

Prisons &
Probation

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Mitchell Rudge, a prisoner at HMP Ashfield, on 5 September 2019

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

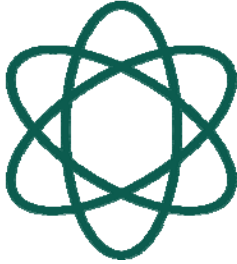
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100



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

OGL

© Crown copyright, 2022

This report is licensed under the terms of the Open Government Licence v3.0. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3

Where we have identified any third-party copyright information you will need to obtain permission from the copyright holders concerned.

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 Mitchell Rudge died in hospital on 5 September 2019 after a seizure in his cell at HMP Ashfield six days earlier. Mr Rudge died due to a brain injury after his heart stopped. The pathologist concluded that Mr Rudge's seizure may have been due to epilepsy or to taking drugs. He was 30 years old. We offer our condolences to Mr Rudge's family and friends.

Mr Rudge suffered from epilepsy and asthma and had learning difficulties. He also had a history of using illicit substances. I am concerned that Mr Rudge's clinical care was not equivalent to that he could have expected in the community and that his long-term conditions were not properly reviewed, communicated or planned for.

I am also concerned that although there is significant intelligence that Mr Rudge was using PS and was allegedly being bullied to do so, staff were apparently unaware of this. This is particularly concerning considering his learning difficulties, apparent vulnerability to coercion and the circumstances of his death. Staff did not consider the impact of his mental and physical health on his behaviour on the wing and substance misuse.

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

April 2021

Contents

Summary	1
The Investigation Process.....	3
Background Information.....	4
Key Events.....	6
Findings	13

Summary

Events

1. In January 2017, Mr Rudge was sentenced to three years in prison for sexual offences. He had epilepsy, asthma and learning difficulties. On 10 July 2018, Mr Rudge was released to Meneghy House Approved Premises on licence. On 28 August, Mr Rudge was recalled to custody and taken to HMP Exeter after he breached his licence conditions.
2. On 19 October, Mr Rudge transferred to HMP Dartmoor. While at Dartmoor, Mr Rudge admitted he used psychoactive substances (PS) and he engaged with substance misuse services.
3. On 25 April 2019, Mr Rudge transferred to HMP Ashfield. He was prescribed medication for epilepsy and asthma. While at Ashfield, Mr Rudge was seen regularly by a psychologist in relation to his learning difficulties and by his key worker. He declined a referral to substance misuse services.
4. On 31 August, several prisoners had been in Mr Rudge's cell in the morning. Mr Rudge then suffered a seizure. Two other prisoners went into the cell and put Mr Rudge in the recovery position. Staff responded, requested an ambulance and paramedics began cardiopulmonary resuscitation (CPR) for a short period when Mr Rudge's heart stopped. Once they had established a pulse, the paramedics took Mr Rudge to hospital, where he was placed on life support.
5. On 5 September, doctors withdrew life support and, at 5.40pm, Mr Rudge was pronounced dead.
6. After Mr Rudge was taken to hospital, there was a considerable amount of intelligence from prisoners that he had been bullied and used PS. Intelligence suggested that he had been coerced into taking PS or other chemicals before he collapsed to clear his debts.

Findings

Clinical care

7. The clinical reviewer concluded that Mr Rudge's clinical care was not equivalent to that he could have expected to receive in the community. Mr Rudge's asthma and epilepsy were not reviewed as they should have been, and he had no care plans in place. The psychologist's records were not shared with other healthcare staff and there was no effective multidisciplinary plan to manage Mr Rudge's substance misuse, epilepsy, asthma and his learning difficulties.

Substance misuse

8. Mr Rudge had a history of substance misuse but declined support and advice from the substance misuse team at Ashfield. We are concerned that, given the particular risks posed by his epilepsy and learning difficulties, staff did not discuss this further with Mr Rudge after he initially refused support.

9. We are also concerned that despite the amount of intelligence received after Mr Rudge died about his involvement in drug use and supply and his vulnerability to exploitation by other prisoners, staff said they were not aware that he was using drugs or being bullied.
10. Although Mr Rudge's key worker saw him regularly, his records of their meetings were largely word-for-word repeats of previous entries. As a result, it is not possible to know what was discussed or whether Mr Rudge's presentation changed during his four months at Ashfield. This may have been a missed opportunity to identify that Mr Rudge was at risk.
11. Ashfield has comprehensive policies to tackle the supply of illicit drugs in the prison. However, we are concerned that, despite this, Mr Rudge was apparently able to access and use drugs in Ashfield.

Learning difficulties

12. Mr Rudge's learning difficulties were not explicitly considered by healthcare or prison staff and no care plan or reasonable adjustments were considered.

