Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Adrian Michaels, a prisoner at HMP Thameside, on 12 January 2020

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.

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 Adrian Michaels died at HMP Thameside on 12 January 2020, after making a deep cut to his neck. He was 43 years old. I offer my condolences to Mr Michaels' family and friends.

Mr Michaels arrived at Thameside on 30 November 2019. He had a history of drug and alcohol misuse and mental health issues, but during his six weeks at Thameside, he gave little indication to prison staff that he was struggling with his mental health or that he was at risk of suicide or self-harm. We are satisfied that staff could not have foreseen or prevented his actions.

On 10 January 2020, Mr Michaels told a drug and alcohol recovery worker that he was hearing voices. It appears that this information was never shared with prison healthcare staff, so they were unaware of this potentially worrying symptom. There needs to be better information sharing on issues that may affect a prisoner's risk of suicide and self-harm.

The clinical reviewer found that the management of Mr Michaels' mental health care was mixed. It took three weeks for staff to undertake a mental health assessment, and no one assessed him before giving him antipsychotic medication.

Mr Michaels told staff that he found it hard to read and write. There is no evidence that staff gave him any help or support with this.

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

Sue McAllister CB
Prisons and Probation Ombudsman **January 2022**

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Summary

Events

1. On 30 November 2019, Mr Adrian Michaels was remanded in prison custody, charged with aggravated burglary, and sent to HMP Thameside.

2. When he arrived at Thameside, Mr Michaels told staff he was schizophrenic and drug and alcohol dependent and that he was prescribed methadone (a heroin substitute). Initially, he said he did not want to be put on a methadone programme in prison but the next day, he changed his mind. He was allocated a shared cell on the substance misuse wing and put on a methadone programme.

3. On 18 December, a mental health nurse saw Mr Michaels for a mental health assessment. He asked for olanzapine (an antipsychotic), which he said he had been prescribed in the past. The next day, a psychiatrist reviewed his records and prescribed him a low dose.

4. On 10 January 2020, a drug and alcohol recovery worker recorded in her records that Mr Michaels had told her that he was hearing voices. There is no written evidence that this information was passed to prison healthcare staff.

5. In the early hours of 12 January, Mr Michaels' cellmate said he was woken by Mr Michaels using the cell bell and saying that police were in their cell. Mr Michaels told his cellmate to wake up as "we're going home". Mr Michaels' cellmate then saw that Mr Michaels had cut his neck and was bleeding heavily. He shouted for help. An operational support officer heard what he thought was a fight in the cell and he called two prison officers for assistance.

6. Staff went to the cell and realised that Mr Michaels had cut his neck. They entered the cell, called a medical emergency code and tried to stem the blood by pressing a towel to Mr Michaels' neck. When healthcare staff arrived, they tried to contain Mr Michael's bleeding and insert an airway but were unable to do so.

7. Paramedics told healthcare staff to start chest compressions, which they did. However, this increased the blood flow from Mr Michaels' wound. After approximately 40 minutes of CPR, Mr Michaels was pronounced dead.

Findings

8. During his six weeks at Thameside, Mr Michaels gave little indication to prison staff that he was at risk of suicide or self-harm. We are satisfied that staff could not have foreseen or prevented his actions.

9. We are concerned that the information about Mr Michaels hearing voices was not passed to prison healthcare staff. This was a potentially worrying symptom as healthcare staff had previously recorded that he showed no signs of psychosis.

10. The clinical reviewer found that the management of Mr Michaels' mental health care was mixed. It took 18 days for him to get a mental health assessment, and no one saw him in person before prescribing antipsychotic medication.

11. The clinical reviewer also identified concerns about record keeping and mistakes in performing standard healthcare tasks.

12. Mr Michaels told staff he found it hard to read and write. There is no evidence that staff provided any help or support.

