

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# **Independent investigation into the death of Mr David Saxton, a prisoner at HMP Stocken, on 6 October 2018**

**A report by the Prisons and Probation Ombudsman**



## 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 David Saxton died of a brain haemorrhage (a kind of stroke) on 6 October 2018. He was found unresponsive in his cell at HMP Stocken. Mr Saxton was 56 years old. I offer my condolences to his family and friends.

Mr Saxton had a number of health concerns including a serious lung condition, vascular disease and chronic back pain. Mr Saxton refused to work, did not exercise and smoked heavily. His self-neglect contributed to his death. The clinical reviewer found that the healthcare provided to Mr Saxton was equivalent to that he would have received in the community.

Mr Saxton was prescribed tramadol for back pain. Toxicology tests after his death found higher levels of tramadol in his body than he had been prescribed. The pathologist said that the tramadol could have raised Mr Saxton's blood pressure and so could have contributed to his fatal bleeding. I am concerned that Mr Saxton was either diverting or trading tramadol, and that staff failed to identify this. Stocken's drug strategy is underdeveloped on the issue of diversion of prescribed medication.

Mr Saxton was found dead at almost the same time as another prisoner, who lived on a different wing. Their deaths do not appear to have been connected. I acknowledge staff efforts to deal with two challenging situations simultaneously but am very concerned that, as in previous investigations at Stocken, we found failings in the emergency response in both cases. These included a considerable delay in paramedics accessing Mr Saxton's cell, which is unacceptable.

I have already escalated my concerns to the Prison Group Director for the North Midlands in a previous investigation. I am now making further recommendations about this issue.

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 McAlister CB**  
**Prisons and Probation Ombudsman**

**November 2019**

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# Summary

## Events

1. On 22 January 2010, Mr David Saxton was given an Indeterminate Sentence for Public Protection (ISPP) with a minimum term of six years imprisonment.
2. On 11 December 2014, Mr Saxton transferred to HMP Stocken. At his reception health screening, Mr Saxton told a nurse that he had Chronic Obstructive Pulmonary Disease (or COPD, a serious lung condition), vascular disease and chronic back pain. His vascular disease caused him pain in his leg when walking. Mr Saxton smoked 20 cigarettes a day and would not give up smoking. He was taking 400mg of tramadol (an opioid painkiller) daily for his back pain.
3. On 13 September 2016, a GP reviewed Mr Saxton's medication. The GP reduced his tramadol to 200mg. Mr Saxton's dose was not changed again.
4. On 28 March 2018, a GP reviewed Mr Saxton again. Mr Saxton told the GP that he "could not be bothered to take a treatment for his cholesterol". The GP noted that Mr Saxton had high blood pressure and ordered further tests. A week later, healthcare staff reviewed Mr Saxton's blood pressure which was normal.
5. On 30 April 2018, another GP reviewed Mr Saxton. Mr Saxton told him that he continued to smoke "whatever I can get on my hands" although not PS. The GP noted that Mr Saxton continued to lead a sedentary lifestyle. His compliance with medication was poor and he was at high risk of having a heart attack or a stroke. The GP advised Mr Saxton to stop smoking and do some exercise. Healthcare staff regularly monitored Mr Saxton's health.
6. On 6 October, at around 5.30am, a member of staff found Mr Saxton unresponsive on the floor, leaning against the cell wall. He radioed for assistance. At around 6.24am, officers entered Mr Saxton's cell. They did not attempt cardiopulmonary resuscitation as they saw obvious signs of rigor mortis. At 6.36am, an ambulance arrived at the prison gate, but paramedics did not reach Mr Saxton until around 7.00am. At 7.05am, Mr Saxton was pronounced dead.
7. The post-mortem examination found that Mr Saxton died of a basal subarachnoid haemorrhage (a fatal bleed in his brain, a kind of stroke). The toxicology analysis did not find PS (or any other drug) in Mr Saxton's body but found high therapeutic levels of tramadol which could have contributed to the bleeding.

