors consult at the prison from 8.00am to 1.00pm on weekdays.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Warren Hill was in December 2019. Inspectors noted there were excellent relationships between staff and prisoners and a positive staff culture which emphasised a professional, caring but challenging approach. All prisoners, regardless of where they were located, had a personal officer or key worker, and unlike many other prisons this was a meaningful relationship, founded on decency. Inspectors found that Warren Hill was the safest Category C prison in the country. Food provision was found to be 'merely adequate'.

23. Inspectors found that health services had improved since their last inspection and were reasonably good. Treatment for those prisoners with long-term conditions had improved, all had care plans and nurses carried out regular reviews. There was evidence of effective joint working between the mental health team and substance misuse services.

24. Inspectors noted there was monthly monitoring of the prescribing of medicines liable to abuse, and the pharmacist personally checked areas of concern and discussed them with the lead GP. Healthcare staff completed regular spot checks to identify if prisoners had the expected amount of medications in their possession and took appropriate actions if they failed these checks.

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 31 May 2020, the IMB reported that there was a positive culture between staff and prisoners. The Board noted that healthcare was of a similar standard to that provided in the community. They found issues relating to medication formed the majority of healthcare complaints.

26. The Board noted that prisoners complained about the quality of food provided, which was a particular challenge during the COVID-19 lockdown and Ramadan, but that it had improved, along with cooking facilities on the wing.

Previous deaths at HMP Warren Hill

27. Mr Rhoden was the second prisoner to die at Warren Hill since May 2019. The previous death was self-inflicted. Although the circumstances in that case were different, we identified issues with the unlock procedures at the prison.

Key Events

28. In April 2000, Mr Jacob Rhoden was sentenced to life imprisonment for murder. He progressed to open conditions, but in January 2020, he absconded for four days and was returned to closed conditions at HMP Wandsworth.

29. Mr Rhoden had a number of physical health conditions, including heart problems (viral cardiomyopathy, mitral valve regurgitation and a dilated ventricle, meaning his heart did not pump blood as well as a healthy heart), epilepsy, high blood pressure, type 2 diabetes and type 1 Chiari malformation (a condition, normally present from birth, where the lower part of the brain pushes down into the spinal canal, which can cause headaches, vomiting, dizziness and neck pain). He was prescribed medications to help manage the symptoms of all these conditions.

30. In 2010, Mr Rhoden was prescribed nefopam for the short-term relief of back and shoulder pain. (Nefopam is a non-opioid painkiller recommended for persistent pain which is unresponsive to other non-opioid painkillers.) He continued to be prescribed pain relief thereafter (sometimes naproxen instead of nefopam).

31. From 2010 onwards, the medical records document that nurses, pharmacy staff and GPs had concerns about the use of nefopam, because of Mr Rhoden's epilepsy and heart conditions, as there were recognised side effects of using the drug. It was also documented in Mr Rhoden's medical record that he had taken several previous overdoses of nefopam in different prisons in July 2011, October 2013, November 2015 and December 2017. (Nefopam abuse is unusual, but it does sometimes occur due to the drug's psychostimulant effects which can cause a 'high' and a feeling of calm, and the drug has been noted to be addictive.) It is not known whether Mr Rhoden took more than his prescribed dose of nefopam on these occasions to change his mood or alleviate any physical pain, but notes made in his prison record at the time state there was no obvious suicidal intent.

HMP Warren Hill

32. On 28 July 2020, Mr Rhoden was moved to HMP Warren Hill. At his reception screening, he said he had no thoughts of suicide or self-harm. He was prescribed various medications and was assessed as suitable to have a 28-day supply 'in possession' (meaning he was allowed to keep his medication in his cell to administer himself, rather than having to attend the medication hatch every day to collect his medication and take it under supervision).

33. Mr Rhoden was not prescribed nefopam when he arrived at Warren Hill - he was last prescribed it at Wandsworth in February 2020.