Recommendations

- The Head of Healthcare and the Head of the Mental Health Team should ensure staff are aware of the targets for all mental health referrals and assessments.
- The Head of Healthcare should ensure that a prisoner is assessed appropriately before being prescribed antipsychotic medication.
- The Head of Healthcare should ensure a system is in place to effectively action and review blood tests.
- The Head of Healthcare should ensure that healthcare staff are aware of the required standard of record keeping, and any learning needs are identified.
- The Head of Healthcare and the lead for Turning Point should establish if there is a clinical requirement to keep parallel paper and electronic records and if there is, develop a system to ensure the records are synchronised.
- The Director should ensure that staff identify and follow up prisoners' educational needs promptly.

The Investigation Process

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

14. The investigator visited Thameside on 15 January 2020 and obtained copies of relevant extracts from Mr Michaels' prison and medical records.

15. NHS England commissioned an independent clinical reviewer to review Mr Michaels' clinical care at the prison.

16. The investigator interviewed two members of staff on 13 February. She also visited Plumstead police station to view CCTV, watched an interview with Mr Michaels' cellmate and obtained statements given to the police.

17. The investigator and clinical reviewer jointly interviewed five members of healthcare staff on 21 February.

18. We informed HM Coroner for Inner South London of the investigation. The coroner gave us the results of Mr Michaels' post-mortem examination and toxicology report. We have sent the coroner a copy of this report.

19. One of the Ombudsman's family liaison officers contacted Mr Michaels' family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They raised no issues.

20. We shared our initial report with HM Prison and Probation Service (HMPPS). There were no factual inaccuracies.

21. We provided Mr Michaels' next of kin with a copy of our initial report. They raised some inaccuracies and issues which have been addressed in separate correspondence.

Background Information

HMP Thameside

22. HMP Thameside is a local prison in south east London that holds up to 1,232 men. It is run by Serco. Oxleas NHS Foundation Trust has provided healthcare services since April 2015. There is 24-hour nursing provision and an 18-bed inpatient unit. Turning Point provide psychosocial services.

HM Inspectorate of Prisons

23. The most recent inspection of Thameside was in May 2017. Prisoners told inspectors it was easy to obtain illicit drugs. Inspectors found that, while Thameside had a focussed drugs supply reduction strategy, too many drugs were available. Outcomes for prisoners with drug and alcohol problems were found to be good, but substance misuse treatment services were not sufficiently integrated and were hampered by Turning Point's lack of access to medical records. There was an identified problem with the provision of healthcare services and a mismatch between supply and demand from the number of prisoners at Thameside.

24. Inspectors found that the prison's mental health team included experienced nurses and comprehensive psychiatrist cover. Urgent mental health referrals were seen promptly, and routine referrals seen within five days.

25. Inspectors found there had been a significant level of prisoner self-harm, but previous PPO recommendations had been rigorously implemented and most actions completed.

Independent Monitoring Board

26. 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 report for the year to 30 June 2020, the IMB identified that Thameside does "broadly effective work" to maintain safety for all prisoners, given the challenges posed by a high number of prisoners with complex mental health needs and substance misuse issues. All mental health referrals are discussed at weekly meetings.

27. The IMB said that previous PPO reports have concluded that Thameside's healthcare was not equivalent to what could be expected in the community.

28. The Board said that drugs continued to be available to prisoners during lockdown, mostly psychoactive substances (PS), such as 'Spice'.

Previous deaths at HMP Thameside

29. Mr Michaels was the eighth prisoner to die at Thameside since January 2018. Of the previous deaths, one was self-inflicted, two were drug-related, three were from natural causes and one is awaiting classification. There were no similarities

between our findings from the investigation into Mr Michaels' death and our investigation findings from the previous deaths.

Key Events

30. On 30 November 2019, Mr Adrian Michaels was remanded in prison custody, charged with aggravated burglary, and sent to HMP Thameside. This was not his first time in prison.

31. Mr Michaels told the reception nurse that he had self-harmed many times in the past, but not for three years and that he had no current thoughts of suicide or self-harm. He said he was on 30mls of methadone daily in the community and usually had seven alcoholic drinks a day.

