Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Benjamin Maslin, a prisoner at HMP Chelmsford, on 17 October 2018

A report by the Prisons and Probation Ombudsman

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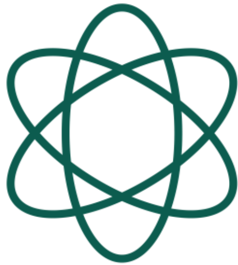
Our vision

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 Benjamin Maslin died from bronchopneumonia and a hypoxic brain injury in hospital on 17 October 2018 while a prisoner at HMP Chelmsford. He was 36 years old. I offer my condolences to his family and friends.

The underlying cause of Mr Maslin's death was unascertained. He was found unresponsive in his cell on 4 October. Although post-mortem toxicology tests taken from hair samples did not identify the presence of illicit substances, the hospital did not take any blood samples from Mr Maslin when he was admitted to hospital. This meant that full toxicology testing could not be undertaken after his death.

Mr Maslin used PS regularly in prison and was frequently treated for its effects. Despite staff warning him about the dangers of PS while taking methadone and other medication, Mr Maslin continued to use it.

I continue to be concerned by the number of deaths my office investigates in which PS has played a part. Mr Maslin's death is yet another example of how dangerous PS are and how prisons are struggling to reduce its use.

I have previously expressed my concerns about how individual prisons are being left to develop local strategies to reduce the supply and demand for drugs. I am pleased to note that HM Prison and Probation Service has now issued a new Prison Drugs Strategy to provide guidance to prison governors on how to tackle the issue.

The clinical review into Mr Maslin's death concluded that his care was of mixed quality, with aspects not equivalent to that which he could have expected in the community. We are concerned that not all clinical providers were told when Mr Maslin had used PS and that no clinical lead was responsible for monitoring his medication. I am concerned that despite his mental health history, it took over a month for the mental health team to assess Mr Maslin. There was also a delay in calling an emergency code blue.

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 **October 2019**

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Summary

Events

1. On 24 August 2018, Mr Benjamin Maslin was convicted and sentenced to 12 weeks in prison for stealing. He had a history of substance misuse, both in the community and during periods of custody, when he would use psychoactive substances (PS). Mr Maslin had mental health issues, including a diagnosis of a personality disorder and depression. He sometimes self-harmed and was being monitored under suicide and self-harm prevention procedures (known as ACCT) on the day he died.

2. Mr Maslin was prescribed methadone (an opiate substitute) and other medications to treat depression, epilepsy and for pain relief.

3. On numerous occasions during the weeks before his death, Mr Maslin was found under the influence of drugs, thought to be PS. He was often treated by healthcare staff for its effects. Mr Maslin was open to staff about his use of PS and repeatedly refused support from the prison's substance misuse team. Staff at Chelmsford warned him frequently about the risk that he posed to his health by using PS while on methadone and other medication.

4. At around 4.23pm on 4 October, two prisoners told staff that Mr Maslin had fallen over. A medical emergency code blue was called and responding staff and nurses treated him until paramedics arrived. Shortly afterwards, Mr Maslin stopped breathing and paramedics began cardiopulmonary resuscitation. Mr Maslin was stabilised and moved to the Critical Care Unit at a hospital. Mr Maslin did not recover and he died in hospital on 17 October, with his family present.

Findings

5. We are concerned that illicit substances continue to be available at Chelmsford, despite a local drug strategy and the prison's continuing efforts to address the issue. We found that not all heads of functions, including the Head of Healthcare and Pharmacy, attended all drug strategy meetings.

6. There was a delay in calling an emergency code blue because the radio network was busy.

7. The clinical reviewer concluded that the care that Mr Maslin received at Chelmsford was of mixed quality and some aspects were not equivalent to that which he could have expected to receive in the community.

8. The clinical reviewer found that all clinical services should be told when a prisoner is treated for substance misuse and that formal guidance should be introduced to record the advice that nurses give officers about the level of checks that a prisoner under the influence of PS might need.

9. The clinical reviewer was concerned that no named person had overall responsibility to monitor Mr Maslin's prescribed medications, which were prescribed by three different prescribers, and to consider any contraindications between the

medications prescribed and the effects on these medications of Mr Maslin's continued use of PS.

10. The clinical reviewer was concerned that despite Mr Maslin's mental health history, it took over a month for the mental health team to assess him. The clinical reviewer also noted the lack of talking therapies offered at Chelmsford at the time of Mr Maslin's death.

11. We consider that it is important for staff who were involved in Maslin's care to see the findings of and learn lessons from our investigation.