34. On 3 August a pharmacy officer, saw Mr Rhoden in his cell and reviewed his medications. Mr Rhoden complained of shoulder pain and asked to be prescribed nefopam. The pharmacy officer noted that nefopam had previously been prescribed and booked Mr Rhoden a GP appointment. The next day Dr A, the prison GP, prescribed nefopam (42 tablets every seven days). She also noted that physiotherapy could be a helpful intervention, although there is no further reference to this. (Mr Rhoden had accessed physiotherapy in previous prisons with little success.)

35. On 17 September, Mr Rhoden told Dr B, another prison GP, that nefopam ruined his appetite and he wanted to revert to naproxen. The GP prescribed naproxen instead.

36. In December, following a parole review, Mr Rhoden was told he was not suitable for transfer to open conditions. Staff noted that Mr Rhoden took the news well and that he remained in contact with his offender manager to focus on what his goals were before his next review.

37. On 19 January 2021, Mr Rhoden self-referred to the Improving Access to Psychological Therapies team (IAPT – for the treatment of anxiety disorders and depression). A cognitive behavioural therapist (CBT – a talking therapy to help manage your problems by changing the way you think and behave) was assigned to work with Mr Rhoden for six sessions. Mr Rhoden wanted to focus on his childhood trauma. During his assessment on 3 February, Mr Rhoden did not disclose any thoughts of suicide or self-harm. Weekly sessions started on 24 February.

38. On 1 April, Nurse A examined Mr Rhoden as he was short of breath, dizzy and had pain in his hands. Mr Rhoden was weighed (97kg) but no other clinical observations were taken. Later, Mr Rhoden had a telephone consultation with the cardiology department at the local hospital. Blood tests were taken, and he was referred for an MRI scan. (Blood tests were repeated on 15 April and the results were satisfactory. Mr Rhoden did not have an MRI scan before he died.)

39. On 9 April, Dr A, examined Mr Rhoden as he had pain in his neck, back, legs and arms and the pain in his shoulder was worse. Mr Rhoden told the doctor that he could not eat properly and wondered if he was having a seizure at night. He said he was tired and did not feel like cooking. The doctor recorded that Mr Rhoden's shoulders were normal and that he had longstanding left shoulder pain but that it was 'not for intervention due to high risk ' (no further explanation is given). The doctor noted that Mr Rhoden 'switches between Nefopam and Naproxen as he feels he gets used to one'. She prescribed nefopam (30mg), two tablets to be taken three times a day.

40. On 13 April, Mr Rhoden asked Nurse B for a sick note as he was fasting for Ramadan and because he said his joint pain and chronic health conditions affected his ability to work. On 19 April, Dr A wrote a long-term sick note for Mr Rhoden.

41. On 21 April, Mr Rhoden went to the medications hatch and returned some old naproxen tablets and said they had been issued to him in error instead of nefopam. Healthcare staff gave him nefopam.

42. The pharmacy manager subsequently realised that Mr Rhoden was not due to have his nefopam medication for another two days, and that the medication had been given in error. The pharmacy manager contacted the wing and insisted that Mr Rhoden return the nefopam given to him, which he did. The pharmacy manager noted in Mr Rhoden's medical record, 'Patient purposefully trying to get Nefopam early - will monitor his compliance.' She submitted an intelligence report saying that Mr Rhoden had tried to collect his medication early and was suspected of possibly selling or trading medication.

43. On 23 April, Mr Rhoden collected his nefopam in line with his prescription. At around 7.45pm that evening, an officer responded to Mr Rhoden's emergency cell bell. Mr Rhoden had a seizure. Prison staff called an ambulance and Mr Rhoden was taken to hospital. He was discharged in the early hours of 24 April and returned to Warren Hill. (Mr Rhoden arrived with no discharge letter from the hospital.)

44. On 24 April, Nurse C, a mental health nurse, met with Mr Rhoden. He told her that he had no appetite and was not eating or sleeping because he was stressed. She noted that he was working with the IAPT team. Mr Rhoden said he had no thoughts of suicide or self-harm and the nurse advised him to contact prison or healthcare staff if things changed.