## Findings

### Clinical Care

8. The clinical reviewer found that the care that Mr Saxton received at Stocken was equivalent to that he would have received in the community. The clinical reviewer did not raise any concerns about the decisions of healthcare staff on Mr Saxton's medication and care plans.

9. Mr Saxton's health declined at Stocken due to his poor lifestyle. A significant contributory factor to his death was his self-neglect. Healthcare staff regularly reviewed Mr Saxton and gave him smoking cessation advice on a number of occasions. A GP told Mr Saxton several times that he was at high-risk of having a heart attack or stroke but Mr Saxton did not act on his advice.

### **Drugs Strategy**

10. We consider that the only way Mr Saxton could have had the amount of tramadol found in his system after his death was by stockpiling his own supply or by trading to acquire additional supplies from other prisoners. We are concerned that staff failed to identify these activities.
11. We recognise that staff took some action, including random drug testing, to monitor Mr Saxton. We are concerned, however, that the prison's drug and alcohol strategy issued in July 2018, does not address the trade and diversion of prescribed medication thoroughly. The strategy is unclear and inconsistent on the matter.

### **Emergency Response**

12. We recognise that on 6 October, staff had to respond to two major incidents on different wings simultaneously (as another prisoner died at about the same time as Mr Saxton). This clearly placed a considerable burden on staff. We are concerned, however, that at no point did staff call a medical emergency code for Mr Saxton to communicate the emergency to the control room. This appears to be a recurrent issue at Stocken.
13. There was also a completely unacceptable delay of about 25 minutes in paramedics reaching Mr Saxton's cell from the prison's gate. This is an issue that we have already criticised in previous investigations and we are concerned that this is yet another investigation where we found significant deficiencies in the emergency response at Stocken.

### **Recommendations**

- The Governor should review the prison's drugs strategy to ensure that a clear and consistent approach is put in place to tackle the supply and demand of illicit drugs, including prescribed medication.
- The Governor should provide evidence to the Ombudsman within 28 days of the actions taken to ensure:
  - immediate access of ambulances to the prison in emergency situations;
  - staff (in particular night staff) fully understand the expectation that preservation of life must take precedence when considering entering a cell on their own;
  - staff are aware of the local emergency response code policy; and
  - staff respond efficiently to emergencies and receive regular training in how to do so.

## The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP Stocken informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator visited Stocken on 18 October 2018 and obtained copies of relevant extracts from Mr Saxton's prison and medical records. He also interviewed a prisoner.
16. The investigation was suspended pending the results of the toxicology examination. The investigator interviewed three members of staff in June 2019.
17. NHS England commissioned a clinical reviewer to review Mr Saxton's clinical care at the prison. The clinical reviewer jointly conducted two interviews with the investigator.
18. We informed HM Coroner for Rutland and North Leicestershire area of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
19. One of the Ombudsman's family liaison officers contacted Mr Saxton's family to explain the investigation and to ask whether they had any matters they wanted the investigation to consider. The family did not raise any concerns.
20. We sent a copy of the initial report to Mr Saxton's family. They did not make any comments.
21. We also sent a copy of the initial report to the Prison Service. They did not raise any factual inaccuracies.

## Background Information

### HMP Stocken

22. HMP Stocken is a medium security prison in Rutland which holds up to 853 men. Care UK provides healthcare services. Mental health services are sub-contracted to Northamptonshire Foundation NHS Trust. Inclusion – managed by Midlands Partnership NHS Foundation Trust - provides substance misuse services. The healthcare service operates from Monday to Friday from 7.30am to 6.30pm and from 8.00am to 5.30pm at weekends. Two GPs provide ten GP sessions per week.

### HM Inspectorate of Prisons

23. The most recent inspection of HMP Stocken was carried out in February 2019. Inspectors noted that the use of illicit drugs, particularly Psychoactive Substances (or PS) remained a serious problem. Although there was a good re-active approach to supply-reduction, the strategy to provide a whole-prison approach to limiting illicit drugs was underdeveloped.
24. Inspectors found serious weaknesses in health care provision, with some poor practice evident in medicines management, stock control and unsafe storage. There was also a worrying lack of managerial and clinical supervision of primary care staff. Staff shortages, including vacant posts and sickness absence, had affected the delivery of mental health services. The waiting time for a routine assessment was too long but the team responded promptly to urgent referrals. There was an effective weekly team meeting and good interaction with prison staff.

