

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr David Atkinson a prisoner at HMP Humber on 16 January 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*

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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.

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

Mr David Atkinson died on 16 January 2018 after falling from a first-floor landing at HMP Humber on 5 January. He was 42 years old. I offer my condolences to his family and friends.

Mr Atkinson fell to his death after protesting about his access to medication. I am satisfied that Mr Atkinson's death was an accident.

However, there were deficiencies in the way that staff managed Mr Atkinson in the days before his death. He was agitated and in a volatile state, banged his head on a desk and threatened to kill himself. Staff took a decision that they would not formally monitor his risk of suicide and self-harm but, having made that decision, did little to understand or address the underlying causes of his agitation.

This was compounded by the actions of healthcare staff who, when Mr Atkinson reported that his prescribed medication had gone missing, failed to refer him for a review of his medication or deal with his continuing frustration and agitation at lack of access to his medication. Humber will need to review its guidance and procedures on tradable medications and the actions that staff should take when prisoners report that their medication is missing.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**September 2018**

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# Summary

## Events

1. On 10 October 2017, Mr David Atkinson was sentenced to 26 weeks in prison, with a conditional release date of 8 January 2018. It was not his first time in prison. He had a history of self-harm and had been monitored previously under suicide and self-harm procedures, known as ACCT.
2. At his initial health screen, Mr Atkinson was identified as receiving methadone as part of a drug withdrawal programme. Healthcare staff assessed that he was suitable to keep his other medications in his own possession, including pregabalin (which is used to treat anxiety and nerve pain).
3. On 3 January, Mr Atkinson told officers that his pregabalin had been stolen. The next day, a nurse told him that a prison GP would have to review his medication and, if appropriate, it would be re-prescribed. Unhappy at what he had been told, Mr Atkinson became agitated and aggressive, banged his head on the table and threatened to kill himself. Staff did not start ACCT procedures. The nurse told her colleagues of the situation and asked that a GP review his medication.
4. On 5 January, Mr Atkinson was again agitated and aggressive. He told officers that he could not cope without his medication, and at around 4.45pm, he raised the issue with a nurse on his wing. Mr Atkinson was again told that only a GP could re-prescribe his pregabalin and he was also told that he was unlikely to receive it before his release in three days' time. Mr Atkinson climbed over the railings of the wing's first floor landing in an apparent protest at not receiving his medication. He lost his footing and fell to the floor below.
5. Mr Atkinson sustained life-threatening injuries and was taken to hospital. He never recovered and died on 16 January.

## Findings

6. Staff did not start ACCT monitoring despite Mr Atkinson harming himself and threatening to kill himself. This decision might have been understandable if effective alternative steps had been taken to understand and address his concerns. They were not.
7. A GP should have reviewed Mr Atkinson's medication when he told staff that it had been stolen. This did not happen.
8. Humber has started work on reviewing its policy of allowing prisoners to keep tradable prescribed drugs in their cells and to administer them themselves, known as holding medication in-possession. We consider that this work should be prioritised.

## Recommendations

- The Governor should ensure that staff start ACCT procedures whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to begin ACCT

procedures for prisoners with significant risk factors, they should clearly record the reasons.

- The Head of Healthcare should ensure that all clinical staff refer prisoners to GPs when they report their medication missing so that decisions on re-prescribing medication are fully considered and promptly taken.
- The Governor and Head of Healthcare should ensure that the ongoing work on the administration of pregabalin and other tradable medications is completed as a matter of urgency, and that Humber's medication in-possession policy is updated to reflect any changes made.

## The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
10. The investigator obtained copies of relevant extracts from Mr Atkinson's prison and medical records.
11. NHS England commissioned a clinical reviewer to review Mr Atkinson's clinical care at the prison.
12. The investigator interviewed twelve members of staff and four prisoners, some jointly with the clinical reviewer.
13. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. We have sent him a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Atkinson's parents to explain the investigation and to ask if they had any matters they wanted the investigator to consider. Mr Atkinson's father asked how staff at Humber dealt with Mr Atkinson's mental health and medication issues. He also asked why there was no safety netting between the wing floors.
15. Mr Atkinson's family received a copy of the initial report. The solicitor representing them wrote to us raising a question that does not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

# Background Information

## HMP Humber

16. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe, which were merged in April 2014. The prison holds up to 1,062 prisoners.
17. City Health Care Partnership provides healthcare services. On site healthcare cover is available 24 hours a day, seven days a week.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Humber was in November-December 2017. Inspectors reported that the prison was reasonably stable but noted high levels of victimisation and intimidation, underpinned by a pervasive drug culture. Inspectors reported that the quality of ACCT documents was good and generally well completed.
19. They found that around 64% of patients received their medication in-possession. Inspectors noted that not all risk assessments for prisoners holding their medication in-possession were reviewed regularly but those prisoners identified as at risk of self-harm were immediately reviewed.