Recommendations

- The Head of Healthcare should ensure that the provision of chronic disease management is in line with NICE guidelines. This should include prompt referrals for prisoners with chronic diseases and appropriate reviews of their condition.
- The Head of Healthcare should ensure that:
 - any medical records for a prisoner are accessible to all healthcare staff; and
 - there is multidisciplinary communication and planning to provide effective care for prisoners.
- The Director and Head of Healthcare should ensure that:
 - prisoners with learning difficulties are identified; and
 - multidisciplinary care plans and reasonable adjustments are put in place for prisoners with learning difficulties where necessary to comply with the Equality Act 2010.
- The Director should discuss the Ombudsman's concerns with the managers responsible for B Wing.
- The Director should ensure that the key drug issues at Ashfield are identified, that the prison's local drugs strategy addresses these key issues and that staff remain vigilant to signs that a prisoner is involved in drug use or supply.
- The Director should ensure that key workers provide an accurate account of their interactions with prisoners and do not simply cut and paste previous entries.
- The Director should share a copy of this report with Mr Rudge's key worker and ensure that a senior manager discusses the Ombudsman's findings with him.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Ashfield informing them of the investigation and asking anyone with relevant information to contact her.
14. The investigator visited Ashfield on 11 September 2019. She obtained copies of relevant extracts from Mr Rudge's prison and medical records. The investigator also interviewed four prisoners.
15. NHS England commissioned a clinical reviewer to review Mr Rudge's clinical care at the prison.
16. The police carried out a criminal investigation into the circumstances surrounding Mr Rudge's death. They interviewed five prisoners under caution as they were concerned they may have provided drugs to Mr Rudge shortly before he died. Police confirmed that we could interview staff but they asked us not to interview any further prisoners.
17. A second investigator interviewed 10 members of staff at Ashfield in November. The second investigator and clinical reviewer jointly interviewed four healthcare staff.
18. We then suspended our investigation pending the outcome of the criminal investigation. On 25 March 2020, the police informed us that their conclusion was that "the evidence is strongly supportive of death from natural causes" and that they were taking no further action. On receipt of the clinical review, we then unsuspending our own investigation.
19. We informed HM Coroner for Avon of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. The Ombudsman's family liaison officer contacted Mr Rudge's parents to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Rudge's mother wanted to know whether her son was prescribed medication for epilepsy and the details of the emergency response. We have answered these questions in the report.
21. We have removed the names of prisoners from this report in order to safeguard individuals in some cases, and in other cases because there is no evidence to substantiate allegations made about them.
22. Mr Rudge's mother received a copy of the draft report. She did not make any comments.
23. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly. The action plan has been annexed to this report.

Background Information

HMP Ashfield

24. HMP Ashfield is a specialist medium secure adult male prison for sex offenders. It accommodates up to 412 men. The prison is operated by Serco. Bristol Community Health provides health services at the prison.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Ashfield was in April 2019. Inspectors found the prison was very safe, and the numbers of violent and bullying incidents were very low. However, they noted that around a third of prisoners said that they had felt unsafe at some point during their time at Ashfield. Inspectors said that this was somewhat at odds with the reality that the prison was generally a very safe place, and that the reasons for these perceptions needed to be understood so that they could be addressed.
26. Inspectors found that the prison provided a respectful environment, and relationships between staff and prisoners were good. The strategic management of equality and diversity was weak.
27. There was a comprehensive safeguarding policy and prisoners' social care needs were well provided for. Inspectors found that all prisoners with long-term health conditions were managed by either a GP or a nurse, and received good care and support. However, not all had a care plan.
28. Inspectors also found that intelligence reports were not regularly collated or analysed. Although the levels of drug use were low, they found that the local drug strategy was not informed by a needs analysis and emerging themes were not discussed at meetings

Independent Monitoring Board

29. 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 June 2019, the IMB reported that Ashfield continued to be a well-run prison despite having a more challenging population than previously. Incidents of aggression had increased, along with evidence of illicit drug use in the prison.

Previous deaths at HMP Ashfield

30. Since January 2017, there have been five deaths at Ashfield, all from natural causes. There are no similarities between these deaths and Mr Rudge's death. There have been two further deaths due to natural causes since that of Mr Rudge.

Psychoactive Substances (PS)

31. 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.
32. 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.
33. 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.

The key worker system

34. The key worker system is a key part of HMPPS’s response to self-inflicted deaths, self-harm and violence in prisons. It is intended to improve safety by engaging with people, building better relationships between staff and prisoners and helping people settle into life in prison. Details of how the system should work are set out in HMPPS’s Manage the Custodial Sentence Policy Framework. This says:
 - All prisoners in the male closed estate must be allocated a key worker whose responsibility is to engage, motivate and support them through the custodial period.
 - Key workers must have completed the required training.
 - Governors in the male closed estate must ensure that time is made available for an average of 45 minutes per prisoner per week for delivery of the key worker role, which includes individual time with each prisoner.
 - Within this allocated time, key workers can vary individual sessions in order to provide a responsive service, reflecting individual need and stage in the sentence. A key worker session can consist of a structured interview or a range of activities such as attending an ACCT review, meeting family during a visit or engaging in conversation during an activity to build relationships.