32. Mr Michaels told the nurse he did not want to start a methadone programme as he wanted to share a cell with his cousin and so did not want to be on the Integrated Drug Treatment Strategy (IDTS) wing. The nurse noted that Mr Michaels appeared calm and stable but, as he said he was schizophrenic, the nurse referred him to the mental health team for an assessment.

33. On 1 December, during a second healthcare screen, Mr Michaels asked for Librium (a sedative) to help with his alcohol withdrawal. A prison GP reviewed Mr Michaels' medical records the next day. He did not prescribe Librium but asked staff to continue to monitor Mr Michaels' withdrawal symptoms. Mr Michaels told a nurse he had taken heroin since arriving at Thameside. He agreed to move to the IDTS Wing and start a methadone programme, which he did later that day. Mr Michaels shared a cell with a cellmate. The cellmate occupied the top bunk and Mr Michaels the lower bunk bed.

34. An officer completed a custody screen with Mr Michaels on 9 December. Mr Michaels said he had difficulty reading and writing, that he was dyslexic and that he would like support with maths and English. The officer emailed the education department the same day. Mr Michaels said he had no physical health issues, but he was schizophrenic and should be prescribed olanzapine (an antipsychotic). The officer emailed the healthcare department about this. Mr Michaels said he had no current thoughts of suicide or self-harm, and that he had no drug issues and did not want to engage with Turning Point (psychosocial substance misuse services).

35. A forensic psychiatrist reviewed Mr Michaels' medical records on 11 December, during a mental health referral meeting. She asked for him to be added to the mental health team's waiting list for a mental health assessment.

36. An officer met Mr Michaels for a key worker session on 12 December. Mr Michaels repeated that he had difficulty reading and writing and would like assistance with maths and English. There is no record of any action.

37. On 13 December, Mr Michaels referred himself to Turning Point, saying his withdrawal from drugs and alcohol meant he could not sleep and had night sweats. A substance misuse worker assessed him two days later. She noted that Mr Michaels had used alcohol and heroin daily since he was 17 years old. Mr Michaels said he was concerned about his mental health and schizophrenia but was not on any medication. She referred Mr Michaels to the mental health team and to the IDTS groups. She gave him in-cell work about drug treatment, tolerance and overdose until he could attend the groups.

38. The substance misuse worker met with Mr Michaels again on 16 December. He told her he felt his current dose of 30ml of methadone was not helping him and should be increased. He said he felt unstable and low in mood. She said she had referred Mr Michaels to the mental health team and told him he would soon get an appointment to see a psychiatrist. The next day, healthcare staff increased Mr Michaels' methadone to 35 mls.

39. On 18 December, a mental health nurse met Mr Michaels. Mr Michaels said he had been prescribed olanzapine for his schizophrenia in the past but had stopped collecting it in 2017. Mr Michaels asked to be prescribed olanzapine again as he felt he was becoming paranoid about people around him and thought they were trying to harm him. The nurse and Mr Michaels discussed the implications and dangers of taking illicit drugs while on prescribed medication. She also encouraged Mr Michaels to engage with Turning Point. During the assessment, Mr Michaels became tearful. She noted that he showed no psychotic symptoms. He was not hearing voices or hallucinating, and had no thoughts of suicide or self-harm, or of harming other people. She made a referral for Mr Michaels to see a psychiatrist and for his case to be discussed again at the next mental health team meeting, and noted that he had requested olanzapine.

40. On 19 December, a forensic psychiatrist reviewed Mr Michaels' medical records and prescribed him 5mg of olanzapine. (He took this medication until he died.) He arranged for blood tests and an electrocardiogram (ECG – a test to check the heart's rhythm) before reviewing the olanzapine dosage. However, Mr Michaels' blood samples were mislabelled, and the laboratory rejected them. He subsequently refused further blood tests. Mr Michaels' ECG was normal.