## Independent Monitoring Board

20. 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 ending December 2016, the IMB said that they were concerned by the number of illegal items and substances coming into the prison. The IMB reported concerns about the effective use of ACCT procedures to manage prisoners with mental health issues.

## Previous deaths at HMP Humber

21. There have been six self-inflicted deaths at HMP Humber since November 2014 and five deaths from natural causes since November 2015. There have been two further deaths at Humber since Mr Atkinson's death.
22. In our investigation report into a death in July 2016, we were concerned that ACCT procedures were not started for a prisoner who expressed suicidal thoughts. In a report we published in 2017, Humber accepted our recommendation that the prison's drug strategy should be reviewed.

## Assessment, Care in Custody and Teamwork

23. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

# Key Events

## Background

24. On 10 October 2017, Mr David Atkinson was convicted of assault and breaching a restraining order. He was sentenced to 26 weeks in prison, with a conditional release date set for 8 January 2018.
25. Mr Atkinson had a number of previous convictions dating back to 1994 for burglary, theft, possession of controlled drugs and other minor offences. He had been to prison several times before. He had a history of self-harm and had been monitored under suicide and self-harm procedures, known as ACCT, on at least two occasions. Mr Atkinson was last released from prison in February 2014.

## HMP Hull

26. Mr Atkinson was sent to HMP Hull. A reception officer completed a first night immediate risk and needs assessment. The officer noted that Mr Atkinson had been convicted of domestic violence and had said that he had no thoughts of suicide or self-harm.
27. At an initial health screen, a nurse assessed Mr Atkinson. The nurse noted that he had arrived with several medications, including pregabalin (used to treat anxiety and nerve pain), and venlafaxine (an antidepressant), both of which were re-prescribed. The nurse also noted that Mr Atkinson was prescribed methadone (a synthetic opiate used as a substitute for heroin in the treatment of heroin addiction) and this was also continued.

## HMP Humber

28. On 25 October, Mr Atkinson was transferred to HMP Humber. An officer completed a first night immediate risk and needs assessment noting that Mr Atkinson had a history of self-harm and had previously been monitored under ACCT procedures. Another officer noted that Mr Atkinson raised no concerns.
29. At an initial health screen, a healthcare manager assessed Mr Atkinson. He told her that he had anxiety symptoms, that he was known to prison mental health services in Hull but had no thoughts of suicide or self-harm. She referred him to the mental health team. She noted that he was considered suitable to keep his pregabalin and venlafaxine in his own possession. (A nurse continued to give Mr Atkinson his methadone medication daily.)
30. On 1 November, Mr Atkinson was admitted to hospital to treat an infected shoulder injury. On 3 November, he was discharged and returned to Humber.
31. On 6 November, a mental health support worker in the mental health team assessed Mr Atkinson's mental health needs. Mr Atkinson told him that although he had anxiety and depression, he had no thoughts of suicide or self-harm. The support worker told the investigator that Mr Atkinson appeared "quite settled" and scheduled a further review and assessment. (He told the investigator that, typically, reviews took place six to eight weeks later.)