Key Events

35. On 9 January 2017, Mr Mitchell Rudge was remanded into custody, charged with the sexual assault of a 16-year-old. He was taken to HMP Exeter.
36. Mr Rudge told staff that he always smoked psychoactive substances (PS) when he was in prison and had had a “few near misses”. Mr Rudge told the nurse that he was epileptic but had not had a fit for over a year. A GP prescribed Mr Rudge sodium valproate (an anticonvulsant used to treat epilepsy). Mr Rudge had learning difficulties and was referred to the learning disability team. He also had asthma for which he was prescribed inhalers.
37. On 17 July, Mr Rudge was sentenced to three years imprisonment. He spent time in HMP Channings Wood, HMP Bullingdon and HMP Whatton where he completed offence-focused work. Mr Rudge was both the victim of and perpetrator of assaults on other prisoners during this time. He was also suspected to be using PS, and to be in debt as a result, and he sometimes said he was being bullied.
38. On 10 July 2018, Mr Rudge was released to Meneghy House Approved Premises on licence. On 28 August, Mr Rudge was recalled to custody having breached his licence conditions. He was taken to HMP Exeter. On 19 October, Mr Rudge transferred to HMP Dartmoor. He said he had been taking PS but wanted to stop. He met several times with a substance misuse worker and engaged with group work sessions.
39. At the end of 2018 and start of 2019, Mr Rudge had several adjudications for being in possession of drugs or testing positive for cannabis. He told staff he had got himself into debt due to his PS use and was found under the influence of PS several times. Improvised weapons were also found in his cell which he said were for self-defence as he was being bullied.
40. On 19 February 2019, Mr Rudge told a nurse that he wanted to stop taking PS and agreed to work with the substance misuse team. A nurse recorded there was no need for Mr Rudge to have any mental health or learning disability interventions.
41. On 7 March, Mr Rudge told a substance misuse support worker that he no longer used drugs and no longer wanted support. On 10 April, Mr Rudge requested a transfer to either HMP Bristol or HMP Ashfield to be nearer his family and to receive support from a psychologist for his learning difficulties.

HMP Ashfield

42. On 25 April, Mr Rudge transferred to HMP Ashfield. A nurse saw him in reception. She recorded his history of asthma, epilepsy and PS use and that he was prescribed epilim chrono (for epilepsy), salbutamol (for asthma) and clenil modulite (for asthma). The nurse told the investigator that Mr Rudge said he had not used any drugs in the last month and did not want to be referred to the substance misuse service. She said that Mr Rudge seemed confused about his asthma inhalers, so she referred him for a medication review. Mr Rudge said he had no mental health issues. He was assessed as suitable to keep his medication in his cell.

43. On 26 April, a prison GP reviewed Mr Rudge's medication. He noted that Mr Rudge's compliance with this medication had been questioned in the past. The prison GP told the clinical reviewer that Mr Rudge appeared to be stable and he therefore re-prescribed Mr Rudge's medication for epilepsy and asthma.
44. On 2 May, Mr Rudge moved from the early days centre to Severn B Wing. Prisoners on the wing are unlocked at 7.30am on weekdays and 8.30am at the weekend. They are locked back in their cells at 5.45pm.
45. On 7 May, a prison custody officer introduced himself to Mr Rudge as his key worker. He recorded that Mr Rudge felt safe at Ashfield and knew some of the other prisoners. Mr Rudge said he had used drugs in the past but wanted to turn his life around. Over the following months, Mr Rudge's key worker (or a secondary key worker) met Mr Rudge regularly. They recorded that he seemed happy being employed as a cleaner on the wing, never raised any concerns and said he was motivated to stay away from drug misuse.
46. On 30 May, a pharmacist reviewed Mr Rudge's asthma inhalers. Mr Rudge also said he had no side effects from his epilepsy medication, felt fine and had not had any seizures.
47. On 31 May, a clinical psychologist from Avon and Wiltshire Mental Health Partnership NHS Trust, met Mr Rudge. He admitted using PS in prison and cannabis when in the community. Mr Rudge agreed to do some weekly one to one work with the clinical psychologist.
48. On 28 June, the clinical psychologist met Mr Rudge. Mr Rudge said he was 'fed up' being in prison and wanted to change his behaviour. The clinical psychologist's record was separate to Mr Rudge's medical record and could not be accessed by other clinical staff. Over the following weeks, they met regularly discussing education, relationships, Mr Rudge's use of drugs and alcohol and friendships. The clinical psychologist discussed Mr Rudge's progress with his key worker.
49. The investigator spoke to four prisoners on B Wing who had known Mr Rudge.
50. Mr A told the investigator that it was clear that Mr Rudge had learning difficulties. He said that Mr Rudge was easily led and coerced by other prisoners and that he tried to protect him from being taken advantage of by other prisoners during his time at Ashfield.
51. Mr A said that other prisoners bullied Mr Rudge to do demeaning things, such as swallowing pepper, in return for PS. He believed that Mr Rudge was in debt due to drugs. He said that it was often obvious that Mr Rudge was under the influence. Some prisoners would laugh at him when this happened and staff did not challenge this behaviour. He said Mr Rudge became increasingly withdrawn when he took PS and would isolate himself in his cell. He said three prisoners in particular, Mr E, Mr F and Mr G, spent increasing amounts of time in Mr Rudge's cell.
52. Mr B told the investigator that around the end of July and during August, Mr Rudge's behaviour changed. He said that Mr Rudge sometimes followed other prisoners out of his own cell and told them not to bully him. Mr B said Mr Rudge became more withdrawn and asked to borrow vapes to repay debts to other prisoners. He said Mr Rudge offered to sell him some tobacco once and PS another time. He told the investigator that he thought that Mr Rudge was often

