Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Boyle, a prisoner at HMP Holme House, on 2 December 2018

A report by the Prisons and Probation Ombudsman

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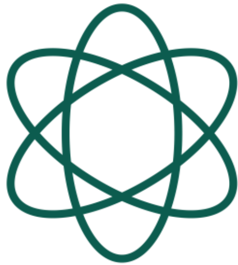
Our vision

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



Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

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

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

Mr Simon Boyle died on 2 December 2018 at HMP Holme House of the effects of the combination of methadone, psychoactive substances (PS) and alprazolam (a powerful tranquilizer). He was 31 years old. I offer my condolences to Mr Boyle's family and friends.

Mr Boyle had a significant history of illicit drug use and was prescribed methadone (a heroin substitute). He refused advice and support from the prison's mental health team and failed to fully engage with the substance misuse team.

The clinical reviewer was satisfied that Mr Boyle's clinical care, including the care he received for his substance misuse, was good and equivalent to that which he could have expected to receive in the community.

However, my investigation identified failings in the emergency response when Mr Boyle was found unresponsive. While this did not affect the outcome for Mr Boyle, these failings could make the difference between life and death in other medical emergencies.

I am concerned that Mr Boyle was able to obtain illicit drugs at Holme House with apparent ease. The prison needs to continue its efforts to prevent the supply of and demand for illicit substances.

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 **December 2020**

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Summary

Events

1. On 8 February 2018, Mr Simon Boyle was recalled to prison for breaching his licence conditions. He was transferred to HMP Holme House on 31 May. On 7 September, he was sentenced to five years in prison for being in possession of a firearm.

2. Mr Boyle had a history of substance misuse and mental health issues. At his reception health screen, Mr Boyle was referred to the prison's drug and alcohol recovery team (DART) for drug intervention programmes and general support. Mr Boyle was on a maintenance dose of methadone (a heroin substitute), but he failed to fully engage with DART.

3. On 25 October, a prison pharmacist noted that Mr Boyle appeared to be under the influence of drugs. She refused to give him his methadone but did not take any further action.

4. At about 5.20am on 2 December, an officer saw that Mr Boyle was lying on the floor of his cell. He was unable to get a response from Mr Boyle or his cellmate (who was Mr Boyle's uncle). The officer telephoned a manager for help. Healthcare staff attended and saw obvious signs that Mr Boyle had been dead for some time. They provided medical support to Mr Boyle's uncle who was breathing but unresponsive.

5. Ambulance paramedics arrived and took Mr Boyle's uncle to hospital. At 7.15am, paramedics confirmed that Mr Boyle had died.

6. The post-mortem report gave Mr Boyle's cause of death as the effects of the combination of methadone, psychoactive substances (PS), and alprazolam (a powerful tranquiliser, also known as Xanax).

Findings

7. The clinical reviewer concluded that, overall, Mr Boyle's substance misuse and mental health care was equivalent to that which he could have expected to receive in the community.

8. However, when Mr Boyle was suspected to be under the influence of drugs in October 2018, a member of healthcare staff did not alert prison staff or refer Mr Boyle to the substance misuse team in line with the prison's substance misuse guidance.

9. An emergency code was not used to effectively communicate the nature of the emergency when Mr Boyle was found unresponsive. The officer was unsure if he was allowed to radio a code blue emergency during the night state. We are satisfied that this did not affect the outcome for Mr Boyle who was clearly dead when he was found.

10. Healthcare staff did not bring the official emergency response bag with them when they responded to the emergency call. This did not make a difference in Mr Boyle's

case but in other circumstances this could make the difference between life and death.

11. Control room staff failed to tell the emergency services that there were two prisoners that needed medical assistance in accordance with prison guidance. This would have enabled the ambulance service to make an informed decision about what resources they needed to deploy. As a result, the paramedics who were attending to Mr Boyle's cellmate could not confirm Mr Boyle's death and a second ambulance had to be called to confirm his death.

12. The prison's liaison with the PPO was poor. The investigator encountered delays in obtaining documentation from Holme House and in interviewing relevant staff. This led to delays in the investigation and meant that the PPO and the clinical reviewer had to return to Holme House to conduct further interviews. Holme House needs to improve its PPO liaison arrangements.