45. On 26 April, the pharmacy officer carried out a medication spot check. Mr Rhoden should have had 26 nefopam tablets in his cell but had none. He told the pharmacy officer he had thrown them in the bin. The pharmacy officer told the pharmacy manager about this and referred Mr Rhoden to the prison GP for review. Dr A noted that Mr Rhoden's nefopam medication was 'not on repeat so wait and see what happens'. The pharmacy manager responded and stopped the nefopam due to Mr Rhoden's failed compliance check and history of trying to collect his medication early.

46. On 28 April, Mr Rhoden was due to complete his last IAPT session, but it was cancelled as the prison was in lockdown for staff training. His appointment was scheduled for the following week.

47. On 29 April, the pharmacy manager and a senior drug worker with Phoenix Futures, Mr Rhoden and his personal officer attended a Multi-Disciplinary Team (MDT) meeting to discuss Mr Rhoden's medication compliance. Mr Rhoden said that he no longer wanted to be prescribed nefopam as it made him feel 'funny'. He said he had been feeling low after his IAPT sessions and had lost weight as he was not eating. Mr Rhoden said he had no thoughts of suicide or self-harm. He agreed to be referred to the health support worker and wellbeing services and he was encouraged to read as a distraction. Mr Rhoden was also referred for an assessment with Phoenix Futures, but this did not take place before he died.

48. Mr Rhoden maintained contact with his family throughout his time at Warren Hill. All prisoners' telephone calls, except those that are legally privileged, are recorded, and prison staff listen to a random sample. The investigator listened to the calls made by Mr Rhoden in the week before he died. During these calls Mr Rhoden told his partner that his legs were sore, his tongue hurt, and he had lots of pain in his muscles and hips. Mr Rhoden said that he had spoken to the Imam about not fasting during Ramadan, that he was not eating properly as he was not hungry, that the food was cold and that there was no orange juice. Mr Rhoden also said that he found talking about his childhood trauma difficult and that it had 'mashed me up' and that he would be able to talk to his family if he was not in prison.

Events of 30 April/1 May 2021

49. On 30 April, Mr Rhoden made two phone calls to his partner, at 1.35pm for around 20 minutes and at 2.00pm for nearly 17 minutes. During these

conversations Mr Rhoden spoke about his old employment and people they knew. Although Mr Rhoden spoke of some of his difficulties and challenges, all the calls listened to were generally upbeat and there was nothing in the calls to suggest he was in crisis.

50. Closed circuit television (CCTV) shows Officer A locked Mr Rhoden's cell for the night at 4.56pm.

51. On 1 May, at around 9.15am, Officer B went to Mr Rhoden's cell to unlock him. In his statement, the officer said he thought he heard someone reply when he said good morning and he continued unlocking the rest of the landing.

52. CCTV shows that at 10.19am, Officer C went to Mr Rhoden's cell door. She saw him lying on his bed. She called his name, but Mr Rhoden did not respond, and she was concerned as she could not see him breathing. The officer radioed a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). Other officers responded and they discovered that Mr Rhoden was cold and had rigor mortis (stiffening of the body that occurs a few hours after death). Staff did not therefore attempt resuscitation.

53. East of England Ambulance Service confirmed they received a request for an ambulance at 10.20am. Paramedics arrived and after they assessed Mr Rhoden, they confirmed he was dead at 10.45am.

Contact with Mr Rhoden's family

54. The prison appointed Custodial Manager (CM), A, as the family liaison officer (FLO). Under normal circumstances next of kin should, wherever possible, be informed of a death in person by a FLO. However, this has not been permitted during the COVID-19 pandemic. The CM therefore informed Mr Rhoden's sister and brother of his death by telephone and offered ongoing support. The prison contributed towards the costs of Mr Rhoden's funeral, in line with national policy.