under the influence of illicit drugs, sometimes in the company of other prisoners in his cell. He saw a lot of prisoners going in and out of Mr Rudge's cell: Mr E, Mr F and Mr G in particular.

53. Mr C, another prisoner on B Wing, gave the investigator a similar account and said that he once witnessed Mr G taking Mr Rudge's vape capsules against his will.
54. Another prisoner, Mr D, said Mr Rudge never seemed unwell or bullied to him. He said he was not aware of Mr Rudge using PS.
55. Officers told police that they did not have any concerns about Mr Rudge. They said he was an energetic, bubbly prisoner who was friends with a particular group of prisoners on the wing. They said they did not believe he was being bullied and did not notice him under the influence of drugs.
56. The investigator listened to telephone calls Mr Rudge made from mid-August onwards. These were not being monitored by the prison. On 16 August, Mr Rudge telephoned his mother and asked her to send him money. She told the police that she had not had contact with him for eighteen months before this call. On 24 August, Mr Rudge telephoned his mother and asked her if she had sent him the money. His speech was slurred during the telephone call.
57. Mr B told the investigator that Mr Rudge looked ill on 29 August. He knew that Mr Rudge had not been eating properly as he had been giving his food away. He said he tried to encourage Mr Rudge to tell staff that he was being bullied but Mr Rudge refused, saying he could cope.
58. On the same day, an officer suspected that Mr Rudge was under the influence of drugs. She submitted an intelligence report. She told police that she did not refer him to substance misuse services as he recovered quickly and she doubted her initial judgement.
59. On 30 August, the clinical psychologist met Mr Rudge. He said that he had fallen out with his friend on the wing. Mr Rudge said there was PS on the wing and he was tempted to have some. He said he kept himself to himself and preferred to stay in his cell. Mr Rudge said he had applied to be transferred to HMP Bristol. The clinical psychologist recorded that she and Mr Rudge discussed his relationship with his sister, mother, step-father and his friend on the wing.
60. At 3.50pm, Mr Rudge telephoned his mother and asked whether she had sent him the money. He had tried to call her three times previously that day but his calls had been unanswered.
61. Later that day, Mr Rudge's key worker met with him and recorded that he was happy, felt safe and several prisoners kept an eye out for him. The key worker told the investigator that Mr Rudge was quieter than usual and said he was tired. The key worker did not work on B Wing so did not see how Mr Rudge interacted with other prisoners. He said he was not concerned about him but told the investigator that he was always worried that Mr Rudge could be "easily led astray" by other prisoners who had an influence over him.
62. Mr B said that he did not see Mr Rudge all day, apart from at roll check. He said that he looked very ill, tired and withdrawn. Mr B said he tried to ask Mr Rudge how he was but as soon as the roll check was finished he went straight back into his cell.

which was unusual. Mr C also saw Mr Rudge before they were locked up that evening. He said that he seemed to be struggling mentally with the issues with other prisoners.