32. On 11 November, an officer introduced herself to Mr Atkinson as his personal officer. Mr Atkinson told the officer that his shoulder was painful, but he was otherwise okay.
33. On 17 November, Mr Atkinson was tested for drugs and on 23 November, was found to have tested positive for cannabis and psychoactive substances (PS). The next day, he told his drug support worker that he was annoyed and upset as he believed the positive results were because he had used the drugs before he was sent to prison.
34. On 29 November, in response to a request from Mr Atkinson, his drug support worker referred him for a place on the prison's drug recovery wing so that he could access the wing's drug rehabilitation and support groups. On 6 December, Mr Atkinson moved to the prison's drug recovery wing.
35. On 9 December, an officer introduced herself to Mr Atkinson as his new personal officer. She explained to him what was expected of him and that he would benefit from the substance misuse team's recovery groups run on the wing. She noted that he had had a positive period in prison and told the investigator that she never saw Mr Atkinson under the influence of drugs.
36. On 20 December, Mr Atkinson was given seven days' worth of venlafaxine to hold in his cell.
37. On 27 December, an officer noted that Mr Atkinson was making excuses not to attend work as he was due to be released from prison on 8 January 2018. Mr Atkinson was locked in his cell when he became aggressive after he was told not to attend work again as he had failed to attend regularly. The next day, his personal officer noted that Mr Atkinson was becoming aggressive frequently and had a poor attitude to staff.
38. On 1 January 2018, Mr Atkinson spoke to his parents by telephone. In the call he raised no concerns about his medication and did not express any thoughts of self-harm.
39. At around lunchtime on 3 January, Mr Atkinson was given seven days' worth of pregabalin in-possession. At around 1.40pm, he told an officer that his pregabalin had been stolen from his cell. The officer submitted an intelligence report which noted that staff had seen three prisoners coming out of Mr Atkinson's cell throughout the day. The personal officer told the investigator that later in the day, Mr Atkinson told her that his medication had gone missing. She said that she told him to check his cell again and to let her know if it was still missing.
40. At around 8.30am on 4 January, the mental health support worker completed his second mental health assessment, as planned on 6 November. He noted that Mr Atkinson engaged with him appropriately, was in high spirits, was looking forward to his release and had no thoughts of self-harm. Mr Atkinson told him that a prisoner had snatched his pregabalin from his hand the previous day. He was unwilling to say who had taken it. He discharged Mr Atkinson from the care of the mental health team.

41. The personal officer told the investigator that just before lunch, Mr Atkinson asked her what she would do about his missing medication. He said that he had not found it and wanted to see someone from the healthcare team to get more. She said that Mr Atkinson's cellmate also said that Mr Atkinson's medication had been stolen. Mr Atkinson also told another officer about his missing medication. Both officers contacted the healthcare team and asked that someone speak to Mr Atkinson.
42. At around 2.30pm, a mental health nurse spoke to Mr Atkinson, with his personal officer present. He noted in Mr Atkinson's medical record that he had demanded that his stolen pregabalin be replaced. He told Mr Atkinson that his pregabalin would have to be re-prescribed and said that he would make an appointment with the prison GP for a medication review. He said that the GP would decide whether Mr Atkinson could continue to hold the medication in-possession or whether it would need to be issued daily. He noted that Mr Atkinson was not happy about this, raised his voice, banged his head on the table and threatened to end his life if he did not get more pregabalin. In an intelligence report submitted after Mr Atkinson's fall, his personal officer said that he banged his head on the table and the wall. She noted that he said, "Just you watch, I will do something to get myself sent out" and began behaving "aggressively and unpredictably". She noted in her statement that Mr Atkinson said that he would "kill himself" if he did not get more medication.
43. The personal officer and a colleague took Mr Atkinson back to his cell. The personal officer told the investigator that she told Mr Atkinson to "cool down" and that she would see him later.
44. The nurse told the investigator that the personal officer said that she would start ACCT procedures for Mr Atkinson because of his threats to kill himself. At 4.21pm, the nurse noted this in Mr Atkinson's medical record. (The nurse told the investigator that he would have started ACCT procedures himself, but he was called away to an incident on another wing.)
45. The personal officer confirmed to the investigator that the nurse had said before he left the wing that he believed ACCT procedures should be started. The officer told the investigator that she told the nurse that she might start ACCT monitoring but to give her a little time with Mr Atkinson, as she knew him. She said that she telephoned the wing manager that day and told him that she might start ACCT procedures and would update him.
46. Officer A told the investigator that he walked over to the table where Mr Atkinson was talking with his personal officer and the nurse when Mr Atkinson became aggressive. He told the investigator that Mr Atkinson was angry and banged his head on the table a few times. Although he said that he was not involved in the discussion about ACCT procedures, he heard the officer and nurse discussing the issue. He told the investigator that later that afternoon, Mr Atkinson apologised for his outburst and said that he had not been serious about the things he had said but was frustrated.
47. At around 3.00pm, the personal officer spoke to Mr Atkinson in his cell to check on him. His cellmate was also there. She told the investigator that she asked Mr Atkinson if he was okay. She said that Mr Atkinson apologised to her, explained

that she should not take his actions personally and that he just wanted his pregabalin. She said that Mr Atkinson was “a bit shaky” but assured her that he had no intention of harming himself or of ending his life. He said that, “he’d lost his temper quickly, that there’d been a withdrawal and now he was coming back down”. She said that Mr Atkinson told her that he did not want to be subject to ACCT monitoring, as he felt it was not necessary. She said that she told Mr Atkinson to have some time in his cell and that the healthcare team would do their best, explaining that there was “nothing more that [wing] staff could actually do for him”. She told a SO that she would not start ACCT monitoring. She gave Mr Atkinson a healthcare complaint form as he wanted to make a formal complaint. (There is no evidence that Mr Atkinson completed this form.)