41. A mental health nurse carried out a mental health assessment with Mr Michaels on 27 December, following his previous assessment on 18 December. She noted that he was due to see a psychiatrist and appeared to have a good insight into his mental health. Mr Michaels told her that he was trying to disassociate himself from the 'bad boys' on his wing who were involved with supplying and using psychoactive substances (PS, also known as 'Spice'). Mr Michaels told her he was expecting a sentence of about 14 years for his offence. She made an entry in Mr Michaels' medical records asking for an immediate medication review by a psychiatrist to consider increasing his medication, and to liaise with the community mental health team about a possible admission to a psychiatric hospital. (She clarified during her interview that this would only be considered if Mr Michaels' symptoms worsened and he appeared to be in crisis, which he was not.) Her record was mixed up with information about Mr Michaels' dental problems. She could not explain how this had happened.

42. Mr Michaels appeared in court, by videolink, on 6 January 2020. He remained remanded in custody at Thameside until a trial date was set.

43. Mr Michaels' keyworker saw him on 9 January. Mr Michaels said he had no physical health issues but was schizophrenic and still had not received any medication (which was not the case).

44. The substance misuse worker met Mr Michaels on 10 January. He told her that he was getting on well and had not used drugs. Mr Michaels said he had made progress with the mental health team and had been prescribed olanzapine. He said

that he was still not feeling his best and that he was hearing voices but had no thoughts of suicide or self-harm. Mr Michaels said he was now on 35ml of methadone but wanted this increased as he was not sleeping well. Mr Michaels said he had not progressed much in-cell work, as he could not read or write well. She said she would make time to see him the following week.

11-12 January 2020

45. On 11 January, all prisoners were locked in their cells at 6.00pm. An officer checked Mr Michaels and his cellmate at 9.33pm. Staff carried out a roll count at approximately 10.45pm. There were no issues.

46. The cellmate said they had watched a film on television together that night, but they had both fallen asleep before it ended. He said he awoke when he heard Mr Michaels pressing the cell bell and saying that police were in his cell. CCTV showed their cell bell first lit up at 1.30am. Mr Michaels said, "Get up, get up, we're going home". He said he pretended to be asleep. He said that Mr Michaels had done something similar two days earlier, although he had not mentioned this to anyone. Mr Michaels then telephoned his mother. Afterwards he said to his cellmate, "Come on, we're going". He ignored him.

47. The cellmate said he heard a snapping sound, as if plastic was being broken. He heard Mr Michaels throw something across the cell and then some scratching noises. He said the toilet light was on, enabling him to see Mr Michaels was not wearing a top and his neck was covered in blood. He asked Mr Michaels what he was doing, and he replied he was going home. He continued to stand in the cell cutting himself. He could see he was using the blade of a disposable razor.

48. The cellmate shouted for help from his bed. He said he repeatedly asked Mr Michaels to stop, but he continued to cut himself and slipped over on the blood that was now on the floor. He got up and slipped again. He tried again to get up, but this time he could not.

49. An operational support officer (OSO) heard what he thought was a fight over the cell bell intercom system in Mr Michaels' and his cellmate's cell, so he telephoned two officers for assistance. They were close by in the Care and Separation Unit (CSU). The officers responded immediately. An officer who had also been in the CSU, telephoned the manager in charge of the prison to let him know of a potential incident on A Wing.

50. CCTV shows the OSO and a colleague standing outside Mr Michaels cell at 1.32am, looking in with a torch. Two officers arrived outside the cell less than a minute later. The OSO told them, "I think he's cut himself", referring to Mr Michaels. One of the officers turned on the cell light and looked through the observation panel. He saw Mr Michaels lying on the floor with a bloody neck.

51. At 1.34am, the officer took the OSO's sealed pouch containing the cell key and went into the cell while the OSO radioed a code red (a medical emergency code used for severe loss of blood). The officer saw Mr Michaels' neck was bleeding. He took a towel from the sink and wrapped it around Mr Michaels' throat to try to stem the blood. The cellmate was still on his bed. The officer shouted for him to

leave the cell, which he did. (The cellmate waited in another cell under constant watch.)