Events of 31 August

63. Two officers were on duty on Severn B wing on 31 August. CCTV shows that at 8.38am, an officer unlocked Mr Rudge's cell, opened the door and then pulled it to. Later that morning both officers began carrying out accommodation fabric checks in the cells on the wing. At 10.13am, they went into Mr Rudge's cell. Mr Rudge stood outside his cell for a minute while the officers checked his cell. An officer said that Mr Rudge seemed "absolutely fine".
64. At 10.30am, Mr Rudge went to the door of his cell briefly. This was the last time he was seen on CCTV. Mr E, Mr F and Mr G went in and out of Mr Rudge's cell that morning. A police summary of the CCTV shows that Mr E had what looked like a mobile telephone in his hand at one point, along with several other unidentifiable items, when he went into Mr Rudge's cell.
65. At 11.07am, Mr G returned to Mr Rudge's cell, looked through the observation panel and beckoned to another prisoner, Mr H, who went over to Mr Rudge's cell and looked in. Other prisoners also looked into the cell and walked away.
66. At 11.08am, Mr C and another prisoner looked into Mr Rudge's cell. Mr C told the investigator he saw Mr Rudge sitting in his chair and thought he was under the influence of drugs. Mr Rudge's head was drooped to the side, his eyes were open and he was smiling.
67. Mr A told the investigator he was alerted to Mr Rudge's cell by hearing a prisoner shouting, "He's fitting." He immediately went to the cell, looked in and pushed the cell door open. Mr G went to the to the wing office and told both officers that Mr Rudge was having a fit in his cell. They left the office immediately and went to Mr Rudge's cell.
68. Meanwhile, Mr A and another prisoner had gone into Mr Rudge's cell. Mr A said he had first aid training and close family members who were epileptic. He told the investigator that Mr Rudge was on the floor, half on his side with his head turned towards the wall. Mr Rudge's head was bleeding and he was having a fit. Mr A and the other prisoner moved Mr Rudge into the recovery position, Mr Rudge started choking so they moved his head backwards to open his airway.
69. At 11.10am, both officers went into Mr Rudge's cell. An officer put a pillow under Mr Rudge's head in case he had another fit. She told the police that Mr Rudge was taking deep breaths but did not respond to her and his eyes were closed. At 11.11am, an officer radioed a code blue, which indicates a prisoner is having difficulty breathing. The control room immediately requested an ambulance.
70. Within 30 seconds, two nurses arrived at Mr Rudge's cell with the emergency equipment. The prisoners left the cell and a few seconds later a Custodial Operations Manager (COM) arrived. The nurses noted that Mr Rudge was continuing to have seizures, his eyes were not responding to light, and his blood pressure was low. They administered oxygen and also gave Mr Rudge diazepam (a sedative) which a nurse said lessened Mr Rudge's seizures.

71. At 11.20am, the nurses noted that Mr Rudge's breathing had become laboured and asked a COM to increase the urgency of the ambulance, which he immediately did. Staff moved Mr Rudge out of the cell so there was more room and attached the defibrillator in case they needed to use it. Mr Rudge remained in the recovery position.
72. The paramedics arrived at the prison at 11.32am and took over Mr Rudge's care. At 11.46am paramedics noted that Mr Rudge had stopped breathing and started cardiopulmonary resuscitation (CPR), assisted by prison staff. At 11.57am, staff stopped CPR as Mr Rudge had a pulse. Emergency services doctors arrived and intubated Mr Rudge.
73. At 12.43pm, paramedics took Mr Rudge to hospital. He was escorted by two officers and no restraints were used. Mr Rudge was put in an induced coma and placed on life support. Police found a white plastic tube in Mr Rudge's trousers and took this and his vape as evidence.
74. The prison's family liaison officer (FLO) tried to telephone Mr Rudge's stepfather, who he had listed as his next of kin, but could not make contact. The FLO then telephoned Mr Rudge's mother and told her that Mr Rudge had been taken to hospital. Along with another member of staff, the FLO met Mr Rudge's family at the hospital.
75. On 5 September, hospital doctors withdrew life support, and at 5.40pm, a hospital doctor pronounced Mr Rudge dead. Mr Rudge's family were present when he died. The FLO remained in contact with the family and offered her condolences after Mr Rudge died. In line with national instructions, the prison offered a contribution to the cost of the funeral.

Security intelligence

76. After Mr Rudge was taken to hospital, there was a considerable amount of intelligence from prisoners that he had been bullied and had been using drugs.
77. On 1 September, Mr E, Mr F and Mr G who were seen going in and out of Mr Rudge's cell on 31 August, were relocated to the early days centre for their own safety. Police started a criminal investigation into their potential involvement in the circumstances surrounding Mr Rudge's collapse. Two other prisoners were also subsequently relocated to another wing.
78. Intelligence reports continued to be submitted by staff after prisoners gave them information about Mr Rudge. This included reports that prisoners, particularly Mr E, Mr G and Mr H, had been supplying drugs on the wing and had coerced Mr Rudge to do demeaning and dangerous things such as drinking cockroach killer, alloy wheel cleaner, nail polish remover and oil with chlorine tablets in return for PS. They also said that Mr Rudge had been taking an increasing amount of PS before he died. Some prisoners also alleged that Mr Rudge had been told that if he took a large amount of PS or other substances on 31 August his debt would be cleared.
79. Police subsequently interviewed every prisoner on B Wing. Prisoners said that, due to Mr Rudge's learning difficulties, he was vulnerable and other prisoners took advantage of him. Several said that Mr Rudge was being bullied and that he wanted to move off the wing. He had told prisoners he was in debt and he had borrowed