48. At 4.28pm, the nurse sent an electronic task to ask the prison GPs to review Mr Atkinson’s medication. The nurse wrote:

“Can you please review medication. [Mr Atkinson] Reports that his pregabalin has been stolen. He has no more left. Due for release on 8 January. Made threats to end his life if he was not given replacement pregabalin tablets. Thanks.”

(Although the nurse intended to send the task to the GPs, it was sent to the healthcare administration team, who did not open it until 7 January, two days after Mr Atkinson’s fall.)

49. At 4.30pm, the nurse sent another task to the prison’s pharmacist. He wrote:

“for your information. [Mr Atkinson] Reports that his in-possession pregabalin was stolen. Has none left in his possession. Thanks.”

At 4.33pm, the pharmacist responded to say that Mr Atkinson would get his medication “when next due” and assigned the task to the prison’s nurses. She told the investigator that her intention was that Mr Atkinson would get his next prescription of pregabalin the following Monday, his release date. She said that she had forwarded the task to the nurses to make them aware that, if Mr Atkinson required the medication, the prison GPs could be contacted to re-prescribe it. (She said that she was not aware of the task that the nurse sent to the administrative team to say that Mr Atkinson had threatened to take his life.) At 4.35pm, a clinical lead closed the task and noted that it had been completed.

50. At 6.32pm, the nurse re-assessed Mr Atkinson’s suitability to hold his medication in-possession, concluding that he was not suitable. At 6.41pm, the nurse sent a further task to the prison’s pharmacist reporting that Mr Atkinson’s pregabalin and venlafaxine medications had been stolen, that he was no longer suitable to hold his medication in-possession and that he was due for release on 8 January.
51. On 5 January, at 9.27am, the pharmacist responded to the task that the nurse sent to her the previous evening. The pharmacist said, “We cannot re-issue, he needs to make a GP appointment”. She forwarded the task to the prison’s nurses. She told the investigator that she did this expecting the nurses to make an appointment with one of the prison GPs. Half an hour later, a nurse closed

the task, noting that it had been completed, despite no appointment with a GP having been made.

52. An officer told the investigator that during the morning, Mr Atkinson told her that his medication had been stolen and that no one had given him pain relief for his shoulder which he said was “killing him”. The officer said that she spoke to someone in the healthcare team who told her that they were already aware of the situation. After a further request from Mr Atkinson, she spoke to a nurse, who agreed to speak to Mr Atkinson later that afternoon. The officer told Mr Atkinson that a nurse would come and speak with him.
53. The personal officer said in an intelligence report, submitted after the incident, that she spoke at length to Mr Atkinson, and noted that he had asked to see someone from the healthcare team as he was withdrawing from his medication and was in pain. Another officer said in his statement that Mr Atkinson had told officers during the afternoon that he was withdrawing from his medication.
54. A prisoner on the wing said that just before the incident Mr Atkinson had been talking to him in his cell. He said that Mr Atkinson was in good spirits and looking forward to his release. He said that Mr Atkinson did not mention his medication, did not say that he would climb the railings in protest and did not talk of harming himself.
55. Another prisoner on the wing said that at around 4.30pm Mr Atkinson told him that he was going to climb over the railings to protest about his medication. He said that another prisoner had got what he wanted by protesting in such a way.
56. At around 4.45pm, shortly before prisoners were about to be locked in their cells, Mr Atkinson approached a nurse and an officer on the ground floor of the wing, not far from his cell. The nurse said that Mr Atkinson demanded to be given pregabalin, that he needed it and could not do without it. The nurse reminded Mr Atkinson about the medications in-possession agreement that he had signed and said that it was only for his use and it was his responsibility to keep his medication safe. The nurse said that Mr Atkinson was very challenging, verbally aggressive and threatening. The officer said that the nurse told Mr Atkinson that he would not get any more medication as a GP needed to re-prescribe it and because he was due for release in three days. She said that he declined alternative pain relief.
57. The nurse later noted in the medical record that Mr Atkinson had “been approaching most, if not all, healthcare staff since the day which he claimed his pregabalin was stolen”. The nurse told the investigator that he recalled that Mr Atkinson had been discussed during healthcare handovers over the previous few days and that he would not be prescribed any more pregabalin before his release.
58. The officer said that Mr Atkinson “stormed off” and that when she asked him to come back, he ignored her and told her to “fuck off”. CCTV footage shows that Mr Atkinson walked away from the officer and nurse, turning around and sticking his middle finger in the air. Mr Atkinson made his way to the first-floor landing and walked to the end.