52. The officer described Mr Michaels' blood as pumping through the towel and over his hands. He said it felt as if Mr Michaels was pushing him off him. He saw blood was going down Mr Michaels throat and appeared to be choking him. He released the pressure on Mr Michaels neck which seemed to slow the blood flow.

53. A nurse arrived at the cell with an emergency bag at 1.35am, closely followed by colleagues at 1.36am.

54. One of the nurses could not find a pulse. He took over applying pressure to Mr Michaels' neck from the officer, who left the cell. He could see Mr Michaels had a broad, deep cut on his neck and asked for an ambulance to be called immediately (which had already been done in response to the code red). Two more nurses arrived within two minutes, along with other staff. A nurse attached the defibrillator pads to Mr Michaels, but no shock was advised. At interview, he said that healthcare staff considered beginning chest compressions, but if they did so without successfully containing the blood from his neck, Mr Michaels' blood would not circulate around his body.

55. CCTV shows paramedics arriving at Mr Michaels' cell at 1.47am. They asked a nurse to begin chest compressions, which he did, but blood came from Mr Michaels' neck during each compression. Paramedics tried to insert an airway but were unable to do so as Mr Michaels' airway was completely obstructed. The paramedics moved Mr Michaels onto the landing to give them more space to work. The Helicopter Emergency Medical Service (HEMS) doctor also attended. She pronounced Mr Michaels' death at 2.36am.

56. Police subsequently found broken remnants of a disposable razor and the razor blade in the cell.

57. Police interviewed all the prisoners on A Wing. Some said they had heard the cellmate shouting for help. One prisoner said there was a particularly strong smell of 'Spice' on the wing, which Mr Michaels had smoked before, but he did not know whether he had done so on this occasion.

Contact with Mr Michaels' family

58. An officer was appointed as the prison's family liaison officer. Due to the circumstances of Mr Michaels' death, the police said they would break the news to Mr Michaels' next of kin. The officer accompanied police officers to Mr Michaels' mother's address at 4.00pm that day.

59. The prison contributed to Mr Michaels' funeral, in line with national guidance.

Support for prisoners and staff

60. Two prison managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

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

Post-mortem report

62. The post-mortem report concluded that Mr Michaels died from an incised wound to his neck. Mr Michaels had cuts to his right hand consistent with holding a razor blade. He had no defensive wounds. The toxicology report noted that he had taken only his prescribed medication.

Findings

Assessment of Mr Michaels' risk of suicide and self-harm

63. Prison Service Instruction (PSI) 64/2011, *Management of prisoners at risk of harm to self, to others and from others (Safer Custody)*, gives guidance to staff on how to identify prisoners at risk of suicide and self-harm and sets out the procedures (known as ACCT) that staff must follow if they identify a prisoner at risk.

64. PSI 64/2011 lists several risk factors and triggers for suicide and self-harm. When he arrived at Thameside, Mr Michaels had some of these risk factors, including a history of self-harm and possibly a mental illness (schizophrenia). However, his history of self-harm was not recent, he was not showing signs of mental illness when he arrived at Thameside and his offence was not one that would have increased his risk. Therefore, we consider that it was reasonable for reception staff not to have started ACCT procedures for Mr Michaels.

65. Mr Michaels spent six weeks at Thameside. During that time, he did not give any serious cause for concern. He was under the care of the mental health team and had asked for antipsychotic medication as he said he thought he was becoming paranoid, but there was no indication that he was at risk of suicide or self-harm.

66. There were reports that psychoactive substances (PS) were available on Mr Michaels' wing and that there was a strong smell of PS on the night that Mr Michaels died. PS has been linked to a deterioration in mental health and increased risk of self-harm. However, toxicology tests found no trace of PS in Mr Michaels' system when he died. We cannot say what prompted Mr Michaels to take the actions he did. We consider that staff could not have foreseen or prevented his actions.