Support for prisoners and staff

55. After Mr Rhoden's death, CM B and a prison manager, debriefed all the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

56. The prison posted notices informing other prisoners of Mr Rhoden's death and offering support. Staff reviewed all prisoners considered to be at risk of suicide and self-harm in case they had been adversely affected by Mr Rhoden's death.

Post-mortem report

57. Post-mortem toxicology tests showed Mr Rhoden had a high concentration of nefopam in his blood (5.47 ug/ml - the normal range for someone prescribed nefopam is 0.07 to 0.15 ug/ml). No other drugs were detected.

58. The pathologist gave Mr Rhoden's cause of death as nefopam toxicity and listed epilepsy as a contributory factor. She concluded, 'Given significantly elevated levels of Nefopam I do believe that the death had occurred due to Nefopam toxicity rather than a sudden unexpected death in epilepsy.'

Findings

Cause of death

59. Mr Rhoden died from nefopam toxicity. While we cannot be certain of Mr Rhoden's intentions, there is no indication that he took a high dose of nefopam with the intention of ending his life. He left no note and his phone calls in the lead up to his death did not suggest that he was in crisis. He may have taken it to get 'high' or in an attempt to relieve his pain.

Clinical Care

60. The clinical reviewer concluded that the clinical care Mr Rhoden received at Warren Hill was not of a good standard and was not equivalent to that which he could have expected to receive in the community. Specifically, she found that the lack of monitoring around the nefopam prescription was very concerning.

Nefopam prescription

61. Mr Rhoden had been prescribed nefopam since 2010, intended as short-term pain relief for his back and shoulder pain. He told several health practitioners over the years that he thought he was addicted to nefopam and on several occasions he took more medication than was prescribed. There are recognised side effects of nefopam, which include sweating, headache, confusion, hallucinations, tachycardia and, in higher concentrations, convulsions. Nefopam should not be used long-term to treat chronic pain. In addition, there were concerns noted in Mr Rhoden's medical record that nefopam should not be used due to his epilepsy and heart conditions.

62. While Mr Rhoden was at Warren Hill, despite a history of nefopam misuse, a seizure that necessitated hospital admission and his change in appetite, staff did not consider whether Mr Rhoden was using his medication inappropriately to cope with his life issues or to manage increasing pain. No formal medication reviews ever took place at Warren Hill. The clinical reviewer considered that staff should have carried out reviews before issuing further medication.

63. We make the following recommendation:

The Head of Healthcare should ensure that medications are prescribed in line with safe prescribing guidelines and that:

- **all staff in the integrated healthcare teams can demonstrate they understand prescribing guidelines; and**
- **prisoners have medication reviews according to their individual needs.**

The Head of Healthcare should share this report with the pharmacy manager and Dr A and discuss the Ombudsman's findings with them.

Unlock procedures

64. Prison Service Instruction (PSI) 75/2011, *Residential Services*, says:

"Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

65. Officer B unlocked Mr Rhoden's cell at 9.15am on 1 May. In his statement, he said he thought that Mr Rhoden responded when he said good morning. However, given that Mr Rhoden had rigor mortis when he was found at 10.19am, and that rigor mortis does not start until at least two hours after death, Mr Rhoden must have been dead when the officer unlocked his cell that morning. When asked about this at interview, the officer said that the television was on and that there was shouting on the landing, which is why he thought he had heard a response.

66. The failure to check Mr Rhoden's wellbeing at 9.15am did not affect the outcome for Mr Rhoden as he was already dead. However, it may make a crucial difference in other cases.

67. On 5 May, the Governor, issued a Governor's Information for Colleagues notice (WH GIFC 095.21), reminding staff that they must check prisoners' wellbeing when they unlock cells. In addition, the prison told us that senior managers have visited all residential units to provide information to staff and raise awareness of the need to ensure a response is obtained at unlock. Given the Governor has already taken action to remind staff of their responsibilities, we do not make a recommendation.

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