Recommendations

- The Head of Healthcare should ensure that healthcare staff follow the prison's substance misuse strategy when a prisoner is suspected of using illicit substances.
- The Governor should ensure that all staff are made aware of and understand their responsibilities during medical emergencies, including using the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.
- The Head of Healthcare should ensure that healthcare staff bring the official emergency response equipment with them when responding to a medical emergency.
- The Governor should ensure that control room staff tell the Ambulance Service how many individuals need medical assistance so they can deploy their resources appropriately.
- The Governor should ensure that the key drug issues at Holme House are identified and that the prison's local drugs strategy is reviewed to ensure that these key issues are being addressed.
- The Governor should ensure that PPO liaison officers are aware of and carry out their duties in line with the requirements of PSI 58/2010.

The Investigation Process

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

14. The investigator visited HMP Holme House on 29 January and 21 March. She obtained copies of relevant extracts from Mr Boyle's prison and medical records.

15. The investigator interviewed six members of staff at HMP Holme House on 29 January and 21 March.

16. NHS England commissioned a clinical reviewer review Mr Boyle's clinical care at the prison. She conducted joint interviews with the investigator on 29 January and 21 March.

17. We informed HM Coroner for Teesside of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Holme House

19. Holme House is a Category C training prison holding over 1,200 men. G4S provides nursing and administrative services at the prison and Spectrum CIC provides GP and pharmacy services. There is a 24-hour healthcare inpatient unit with 16 beds.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Holme House was in July 2017. Inspectors were concerned that drugs were readily available, with mandatory testing revealing 10.45% positive results which rose to 36% when psychoactive substances (PS) were included. Nearly 60% of prisoners said it was easy to get drugs in the prison, with a quarter saying they had developed a drug problem at the prison. The inspectors found that despite these statistics, the prison did not have an integrated or effective supply reduction strategy in place.

21. Inspectors reported that the interactions between healthcare staff and prisoners were very good but there were chronic staff shortages in the primary care nursing team which had affected service delivery. Inspectors found that only 22% of prisoners said that the quality of health services was good. Many prisoners complained about long waiting times and inspectors found that prisoners were waiting up to five weeks for routine doctor and nurse practitioner appointments. However, they found that patients with urgent needs were seen quickly.

Independent Monitoring Board

22. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to 31 December 2018, the IMB said they did not consider that the services provided to prisoners by the healthcare team were equivalent to what they would receive in the community, and in some instances, they were considerably worse, with unacceptably long waiting lists.

Previous deaths at HMP Holme House

23. Mr Boyle was the thirteenth prisoner to die at Holme House since November 2016. Of the previous deaths, nine were from natural causes, two were self-inflicted deaths and one was a drug-related death.

24. There have been thirteen deaths since Mr Boyle's death. Of these, nine were from natural causes, three were self-inflicted and in one the cause of death is unascertained.

Psychoactive Substances (PS)

25. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to

detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

27. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

28. In October 2015, Mr Simon Boyle was sentenced to three years and six months in prison for robbery. In January 2017, he was released on licence.

29. On 8 February 2018, Mr Boyle's licence was revoked, and he was recalled to prison for breaching the terms of his licence conditions and committing further offences. Between February and May, Mr Boyle was transferred between several prisons, including HMP Holme House, before returning to Holme House on 31 May.

30. Mr Boyle had a history of substance misuse. He had been in prison before and his prison record showed evidence of involvement in the prison drug culture. On 19 March 2018, Mr Boyle was suspected of 'dealing' drugs at HMP Durham and on 24 April and 11 May he appeared to be under the influence of drugs at Holme House.

31. A nurse completed Mr Boyle's first reception screening at Holme House. She noted his history of substance misuse, depression and self-harm. She did not note any mental health concerns, but Mr Boyle had just returned from attending his grandmother's funeral, so she referred him to the mental health team.