### 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 April 2018, the IMB reported that the inadequacy of the mental health provision at Stocken remained a concern. The IMB reported that the prison had been successful in reducing the level of violence and drug trading through searches and local intelligence led initiatives. But the level of drug and substance misuse remained high.

### Previous deaths at HMP Stocken

26. Mr Saxton was the sixth prisoner to die at Stocken, since October 2016. Three of the previous deaths were from natural causes, the cause of one has not been determined, and another prisoner died at Stocken due to an overdose of PS on the same day as Mr Saxton in October 2018. Mr Saxton was pronounced dead only two minutes after the other prisoner. In both investigations we found very significant delays in the emergency response including unacceptable delays in the ambulance access to the prison.
27. In January 2019, another prisoner killed himself at Stocken. In that case too the member of staff who found the prisoner unresponsive, did not act with any sense of urgency and did not use the radio system to call an emergency medical code. As a

result, there was a significant delay of about 15 minutes before the medical emergency code was called. There was also a delay of 12 minutes in paramedics reaching the prisoner's cell from the prison's gate. We made recommendations that the Governor of Stocken should improve the prison's response to medical emergencies, and that the Prison Group Director for the North Midlands should provide the Ombudsman with an account of the action he is taking to improve the response to medical emergencies at Stocken.

28. In August 2019, the prison responded to our recommendations. They said that all members of staff have been provided with pocket cards and speed training on emergency code responses. The prison committed to providing scenario-based training to Operational Support Grade (OSG) staff to improve their confidence in entering a cell during night state. The prison published a notice to staff in June 2019 reminding them of the emergency code procedures. The prison also committed to ensuring prompt access for ambulance staff.
29. The Prison Group Director said in August 2019 that the Governor provided assurance to him of actions taken to improve the response to medical emergencies at Stocken. Assurance discussions have been added to his monthly bi-laterals with the Governor, to the Quarterly Performance and Assurance Review meetings and through the online assurance framework (Insight). The Group Safety Team have also added medical response to their monthly assurance visits. Reports are produced at each visit and fed back directly to the Group Director.

## Key Events

30. On 22 January 2010, Mr David Saxton was convicted of Grievous Bodily Harm (GBH) with intent, his partner being his victim, and was given an Indeterminate Sentence for Public Protection (ISPP) with a minimum term of six years imprisonment.
31. Mr Saxton spent time at HMP Lincoln, HMP Lowdham Grange and HMP Ranby. The Parole Board reviewed his case in 2015 and 2017 and did not recommend progression or release as Mr Saxton had not engaged with his offender manager and had not completed core courses. His next parole review was due to take place in 2019.
32. On 11 December 2014, Mr Saxton transferred to HMP Stocken. At his reception health screening, Mr Saxton told a nurse that he had COPD, vascular disease and chronic back pain. His vascular disease caused him pain in his leg when walking. Mr Saxton smoked 20 cigarettes a day and told the nurse that he did not want to give up smoking. The nurse assessed that Mr Saxton was fit for standard location, work and cell occupancy.
33. Mr Saxton was taking 400mg of tramadol (an opioid painkiller) daily for his back pain. Tramadol (and pregabalin – another pain killer) cannot be kept by prisoners in their cells as they are often illicitly traded. Mr Saxton therefore attended the medication hatch on his wing every day to collect his medication.
34. On 30 January 2015, a prison GP reviewed Mr Saxton. He found that he was at high-risk of having a heart attack or a stroke. The prison GP had prescribed Mr Saxton aspirin and atorvastatin (a medication to lower cholesterol levels) but Mr Saxton told the doctor that he was not taking the medication very often.
35. In 2015 and 2016, a prison GP continued to examine Mr Saxton and monitored his medication frequently but recorded that Mr Saxton's compliance with treatment was poor. Mr Saxton lived in a single cell in L wing, a standard residential location.
36. In July 2015 and July 2016, Mr Saxton self-harmed. Mr Saxton said that he was stressed about his parole process and was hearing voices. Mr Saxton also told staff that he had been "desperate for tobacco" and did not want to borrow it from other prisoners so "had been picking up discarded roll ups and smoking them". Staff began ACCT monitoring for Mr Saxton and referred him to the mental health team. A nurse assessed that he did not have any acute mental health problems.
37. On 1 September 2016, a prison GP reviewed Mr Saxton's back problem and prescribed him 50mg of pregabalin twice daily. Her plan was to reduce Mr Saxton's use of tramadol. The prison GP told the investigator that she preferred to prescribe Mr Saxton pregabalin rather than tramadol which was a highly addictive medication. She assessed that Mr Saxton was fit to work on light duties.
38. On 3 October 2016, Mr Saxton was subject to a random mandatory drug testing (MDT). The test came back negative both for illicit substances and prescribed medication such as tramadol or pregabalin. The Head of Security told the investigator that the MDT would have shown a positive result if the amount of tramadol or pregabalin found were above the prescribed doses.