Mr Michaels' mental health

67. The clinical reviewer found that Thameside's management of Mr Michaels' mental health was mixed.

68. The reception nurse referred Mr Michaels for a mental health assessment on 30 November, the day he arrived at Thameside, but he was not assessed until almost three weeks later, on 18 December. When interviewed, healthcare staff were unable to say if this waiting time was typical and were unaware of any targets. The Head of Healthcare subsequently told us that the target for routine mental health referrals is 72 hours. We recommend:

    The Head of Healthcare and the Head of the Mental Health Team should ensure staff are aware of the targets for all mental health referrals and assessments.

69. Mr Michaels told wing staff he had not received medication when he had. The clinical reviewer considered that Mr Michaels seemed focused on being prescribed medication, despite not presenting as acutely unwell, and she was concerned that he was prescribed a low dose of olanzapine without a face-to-face assessment or a medication review. We make the following recommendation:

The Head of Healthcare should ensure that a prisoner is assessed appropriately before being prescribed antipsychotic medication.

70. When the decision to prescribe olanzapine was made, Mr Michaels' blood should have been tested. Although a blood sample was taken, it was mislabelled and rejected by the laboratory. Mr Michaels refused to give another blood sample, so it was never tested. A Root Cause Analysis Report also identified this issue. We make the following recommendation:

The Head of Healthcare should ensure a system is in place to effectively action and review blood tests.

71. The clinical reviewer found that the note of a mental health review held on 27 December, and recorded in Mr Michaels' medical record, was confusing and inaccurate. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff are aware of the required standard of record keeping, and any learning needs are identified.

72. On 10 January 2020, a worker from Turning Point met with Mr Michaels. She noted in Turning Point records that Mr Michaels told her that he was hearing voices. This was a potentially worrying symptom. She told the investigator that she shared this information with prison healthcare staff, but there is no reference to this information in Mr Michaels' medical record. We recommend:

The Head of Healthcare and the lead for Turning Point should establish if there is a clinical requirement to keep parallel paper and electronic records and if there is, develop a system to ensure the records are synchronised.

Education

73. Mr Michaels told staff on at least two occasions that he could not read or write. On 9 December, an officer emailed the education department about this. Mr Michaels raised this issue again during a key worker session on 12 December. There is no evidence that the prison took any action. Mr Michaels' cellmate told police that he helped Mr Michaels complete any prison paperwork, such as his menu requirements.

74. However, Turning Point gave Mr Michaels in-cell substance misuse work that he would clearly be unable to complete. It would have been inappropriate for him to rely on his cellmate to help him with this. Mr Michaels eventually told the substance misuse worker on 10 January 2020, that he had not made much progress. She said she would make some time the following week to go through the work with him.

75. Prison can be even more isolating for prisoners who cannot read or write very well, and especially if they are relying on in-cell work to address their substance misuse. There is no evidence in Mr Michaels' prison records that he was ever identified to attend education classes. We make the following recommendation:

The Director should ensure that staff identify and follow up prisoners' educational needs promptly.

Emergency response

76. Staff responded quickly to the emergency. As Mr Michaels was in a double cell, we consider it was reasonable that the OSO called for assistance and did not enter the cell on his own. Two officers arrived and went into the cell less than a minute after the OSO telephoned them. The first healthcare staff arrived at 1.35am, and the paramedics at 1.48am.

77. The clinical reviewer commented that staff were faced with a truly shocking situation and that nothing in their professional training or the basic life support course would have equipped them to deal with Mr Michaels' injuries. They were faced with the dilemma of starting chest compressions in someone who had a wound that continued to bleed. They tried to use their training and experience to provide support and responded to the request to start chest compressions under the supervision of trained paramedics.

78. The clinical reviewer said that it would be inappropriate to assume that training and equipment alone would allow staff to provide a more effective response; events such as this are rare and require immediate specialised support.

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