32. Mr Boyle scored 8 on the Opiate Withdrawal Custody Health Observation (COWS) tool which indicated that he was experiencing mild withdrawal. He said that he had a previous history of misusing buprenorphine (an opioid substitute) "on top of prescribed methadone" and that he had previously "had a problem with alcohol". The nurse referred Mr Boyle to the clinical and non-clinical DART (drug and alcohol recovery team).

33. Later that day, a nurse saw Mr Boyle to assess his substance misuse. Due to his recent bereavement, the nurse kept Mr Boyle on a maintenance programme of 40ml of methadone. His alcohol use was assessed but the results did not identify any concerns.

34. Mr Boyle was allocated to a double cell which he shared with his uncle.

35. On 2 June, a nurse from the mental health team, reviewed Mr Boyle and made an appointment for a routine assessment on 14 June. However, he failed to attend. The mental health team wrote to Mr Boyle asking him to respond if he wanted to engage with the service. Mr Boyle did not respond and on 22 June he was discharged from the service.

36. On 4 June, a DART recovery worker completed an assessment with Mr Boyle to determine the level of support he needed. Mr Boyle was offered bereavement support but he declined.

37. On 22 August, Mr Boyle attended the clinic for his 13-week DART review. However, he refused to stay and said that he would rather go to work. Another appointment was made for 18 October, which Mr Boyle failed to attend. A further appointment was made for 8 November.

38. On 7 September, Mr Boyle was sentenced to five years in prison for possession of a firearm.

39. On 23 October, Mr Boyle's DART key worker reviewed Mr Boyle and discussed reducing his methadone by 2mls. Mr Boyle told her that he was not ready. He also said that his cell had been recently searched and tablets which he had not been prescribed had been found. Mr Boyle did not disclose whether he had been misusing drugs.

40. Later that morning, Mr Boyle went to the prison pharmacy to collect his methadone. A pharmacist technician noted that Mr Boyle appeared to be under the influence of drugs. She therefore refused to give him his prescribed methadone. She did not alert prison staff or DART.

41. On 6 November, a nurse saw Mr Boyle for his rescheduled 13-week DART review. Mr Boyle said that he was keen to start reducing his methadone. The nurse scheduled an appointment for a review in six weeks' time.

42. On 8 November, a nurse saw Mr Boyle and reduced his methadone from 40 ml to 35 ml. The nurse scheduled a review for 26 November. At the review, Mr Boyle told a nurse that he was happy to stay on 35 ml of methadone.

Events of 2 December

43. At 5.20am, an officer began the morning roll checks. At about 5.25am, he looked through the observation hatch of Mr Boyle's cell and saw him lying on the floor. He could not see his face. He told the investigator that he thought Mr Boyle might have fallen out of bed.

44. Mr Boyle's cellmate appeared to be asleep on his bed and the officer saw his leg move. The officer banged on the door and turned the light on and off to try to get a response from them, but they did not respond. The officer went downstairs to the office and called the night orderly officer, a Custodial Manager (CM), and told her he thought there was a possible code blue emergency (meaning a prisoner is having difficulty breathing or is unconscious). She told the officer to call a nurse, who was the medical first responder. The officer rang and told him there was a potential code blue and then went back to the cell and waited for staff to arrive to open the cell.

45. The CM and two prison officers arrived at the cell. The medical first responder and another nurse also arrived. They did not bring the emergency response bag with them. When they entered the cell, the medical first responder assessed that Mr Boyle had rigor mortis and was clinically dead. The medical first responder saw that Mr Boyle had vomit coming out of his mouth and was blue in colour. She provided medical assistance to Mr Boyle's cellmate (his uncle), who was breathing but unresponsive.

46. The control room log shows that they were informed at 5.28am that there had been a death and that the prisoner's cellmate also required medical assistance. They called an ambulance at 5.29am. At 5.45am, ambulance paramedics arrived and focused their attention on Mr Boyle's cellmate. The paramedics told prison staff to call a second ambulance to confirm Mr Boyle's death. At 7.15am, the second ambulance arrived and paramedics confirmed that Mr Boyle had died.