39. On 2 January 2017, Mr Saxton cut his right ear with a razor blade. (This was the third occasion that Mr Saxton had self-harmed at Stocken.) An officer placed Mr Saxton on ACCT monitoring for two days. Mr Saxton said that he was hearing voices. A Supervising Officer (SO) referred Mr Saxton to the mental health team but a nurse assessed that Mr Saxton did not present with acute mental health issues. Mr Saxton's death did not have direct connection to his mental health or self-harm.
40. On 13 September 2016, a prison GP reviewed Mr Saxton's medication. She decided to reduce his dose of tramadol to 300mg. On 26 September, she increased Mr Saxton's dose of pregabalin to 100mg and further reduced his tramadol to 200mg. Healthcare staff did not change Mr Saxton's doses again. Healthcare staff dispensed Mr Saxton with one tablet of tramadol every morning and two capsules of pregabalin in the morning and afternoon. Mr Saxton always collected his medication.
41. On 12 January 2017, a prison GP recorded that Mr Saxton had stopped taking his aspirin and atorvastatin tablets. Mr Saxton did not provide any reasonable explanation, simply that he did not want to take them any longer. Mr Saxton's blood tests showed high fat levels. The prison GP sent Mr Saxton a letter reminding him of the risks of not complying with his treatment – including a high risk of having a heart attack or stroke.
42. On 17 January, Mr Saxton was given another random MDT. Staff recorded that the sample was mishandled and so it was not analysed.
43. On 5 May, Mr Saxton moved to M wing, another standard residential location. On 27 May, Mr Saxton was given another MDT which showed negative results. This was the last drug test Mr Saxton was given at Stocken.
44. On 9 November, Mr Saxton asked a prison GP to increase his tramadol and pregabalin. He said that his pain tended to get worse during the winter. The prison GP explained the risks of long-term opiate use to Mr Saxton and said that he wanted to examine him (including by means of an MRI scan) before making any changes. Mr Saxton refused to be examined and left the consultation.
45. From 15 January 2018, Mr Saxton did not attend his work at the art class. An officer spoke to Mr Saxton in his cell and noted that he appeared to be ill. Mr Saxton said that he had a cold and a potential chest infection. On 24 April 2018, an officer recorded that Mr Saxton continued to be unemployed, stayed behind his door and did not associate.
46. On 25 January 2018, staff found Mr Saxton's name in another prisoner's list of people who owed him money. Staff submitted an intelligence report and recorded that the debt could have been for PS. The prison identified the dealer, his friends and relatives involved.
47. There are no other relevant intelligence reports relating to Mr Saxton. There are no records indicating that Mr Saxton was involved in trading prescribed medication. Staff never searched Mr Saxton's cell at Stocken and Mr Saxton had no adjudications related to drugs.