things from other prisoners to try to repay his debts. Prisoners also said that Mr Rudge frequently used PS and was sometimes given it by other prisoners to test a new batch. Some prisoners said that they had told officers that they were concerned that Mr Rudge was being bullied but officers either took no action or Mr Rudge denied this was the case. They said that Mr Rudge seemed more withdrawn in the weeks before he died and that it was often obvious that Mr Rudge was under the influence of drugs, but staff did not tackle this.

80. Two of the prisoners seen going into his cell on 31 August told the police that they did not see any drugs in Mr Rudge's cell that morning. Mr G said he went into Mr Rudge's cell for a coffee. He said he left the cell and when he returned, he opened the observation panel and Mr Rudge was on the bed, yelling. He told police that he thought Mr Rudge was joking, so he opened the door and started laughing. He said when he turned back towards the cell Mr Rudge was face down on the floor, bleeding from his head and he realised it was serious. He said that he ran upstairs and told officers that Mr Rudge was having a fit.
81. A red and white vape was tested after Mr Rudge's death (it is not clear whether this was in his possession when he died or found in his room) and was positive for PS and heroin. A homemade smoking device (a tube, foil and rubber band) found on the floor beside Mr Rudge's desk was also positive for PS. It was tested for DNA and was found to have that most likely relating to one of the three prisoners on it and potentially Mr Rudge.
82. Mr Rudge's sister told the police that, Mr Rudge had told her during his telephone calls that he and his friends at the prison took PS. She last spoke to Mr Rudge around six weeks before he died, when he asked her for money.

Support for prisoners and staff

83. After Mr Rudge was taken to hospital, the assistant director, 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.
84. The prison posted notices informing staff and prisoners of Mr Rudge'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 Rudge's death.

Post-mortem report

85. The post-mortem report concluded that Mr Rudge's cause of death was "hypoxic-ischaemic encephalopathy following prolonged cardiorespiratory arrest in a known epileptic". This means that Mr Rudge suffered a brain injury because his brain was deprived of oxygen after his heart stopped.
86. The toxicologist noted that apart from ketamine (which is often administered during emergency medical treatment), no other drugs were detected in Mr Rudge's system. However, the toxicologist also noted that because there are so many types of PS available and other factors, it was not possible to entirely exclude the possibility that Mr Rudge had used PS before he started having seizures.

87. The pathologist concluded that Mr Rudge's collapse may have been caused by drugs or by an epileptic seizure.
88. The investigator asked the coroner to test for other substances Mr Rudge was alleged to have been bullied into taking (including nail polish remover, cockroach killer, chlorine tablets and alloy wheel cleaner). Unfortunately, it was not possible to test for these substances.

Findings

89. In the light of the pathologist's conclusion that Mr Rudge's death could have been caused by either epilepsy or drugs, we have looked at both.

Clinical Care

90. The clinical reviewer concluded that Mr Rudge's clinical care was not equivalent to that he could have expected to have received in the community.

Physical health care

91. Mr Rudge was not seen by a GP during his four months at Ashfield. His chronic diseases - asthma and epilepsy - were noted and he was prescribed medication, but staff did not formally review them.
92. National Institute for Clinical Excellence (NICE) guidance on epilepsy states that a regular structured review should take place with a GP at least annually. This should include a treatment plan and consideration of how well the patient's seizures are being controlled, how their epilepsy is affecting their life and any adverse effects of their medication.
93. A prison GP told the clinical reviewer that patients with epilepsy would be reviewed annually in the community and therefore he did not schedule a review with Mr Rudge when he arrived at Ashfield as he had last had a review in November 2018. In fact, Mr Rudge's most recent review was in February 2018. Despite the prison GP noting that Mr Rudge's compliance with his medication had been questioned in November 2018, no one checked his compliance while he was at Ashfield.
94. The clinical reviewer also noted that a nurse did not make a referral to the asthma nurse for review, nor was an asthma care plan considered. Mr Rudge's asthma care plan had previously been reviewed in October 2018. Mr Rudge's last review for asthma had been in October 2018 and his annual review should have been scheduled before October 2019. This had not been noted in his record.
95. The Head of Healthcare told the investigator that a more comprehensive review of Mr Rudge's epilepsy should have taken place. She said that she was reviewing the process for ensuring that prisoners had annual reviews for long-term medical conditions. She said that she was also hoping to have a nurse who specialised in epilepsy, as they did with other long-term conditions. We recommend:

The Head of Healthcare should ensure that the provision of chronic disease management is in line with NICE guidelines. This should include prompt referrals for prisoners with chronic diseases and appropriate reviews of their condition.