Contact with Mr Boyle's family

47. Prison instructions say that a visit should be made to the next of kin's home in the event of a death in custody. However, the duty governor was concerned that Mr Boyle's next of kin would find out about his death before a home visit could be made because his uncle was also involved in the incident. She therefore decided to telephone Mr Boyle's family to break the news of his death, and she did so at 7.53am.

48. At 9.15am, the prison's family liaison officers and a prison chaplain left the prison to visit Mr Boyle's family home to offer support and explain what would happen next.

49. Mr Boyle's funeral was held on 21 December 2018. In line with national instructions, the prison contributed to the costs of the funeral.

Support for prisoners and staff

50. After Mr Boyle's death, a prison manager debriefed the prison staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

51. The prison posted notices informing other prisoners of Mr Boyle'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 Boyle's death.

Post-mortem report

52. Toxicology tests showed that Mr Boyle had taken methadone (which he was prescribed), alprazolam (which he was not prescribed) and PS before he died. The post-mortem report gave Mr Boyle's cause of death as the combined effects of these drugs. The pathologist noted that all three drugs have the effect of depressing breathing and that this effect was increased when they were combined.

53. The pathologist also noted that Mr Boyle had a moderate amount of vomit in his main airways and that vomiting and inhalation of vomit is a common mode of death in drug abuse. He noted that the vomit might have been the immediate cause of death.

54. A plastic wrap containing tablets was found in Mr Boyle's rectum during the post-mortem.

Findings

Clinical care

55. The clinical reviewer concluded that the clinical care Mr Boyle received at Holme House was of a reasonable standard and equivalent to that which he could have expected to receive in the community.

56. Mr Boyle had a history of depression, including self-harm, which was appropriately identified at the reception screening. Mr Boyle did not display any symptoms and told staff he felt fine. However, Mr Boyle had a recent family bereavement and he was referred to the mental health team. Mr Boyle failed to engage and he was discharged from the service. The clinical reviewer was satisfied that the mental health team took appropriate steps to engage with Mr Boyle.

Substance misuse

57. Mr Boyle had a long history of substance misuse. He was already on a maintenance regime of methadone when he arrived at Holme House. It was agreed that he would remain on a daily dose of 40mls due to a recent bereavement. In November, Mr Boyle agreed to reduce his methadone to 35mls.

58. We are satisfied that Mr Boyle was appropriately referred to the clinical and non-clinical DART who offered support for his drug misuse. He did not always engage with the DART but staff rearranged his appointments when he failed to attend and reviewed him regularly.

59. However, we are concerned that when a pharmacist considered that Mr Boyle was under the influence of drugs in October, she failed to alert prison custody staff or DART which is not in line with the prison's substance misuse guidance. The DART co-ordinator told the investigator that this should have been brought to the attention of the clinical and non-clinical DART who would have reviewed Mr Boyle immediately. The pharmacist was on sick leave when the interviews were undertaken and the investigator has not been able to establish why she did not communicate her concerns.

60. While this did not have a direct impact on Mr Boyle's death, it is important that the correct processes are followed. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff follow the prison's substance misuse strategy when a prisoner is suspected of using illegal substances.

Emergency response

61. We have a number of concerns about the emergency response on 2 December.

62. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then

cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

63. PSI 3/2013, *Medical emergency response codes*, says that prisons must have a medical emergency response code protocol in place to ensure that the nature of a medical emergency is efficiently communicated; healthcare staff take the relevant equipment to the scene; and the control room immediately calls an ambulance.

64. When an officer failed to get a response from Mr Boyle and his cellmate he should have radioed a code blue emergency. Instead he went to the office and telephoned the night orderly officer to tell her there was a possible code blue emergency.

65. We do not criticise the officer for not entering the cell on his own given that there were two prisoners in it. However, we are concerned that he did not radio a code blue when he found Mr Boyle and his cellmate unresponsive. When asked at interview why he had not done so, the officer said that he was a new member of staff doing his first set of night shifts and, although he would have radioed a code blue during the day, he was unsure if he could use his radio to do this during the night state.