48. On 28 March 2018, a prison GP reviewed Mr Saxton. Mr Saxton told the prison GP that he “could not be bothered to take the treatment for his cholesterol”. The prison GP noted that Mr Saxton had high blood pressure and ordered further tests. A week later, healthcare staff reviewed Mr Saxton’s blood pressure which was normal.
49. On 30 April 2018, a prison GP reviewed Mr Saxton. He recorded that Mr Saxton told him that he continued to smoke “whatever I can get my hands on”, although not PS. The prison GP told the investigator that some prisoners smoke teabags or the nicotine taken from scrapped nicotine replacement patches. He speculated that Mr Saxton could have been referring to these. The prison GP recorded that Mr Saxton continued leading a sedentary lifestyle with poor compliance with his medication. He again advised Mr Saxton to stop smoking and to take up some exercise.
50. From 21 August 2018, Mr Saxton was placed on the basic level of the Incentives and Earned Privileges (or IEP) scheme because he refused to work. Staff at Stocken placed Mr Saxton on the basic IEP level on seven occasions in total. All IEP downgrades were because of his refusal to work.
51. On 5 October, at 8:03am, Mr Saxton took his last tablet of tramadol and at 4.21pm his last pregabalin capsule at the medication hatch. Staff did not record any further issues or concerns in his NOMIS (the electronic records system), medical records or wing observation book. Mr Saxton was locked into his cell at around 7.30pm that evening in line with standard prison procedure.

## **Events on 6 October**

52. On 6 October, at around 5.30am, an Operational Support Grade (OSG) started to carry out the morning roll check on M wing. The OSG arrived at Mr Saxton’s cell and saw that Mr Saxton was on the floor leaning against the wall beneath the window. The OSG knocked at the door but obtained no response. The OSG said that he was not concerned because “in my 12 years career I have seen prisoners in many different positions while asleep”. He left the cell and continued with the roll check.
53. Around five minutes later, the OSG returned to Mr Saxton’s cell and again knocked at the door, obtaining no response. The OSG said that Mr Saxton had covered his main light with paper which made the cell appear dull. He told the police that he was not allowed to enter the cell so he informed a Custodial Manager (CM) who was the Night Orderly Officer, over the radio that a prisoner was unresponsive.
54. At around 6.20am, the CM was on K wing attending to an emergency involving another prisoner who had also been found unresponsive. The CM left K wing and went to Mr Saxton’s cell, together with three officers.
55. At around 6.24am, the CM and an officer entered the cell and saw that Mr Saxton was on the floor, face down with his legs under his chest. The CM checked Mr Saxton’s pulse but found none. The CM said that Mr Saxton was very cold to touch, his legs were rigid and he showed obvious signs of rigor mortis. The CM instructed officers not to begin CPR. The CM radioed the control room and asked for an ambulance. The ambulance service records show that they received the call at 6.25am.

56. At 6.36am, the ambulance crew arrived at the prison gate. A paramedic told the police that “nobody was present to let either myself or the crew inside the prison”. She said that she knocked at the reception and somebody eventually opened the main gate and allowed them access. She said that they were not allowed to move until that gate had been closed. Paramedics then had to wait around 10 minutes in a sterile area before staff came to pick them up in a vehicle which allowed them to pass through five further gates before they reached Mr Saxton’s cell.
57. At around 7.00am, paramedics arrived at Mr Saxton’s cell. The paramedic said that, on arrival, it was obvious that he was dead as rigor mortis had set in. The paramedic also said that she saw a razor blade and a “fine-looking red-brown powder on a piece of paper on a table in his cell”.
58. At 7.05am, the paramedic pronounced Mr Saxton dead. The CM and an officer said that paramedics believed Mr Saxton had been dead for ten to twelve hours.
59. After Mr Saxton’s death, the police examined Mr Saxton’s cell. They found what appeared to be a large hand-rolled cigarette and what appeared to be tea leaves but no specific or obvious drug paraphernalia. The police tested this material and no drugs were found.