Mental health care

96. Mr Rudge had learning difficulties and had regularly seen mental health services before his transfer to Ashfield. Mr Rudge's learning difficulties were not identified at

his reception healthscreen and a learning difficulties assessment was not carried out.

97. Mr Rudge was seen regularly by a clinical psychologist at Ashfield but her notes were kept separately from the rest of his medical record and healthcare staff at the prison could not access them. The psychologist did not have access to SystemOne (Mr Rudge's medical record) or communicate with healthcare staff, and no multidisciplinary meetings were held to discuss Mr Rudge's care. Mr Rudge's key worker was aware of these sessions because Mr Rudge told him and he was proactive in requesting to meet the clinical psychologist. No healthcare staff were aware of these meetings. The clinical reviewer notes that Mr Rudge's learning difficulty needs were not acknowledged or addressed by other healthcare staff.
98. The Head of Healthcare told the investigator that prisoners are asked at reception whether they have any learning difficulties and then staff will assess them on an ongoing informal basis as to whether they need any additional support with healthcare issues. The Head of Healthcare did not know about the clinical psychology sessions provided by the clinical psychologist. She said that since Mr Rudge's death, she has set up multidisciplinary sentence planning meetings, which include key workers and healthcare staff, to discuss all new prisoners. She agreed that the psychology sessions should have been recorded in Mr Rudge's medical record and discussed with healthcare staff. This would have helped them consider whether any reasonable adjustments needed to be made in relation to Mr Rudge's learning difficulties (which we discuss further below).
99. The Head of Healthcare told the investigator that they intend to consider prisoners' healthcare more holistically in future. In Mr Rudge's case, this would have ensured that the risks for someone with epilepsy taking drugs were explained to Mr Rudge, along with a consideration of his learning difficulties.

100. We recommend that:

The Head of Healthcare should ensure that:

- **any medical records for a prisoner are accessible to all healthcare staff; and**
- **there is multidisciplinary communication and planning to provide effective care for prisoners.**

Learning Difficulties

101. Mr Rudge had learning difficulties which both staff and prisoners said were clearly apparent, and which may have made him more vulnerable to the influence of other prisoners. This is particularly significant given the allegations from other prisoners that Mr Rudge was being bullied and made to take poisonous substances and test PS when it came into the prison.
102. Ashfield's *Equality Policy for Staff and Prisoners* says:

“Prisoners entering the establishment with Learning Difficulties will be held safely and have full access to education, training and reducing reoffending

courses which are suitable to their needs, while also ensuring a full care plan is initiated on their residential unit involving officers and support staff.”

103. The policy says that reasonable adjustments should be made where necessary and support services should be monitored. The investigator saw no evidence of a support plan on the wing, or that healthcare staff explicitly considered whether any reasonable adjustments were needed. The Head of Healthcare said that they have two learning difficulties’ nurses at Ashfield who accept referrals for prisoners needing assessment or support, but they were not involved in Mr Rudge’s care.
104. We make the following recommendation:

The Director and Head of Healthcare should ensure that:

- **prisoners with learning difficulties are identified; and**
- **multidisciplinary care plans and reasonable adjustments are put in place for prisoners with learning difficulties where necessary to comply with the Equality Act 2010.**

Substance misuse and bullying

105. Mr Rudge had a history of using cannabis, cocaine, heroin and PS. He had admitted using drugs and had been regularly seen by substance misuse services at previous prisons. Mr Rudge declined a referral to substance misuse services when he arrived at Ashfield. The clinical reviewer noted that no one spoke to clinical staff about a referral. He considered that this would have been appropriate given Mr Rudge’s learning difficulties and the additional risk of him using drugs when he had epilepsy.
106. The only record that a member of staff suspected Mr Rudge had been using drugs was on 29 August. An officer submitted an intelligence report but said she did not refer Mr Rudge to substance misuse services because he seemed to recover quickly and she said she doubted her suspicions.
107. There was a considerable amount of intelligence after Mr Rudge died that he had been using PS, was in debt because of it, was involved in its supply, was used to test PS and was bullied into taking other dangerous chemicals. He associated with other prisoners who were suspected to be involved in the supply of PS. Other prisoners told us that Mr Rudge was often seen under the influence of drugs, and the investigator noted that he was noticeably slurring his speech during one of the telephone calls she listened to. Prisoners also said that prison staff were aware of Mr Rudge’s drug use but took no action. Mr Rudge’s sister said that he told her that he and his friends took PS at the prison. In addition, items found in Mr Rudge’s room or in his possession after his death tested positive for PS or heroin.
108. Given this intelligence and evidence, we are very concerned that all the staff we and the police spoke to said that they did not suspect that Mr Rudge was involved in the use or supply of drugs at Ashfield. We would have expected that staff would have paid particular attention to a prisoner with learning difficulties which would have made him vulnerable to exploitation, and we find it difficult to understand how staff failed to notice Mr Rudge’s drug use when it was so obvious to other prisoners.