66. We are satisfied that the officer now understands the importance of calling a medical emergency code promptly. Although his failure to do so did not affect the outcome for Mr Boyle, who was already dead when he was found, a delay of even a minute or so may make a critical difference in a medical emergency.

67. We are also concerned that the CM, the night orderly officer, did not tell the officer to call a code blue but instead told him to call healthcare. It appears that a code blue was never called.

68. We make the following recommendation:

    The Governor should ensure that all staff are made aware of, and understand, their responsibilities during medical emergencies, including using the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

69. We are concerned the medical first responder failed to take the emergency response bag with him when he received the officer's call saying there was a potential code blue. Instead he took his own bag which contained basic equipment. The medical first responder was not available for interview as he was suspended from duties and was under investigation by NHS England.

70. A nurse told the investigator that the medical first responder had taken a black drawstring bag with a BP cuff, stethoscope and dressings inside. She said that she did not know why he had not responded with the appropriate equipment. She also said that as a newly qualified nurse who had only been in post for two weeks, she did not feel able to challenge him.

71. The clinical reviewer said that all appropriate resuscitation equipment must be taken to all code blue emergencies. While this did not have any impact on the outcome

for Mr Boyle, it might prove critical in other emergency situations. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff bring the official emergency response equipment with them when responding to a medical emergency.

72. When Mr Boyle and his cellmate were found unresponsive, only one ambulance was requested. When the paramedics arrived, they said they were unable to confirm Mr Boyle's death because they had to provide emergency medical assistance to his cellmate. As a result, a second ambulance crew was called to confirm Mr Boyle's death.

73. Control room staff should have told the emergency services that there were two prisoners who needed medical assistance in accordance with prison guidance. This would have enabled the ambulance service to make an informed decision about what resources they needed to deploy. While this did not make a difference for Mr Boyle, this could be critical in other emergency situations. We make the following recommendation:

The Governor and Head of Healthcare should ensure that control room staff tell the Ambulance Service how many individuals need medical assistance so that they can deploy their resources appropriately.

Drugs at Holme House

74. Mr Boyle had a significant history of illicit drug use. Toxicology results show that he had used methadone, PS and alprazolam before his death and the combination of these drugs caused his death.

75. Holme House has a strategy to address both the supply of and demand for PS and other illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. Examples of this include photocopying mail to prevent paper soaked in PS entering the prison and providing additional staff resources to carry out mandatory drugs tests and cell searches. There are also measures to educate prisoners about the dangers of PS and support those known to use the drugs, plus additional disciplinary measures to deter drug use.

76. We are concerned that, despite this, Mr Boyle was able to obtain illegal substances with apparent ease at Holme House

77. Drug taking and trading is a serious problem across much of the prison estate. In April 2019, HMPPS issued guidance to prisons on tackling this problem, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons. In relation to reducing the supply of drugs, the Prison Service strategy says:

"Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10

Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

78. We, therefore, recommend:

The Governor should ensure that the key drug issues at Holme House are identified and that the prison's local drugs strategy is reviewed to ensure that these key issues are being addressed.

Liaison with the PPO

79. The prison's liaison with the PPO was poor from the start. The most basic paperwork (such as the control room log) took several weeks to arrive despite numerous requests.

80. Liaison duties were eventually transferred to a prison manager and matters improved. However, staff failed to provide interview availability in a timely manner, if at all. When interviews were finally scheduled, staff failed to turn up as expected because they had changed shifts or were on leave or sick leave. As a result, the investigator and the clinical reviewer had to go back to Holme House to conduct more interviews.

81. While we accept the role of liaison officer can be difficult, PSI 58/2010, *Prisons and Probation Ombudsman*, makes it clear that the PPO's access to all documentation will be facilitated by the designated liaison officer. We also expect that the same liaison officer will take responsibility for arranging all interviews requested by the Ombudsman's investigator, including interviews with prison and healthcare staff and contractors' staff. Interviews should be arranged at times that suit the shift arrangements of different staff in consultation with their managers. We make the following recommendation:

The Governor should ensure that PPO liaison officers are aware of, and carry out, their duties in line with the requirements of PSI 58/2010.

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