### **Post-mortem report**

60. The post-mortem examination found that Mr Saxton died of a basal subarachnoid haemorrhage (a fatal bleed in his brain, a kind of stroke).
61. The toxicology analysis did not find PS in Mr Saxton’s body but found therapeutic levels of pregabalin and excessive levels of tramadol, higher than the level at which he was being prescribed. The pathologist said that it is possible that the tramadol could have increased Mr Saxton’s blood pressure and that the increased blood pressure could have contributed to the bleeding in Mr Saxton’s brain.

### **Contact with Mr Saxton’s family**

62. On 6 October, at 12:00pm, an officer and a chaplain visited Mr Saxton’s mother at her home and broke the news of her son’s death.
63. Mr Saxton’s funeral took place on 30 October 2018. The prison contributed to the funeral costs in line with national policy.

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

64. In line with PSI 02/2018, Post-incident care, the Head of Safer Custody spoke individually to the staff involved in the emergency response and offered them support. The staff care team also offered support to staff. No hot debrief was carried out, which would have been a good practice.
65. The prison posted notices informing other prisoners of Mr Saxton’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 Saxton’s death.

# Findings

## Clinical Care

66. The clinical reviewer found that the healthcare that Mr Saxton received at HMP Stocken was at least equivalent to that he would have received in the community.
67. Mr Saxton had COPD, vascular disease and chronic back pain. His health declined at Stocken due to his poor lifestyle. A significant contributory factor to Mr Saxton's outcome was his self-neglect. Healthcare staff regularly reviewed him and offered him smoking cessation advice on a number of occasions. A prison GP repeated to Mr Saxton several times that he was at high-risk of having a heart attack or stroke, but Mr Saxton did not act on his advice.
68. The post-mortem examination suggests that another contributory factor for Mr Saxton's outcome could have been the amount of tramadol he had taken. Healthcare staff prescribed Mr Saxton 200mg of tramadol for his back pain at the time of his death, but the post-mortem results found higher levels in his body. The levels found were not lethal on their own, but the pathologist said that they could have caused a rise in Mr Saxton's blood pressure, which in turn could have caused the fatal bleeding in his brain.
69. The clinical reviewer did not raise any concerns over the management of Mr Saxton's tramadol while at Stocken. This included a prison GP's decision to reduce it in September 2016 and a prison GP's refusal to increase it in November 2017. Healthcare staff regularly reviewed Mr Saxton's tramadol and pregabalin prescriptions, and there is no evidence that Mr Saxton diverted it or stockpiled it.
70. From January 2018, Mr Saxton's blood pressure started to rise and by this time his weight had increased considerably. Again, the clinical reviewer said that Mr Saxton's lifestyle and self-neglect contributed to his increased blood pressure. Mr Saxton's blood-pressure readings at Stocken were borderline and the clinical reviewer assessed that healthcare staff were therefore not bound to start any specific long-term treatment to manage this condition.
71. The clinical reviewer noted that Mr Saxton did not display any symptoms such as headaches or dizziness that would have suggested he had a vascular problem in his brain. Healthcare staff did everything they could to address Mr Saxton's health conditions and prevent his death. The clinical reviewer made no recommendations.

## Drug Strategy

72. Mr Saxton does not appear to have been heavily involved in the prison's drug culture. Staff issued only two relevant intelligence reports which suggested that he could have been smoking cannabis and taking PS. The findings in the toxicology report following his death, however, indicate that Mr Saxton was abusing tramadol at Stocken.
73. We consider that Mr Saxton could only have had the amount of tramadol found in his system either by storing up his own personal supply or by trading something in

exchange for additional medication from other prisoners. Either method is unacceptable and staff failed to identify what was going on.