59. At around 4.50pm, Mr Atkinson tried unsuccessfully to climb over the landing rail. Seeing what was happening, the officer told the nurse that she would start locking the other prisoners in their cells for security reasons. She said that when she turned back to look at Mr Atkinson, she saw that he had successfully climbed over the rail.
60. CCTV footage shows that once Mr Atkinson had climbed over the rail, he placed his foot - it would appear to steady himself - on a red alarm bell. The alarm bell was unable to hold Mr Atkinson's weight, gave way and he fell to the floor.
61. The nurse and the officer ran to Mr Atkinson and arrived within seconds of his fall. The officer immediately called the control room for an ambulance and for further staff assistance. The nurse asked for healthcare colleagues to attend with the emergency response bag. The nurse provided medical assistance by maintaining Mr Atkinson's airway and giving him oxygen, with the assistance of nurses who arrived on the wing soon afterwards.
62. At about 5.01pm, paramedics arrived and took the lead in providing clinical care to Mr Atkinson. Paramedics stabilised his condition and at around 5.20pm, he was transferred by ambulance to hospital.
63. A prisoner on the wing told the investigator that Mr Atkinson used to smoke Spice, a psychoactive substance, and on the day of the incident he was "swaying" around.
64. On 8 January, while he was in hospital, Mr Atkinson was released from prison. His prison officer escort at the hospital was withdrawn.
65. We asked Humber, on behalf of Mr Atkinson's family, why there was no safety netting in place between the first and ground floor of the wing, which would have prevented Mr Atkinson from falling. The prison said that the railings on the wing were of a sufficient height, as specified during construction, to prevent prisoners from accidentally falling or being pushed over them. They said that no concerns had previously been raised.

### **Contact with Mr Atkinson's family**

66. At 5.45pm the Head of Reducing Reoffending told Mr Atkinson's parents, who were his nominated next of kin, that he had been admitted to hospital. Two officers were appointed as family liaison officers. The family liaison officers introduced themselves to Mr Atkinson's family that evening. The prison offered to contribute to the cost of his funeral in line with national policy.

### **Support for prisoners and staff**

67. The Head of Reducing Reoffending debriefed the staff involved in the emergency response and offered support. Prisoners on the wing where Mr Atkinson lived were told of the incident and later of his death. They were offered support on both occasions.

## Post-mortem report

68. The post-mortem examination was not available at the time of our report, and no toxicology tests were completed after Mr Atkinson's death.

# Findings

## Assessment of risk of suicide or self-harm

69. Prison Service Instruction (PSI) 64/2011, which governs ACCT suicide and self-harm prevention procedures, requires all staff in contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self-harm and to take appropriate action. Any member of staff who receives information or observes behaviour which may indicate a risk of suicide or self-harm must start ACCT procedures. While a prisoner's presentation is important and reveals something of their level of risk, it is only one piece of evidence in assessing risk. Staff should make a considered, objective evaluation of all risk factors when assessing the risk of suicide and self-harm.
70. On 4 January, Mr Atkinson banged his head on a table and threatened to end his life if he was not given his medication. A nurse and the personal officer discussed starting ACCT procedures. The personal officer said that after she spoke to Mr Atkinson, she concluded that he did not need to be monitored under ACCT procedures as he had assured her that he had not intended to end his life and said that such monitoring was unnecessary. She did not start ACCT procedures.
71. In April 2014, we published a Learning Lessons Bulletin on 'Risk Factors in Self-Inflicted Deaths in Prison' where we identified that too often, staff place too much weight on how a prisoner 'presented', rather than indications of risk, even where there had been very recent acts of self-harm. The bulletin also highlighted that prisoners will often withhold the extent of their distress from staff and evidence of risk should be fully balanced against how a prisoner presents.
72. We consider that staff should have recognised that Mr Atkinson was in a highly agitated state, possibly at an increased risk of suicide or self-harm, and started ACCT procedures after he said that he would kill himself and banged his head on the table, which his personal officer agreed was an act of self-harm. It may very well be that she was correct in her assessment that Mr Atkinson did not, in fact, intend to harm himself (and another account supports this). However, we are concerned that, without the rigour of the ACCT processes, staff did nothing to understand or address his obvious agitation and concerns.
73. Having reviewed the CCTV footage, we consider that it was unlikely that Mr Atkinson intended to take his life when he fell. However, by failing to start ACCT procedures, staff, including members of the healthcare team, missed an opportunity to understand Mr Atkinson's concerns about not being prescribed pregabalin. If staff had assessed and reviewed Mr Atkinson under ACCT procedures, they might have helped him identify a satisfactory way forward. This in turn might have negated his need to protest or at least might have identified additional support. We make the following recommendation:

**The Governor should ensure that staff should start ACCT procedures whenever a prisoner has recently self-harmed, expressed suicidal intent or has other significant risk factors. When, exceptionally, they decide not to**

**begin ACCT procedures for prisoners with significant risk factors, they should clearly record the reasons.**

### **Clinical care**

74. The clinical reviewer concluded that the clinical care that Mr Atkinson received at Humber was equivalent to that which he could have expected to receive in the community. She concluded that the emergency response after Mr Atkinson fell, was prompt and appropriate.
75. However, the clinical reviewer identified a number of issues which the Head of Healthcare will need to address, some of which we have set out below.

### **Review of Mr Atkinson's missing medication**

76. The clinical reviewer reported that when Mr Atkinson reported his medication missing, healthcare staff did not review his medication or consider whether it should be replaced, irrespective of whether it had been stolen or traded.
77. A nurse sent an electronic task to the prison GP on 4 January to review Mr Atkinson's missing pregabalin and noted that he had threatened to end his life. The task was sent to the healthcare administration team in error and was not actioned until 7 January. The nurse also sent an electronic task about the missing medication to the prison pharmacist. She told the investigator that she could not recall why she had not asked a GP to review Mr Atkinson's medication, but presumed that no GPs were available at the time.
78. The clinical reviewer noted that as Mr Atkinson had taken pregabalin for several years, sudden withdrawal was likely to have heightened his anxiety levels, which she noted was reflected in his behaviour on 4 January. She was concerned that healthcare staff did not consider the withdrawal effects that Mr Atkinson might have.
79. A healthcare manager said that the electronic task sent to the administration team should have been actioned the next day, 5 January. She also said that her expectation would have been for the pharmacist to have either discussed the missing medication with a GP, or referred the matter to the GP, neither of which were done. She said that if the GPs had received the task about the missing medication and knew of Mr Atkinson's threat to take his life, they would have reviewed him. However, she said that it was unlikely that his pregabalin would have been re-prescribed.
80. Not reviewing Mr Atkinson's pregabalin was a missed opportunity to address his concerns and issues and to have assessed how a decision not to re-prescribe his pregabalin would have affected both his physical and mental health. We recommend that:

**The Head of Healthcare should ensure that all clinical staff refer prisoners to GPs when they report their medication missing so that decisions on re-prescribing medication are fully considered and promptly taken.**

## Management of tradable medications

81. Pregabalin can produce feelings of relaxation, calmness and euphoria and can also enhance the euphoric effects of other drugs. It is therefore highly tradable in prison. Prisoners sometimes trade their medication and then say it has been stolen. Prisoners who are about to be released sometimes trade their prescribed medication in the expectation that it will be re-prescribed in the community.
82. Although Humber has policies on concealing medication and prisoners holding their medication in-possession, there is no clear guidance about what prison and healthcare staff should do when prisoners report that their medication has gone missing.
83. We understand that before Mr Atkinson's fall, the Governor and the Head of Healthcare had discussed at Humber's drug strategy meeting whether prisoners should be allowed to hold pregabalin, and other tradable prescribed drugs, in-possession, or whether tradable prescribed drugs might more appropriately be administered by nurses. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that the ongoing work on the administration of pregabalin and other tradable medications is completed as a matter of urgency, and that Humber's medication in-possession policy is updated to reflect any changes made.**

## Psychoactive substances

84. Mr Atkinson tested positive for psychoactive substances and cannabis in November 2017, and after his death, another prisoner alleged that Mr Atkinson used Spice (PS) and that on the day he fell he had been "swaying around". Mr Atkinson denied taking psychoactive substances in prison in November 2017, and no toxicology tests were taken when he died. While we are concerned that HMIP identified a "pervasive drug culture" at Humber, there is insufficient evidence to enable us to say whether or not Mr Atkinson had taken psychoactive substances or other illicit drugs before he died or whether they played a part in his death. We therefore make no recommendation.

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