109. Other prisoners told us that Mr Rudge was being bullied by Mr E, Mr F and Mr G. CCTV shows that they were in and out of his cell on the morning he died and just before he was found unresponsive. It is possible that they may have been involved in supplying and encouraging Mr Rudge to take drugs or other poisonous substances that morning, although the police have concluded that there is no criminal case to answer. There was already intelligence suggesting that these prisoners were involved in the supply of drugs at Ashfield and we are concerned that staff did not notice their presence in and around Mr Rudge's cell given his vulnerability.

110. We recommend:

The Director should discuss the Ombudsman's concerns with the managers responsible for B Wing.

111. Ashfield has a strategy to address both the supply of and demand for illicit drugs. It includes numerous actions intended to reduce the supply of drugs into the prison and movement of drugs around the prison. 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.

112. The Deputy Director told the investigator that during Mr Rudge's time at Ashfield they were concerned that PS was being supplied at the prison, whereas it had not previously been an issue. The Deputy Director said they had delivered training to staff about PS with Avon and Wiltshire Mental Health Partnership Trust. They had also tried to educate prisoners about the risks of taking PS.

113. The Deputy Director told the investigator that the three prisoners suspected to have been involved in the drug supply at Ashfield (Mr E, Mr F and Mr G) had been transferred after Mr Rudge's death and that since then, the prison had had no positive drug tests or significant discovery of drugs. The Deputy Director said that analysis suggested that PS had been coming through the mail and they had started testing mail more frequently. (They do not photocopy the mail at Ashfield, a measure employed in other prisons to block supply, as the issue is not deemed to be significant enough.)

114. The Deputy Director said that the three prisoners had previously been challenged about their alleged behaviour and had been subject to searches but nothing had been found, although a mobile phone had been found on Mr G when he transferred. The Deputy Director said that there had not been any significant issues with drugs in the prison since September 2019. Despite this, we are concerned that staff need to remain vigilant to the potential signs that a prisoner is involved in drug use or supply.

115. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are, for the most part, doing their best to tackle the problem by developing their own local drug strategies. In April 2019, the Prison Service strategy introduced a national drug strategy. This notes that:

“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.”

116. We are not convinced that Ashfield had adequately analysed and acted on intelligence regarding the supply of PS at Ashfield before Mr Rudge died. We recommend:

The Director should ensure that the key drug issues at Ashfield are identified, that the prison’s local drugs strategy addresses these key issues and that staff remain vigilant to signs that a prisoner is involved in drug use or supply.

Key worker scheme

117. The key worker scheme provides for a dedicated member of staff to establish a relationship with a prisoner and should therefore provide opportunities to identify any concerns a prisoner may have and help to put support in place.
118. In Mr Rudge’s case there was some good practice. His key worker (or occasionally a secondary officer) saw him 15 times in the four months he spent at Ashfield and spoke to the clinical psychologist who was working with Mr Rudge.
119. On the face of it, the key worker also made lengthy, detailed entries in Mr Rudge’s record. However, in practice these entries were cut and pasted and for the most part simply used identical words to repeat what had been said in all the previous entries.
120. For example, at interview the key worker told us that when he saw him the day before his collapse, Mr Rudge was quieter than usual and said he was tired. However, the key worker did not mention that in his record of their meeting but simply recorded, as he had after all their previous meetings:

“Mitchell is currently housed in a single cell on Severn B wing he states he is happy on the wing and knows others on the wing through his previous time in Ashfield and his time in other establishments.”

Because the words used are exactly the same as in the previous entries, it is impossible to know whether the key worker discussed Mr Rudge’s state of mind with him or not on 30 August, or whether Mr Rudge’s presentation had changed in any way over the four months (as prisoners told us it had).

121. The same applies to the other subjects covered in each entry. For example, on drug use, the key worker recorded each time:

“Mitchell admits to drinking and smoking cannabis before custody. He has an adjudication on record for a failed MDT due to cannabis but states that he wants to turn his life around and will not do this on release. No failed MDTs at Ashfield since returning.”

122. As a result, the key worker entries do not give any sense of a developing relationship or provide a meaningful record of what was actually discussed and whether there had been any changes. We recommend:

The Director should ensure that key workers provide an accurate account of their interactions with prisoners and do not simply cut and paste previous entries.

The Director should share a copy of this report with Mr Rudge's key worker and ensure that a senior manager discusses the Ombudsman's findings with him.

Prisons &
Probation

Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100