74. A prisoner told the investigator that the trade of prescribed medication is common at Stocken, and it includes pregabalin, gabapentin and tramadol. The Head of Safer Custody told the investigator that the prison takes many actions to tackle the illicit trade in prescribed medication. These include random medication checks carried out by healthcare staff, operational searches and random testing to see whether any prisoner is storing drugs.
75. We recognise that staff took some action, such as random drug testing, which could have helped them identify Mr Saxton's illicit activity with tramadol. We remain concerned, however, that the prison's drug and alcohol strategy issued in July 2018, does not address the matter thoroughly.
76. The strategy relies on a multidisciplinary committee to "significantly disrupt, detect and reduce demand for illicit substance" but does not formally acknowledge the inappropriate use of prescribed medication. The committee meets every two months and is attended by the Head of Security, Head of Safer Custody and the Head of Healthcare. The committee updates an action plan after each meeting to monitor progress and develop local policy and practices.
77. We reviewed the updated action plan at the time of Mr Saxton's death but found no significant actions in relation to the trading of prescribed medication. Although we consider that the approach adopted by Stocken is dynamic and well-intended, it is not coherent, clear or consistent. We make the following recommendation:

**The Governor should review the prison's drugs strategy to ensure that a clear and consistent approach is put in place to tackle the supply and demand of illicit drugs, including prescribed medication.**

## Emergency Response

78. Prison Service Instruction (PSI) 03/2013 on medical emergency response codes requires that a code blue emergency is called if a prisoner has breathing difficulties or is unconscious, so that an ambulance is called immediately. The PSI says that it is better for staff to err on the side of caution and call an emergency code when the situation is not clear.
79. PSI 24/2011 on management and security at nights requires that all prisoners are locked in their cells while the prison is in night state. Under normal circumstances, the night orderly officer must give authority to unlock a cell during night state, and no cell should be opened unless at least two or three members of staff are present. One of these should be the Night Orderly Officer. However, the PSI states that the preservation of life must take precedence. It says that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff may go into the cell on their own. However, night staff should not take action that they feel would put themselves or others in unnecessary danger.
80. The PSI states that before going into a cell, staff should make every effort to gain a verbal response from the prisoner. This, together with what the member of staff

observes through the panel and any knowledge of the prisoner, should inform a rapid dynamic risk assessment of the situation and a decision about whether to enter immediately or wait for assistance.

81. In line with the PSI, Stocken's security strategy states that the preservation of life overrides security concerns in the case of a life-threatening emergency. It says that a member of staff may enter a cell with caution, ensuring his or her own safety under these circumstances.
82. While we do not maintain that an OSG should necessarily have entered the cell alone when he found Mr Saxton unresponsive in his cell, we are concerned that he thought that he was "not allowed" to enter any cell on his own at all. This shows that he fundamentally misunderstood national and local policy.
83. We recognise that on 6 October, staff had to respond to two major incidents simultaneously occurring on two different wings. This clearly placed a considerable burden on staff. We are very concerned, however, that at no point did staff, including a CM, call a code blue emergency to communicate the emergency to the control room. The code system is designed to make communication more effective and efficient but was not used adequately at Stocken.
84. There was also an unacceptable delay of about 25 minutes in paramedics reaching Mr Saxton's cell from the prison gate. A paramedics description of events that caused the delay in paramedics accessing Mr Saxton's cell is shocking. This is an issue that we have already criticised in previous investigations and remains a significant concern.
85. Although the delays in this case did not affect the outcome for Mr Saxton (as he appears to have been dead for some time when he was found), they could be crucial in other cases. We are very concerned that this is the fourth investigation since January 2017 in which we found significant delays during the emergency response. We consider that there is a systemic failure in this regard at Stocken.
86. In our most recent investigation report into the death of another prisoner in January 2019, we made a recommendation on this point. We also asked the Prison Group Director for the North Midlands to act to improve the response to medical emergencies at Stocken. The prison and the Prison Group Director accepted our recommendations and responded with an action plan in August 2019. We welcome the actions outlined but given our findings in this case we make the following recommendation:

**The Governor should provide evidence to the Ombudsman within 28 days of the actions taken to ensure:**

- **immediate access of ambulances to the prison in emergency situations;**
- **staff (in particular night staff) fully understand the expectation that preservation of life must take precedence when considering entering a cell on their own;**
- **staff are aware of the local emergency response code policy; and**
- **staff respond efficiently to emergencies and receive regular training in how to do so.**

**Prisons &  
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