Recommendations

- The Governor should ensure that the key drug issues at Chelmsford are identified, and that the prison's local drugs strategy is promptly revised to ensure that these key issues are being addressed.
- The Governor should remind all prison staff to radio an appropriate medical emergency code as soon as they find a prisoner in a potentially life-threatening situation, even if the prison radio network is busy.
- The Governor should ensure that all heads of function attend all drug strategy meetings or send a representative in their absence.
- The Head of Healthcare should ensure that all clinical services at Chelmsford are aware of the treatment that prisoners using illicit substances receive to enable them to assess and review treatments and prescribed medications and their potential interactions with illicit substances.
- The Governor and Head of Healthcare should ensure that a formal process is implemented so that healthcare staff to advise officers how to monitor prisoners found under the influence of illicit substances.
- The Head of Healthcare and other clinical leads should ensure that a process is implemented to give a named individual responsibility to oversee medications prescribed from multiple prescribers.
- The Head of Healthcare should ensure that prisoners with mental health issues and who self-harm are given a full mental health risk assessment on arrival at prison and that those who meet the criteria for secondary mental healthcare receive a comprehensive assessment within 72 hours of arrival, a care plan and risk assessment is put in place and a keyworker identified.
- The Head of Healthcare should ensure that talking therapies are available to prisoners in HMP Chelmsford.
- The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Chelmsford informing them of the investigation and asking anyone with relevant information to contact him.

13. The investigator obtained copies of relevant extracts from Mr Maslin's prison and medical records.

14. NHS England commissioned a clinical reviewer to review Mr Maslin's clinical care at the prison.

15. The investigator interviewed fourteen members of staff and two prisoners, some jointly with the clinical reviewer, in January 2019.

16. We informed HM Coroner for Essex and Thurrock of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. We contacted Mr Maslin's family to explain the investigation and ask if they had any matters they wanted us to consider. The family asked about Mr Maslin's mental health, how he could access drugs in prison and whether he was monitored under suicide and self-harm prevention procedures.

Background Information

HMP Chelmsford

18. HMP Chelmsford is a local prison that takes prisoners directly from the courts. It holds nearly 730 men. Essex Partnership University NHS Foundation Trust is commissioned to provide 24-hour healthcare, which includes a range of primary care and secondary mental health services. The prison has a twelve-bed inpatient unit.

19. Between 3 May 2018 and 2 July 2019 Chelmsford was under special measures. This means that HM Prisons and Probation Service has determined that it needs additional, specialist support to improve its performance.

HM Inspectorate of Prisons

20. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Chelmsford in June 2018. Inspectors said that aspects of healthcare provision needed attention, leadership needed to be stronger and significant staffing shortages in healthcare affected service delivery and leadership. They reported that waiting times for some aspects of care were too long and mental health services were very stretched, with prisoners waiting weeks for an assessment and that services were reactive. However, they noted that substance misuse support was generally good.

21. Inspectors reported that drugs were readily available at Chelmsford and that 40 per cent of prisoners reported that it was easy to get illegal drugs. They found that mandatory drug testing focussed on targets which meant that the prison had too few resources left to undertake frequent or suspicion testing programmes. Inspectors recommended that managers should invest in staff, processes, resources and technology to help reduce the drug supply into the prison. Chelmsford partially accepted the recommendation. Inspectors also noted that drug strategy meetings were poorly attended by some prison departments.

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 August 2018, the IMB reported that there were significant healthcare staff shortages and lengthy delays in mental healthcare provision. The IMB noted that the widespread availability of drugs continued, despite Chelmsford's efforts.

Previous deaths at HMP Chelmsford

23. Since December 2016 and before Mr Maslin's death, nine prisoners died at Chelmsford, five from self-inflicted deaths, one from drug-related deaths, one unknown, one from natural causes and on which remains under investigation but is currently suspended. There were a number of broad similarities between our findings in our investigation of Mr Maslin's death and our previous investigations of

deaths at Chelmsford. We have previously made similar but not identical recommendations about the treatment for prisoners with dual diagnoses, mental health services, Chelmsford's substance misuse strategy, addressing the risk of multiple prescribing in substance misuse patients and responding to emergencies.

Integrated Drug Treatment Services (IDTS)

24. The integrated drug treatment services aim to improve the quality of substance misuse treatment available for prisoners, with emphasis on those in the early days of custody and improving the integration between clinical and other drug workers. This includes establishing an appropriate approach to opiate withdrawal in prescribing opiate substitutes with an aim of detoxification, gradual reduction or opiate maintenance and monitoring.

Psychoactive substances (PS)

25. PS 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 many 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. There is emerging evidence to link PS use to endangering physical health, precipitating or exacerbating the deterioration of mental health and the risk of suicide or self-harm.

26. In July 2015, we published a Learning Lessons Bulletin about the use of PS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for staff and prisoners to be more aware 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 PS as part of established mandatory drugs testing arrangements.

Assessment, Care in Custody and Teamwork (ACCT)

28. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner.

29. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Prison Service Instruction (PSI) 64/2011 on safer custody sets out how staff should operate ACCT procedures.

Key Events

Background

30. Mr Benjamin Maslin had a history of substance misuse, both in the community and in prison. Mr Maslin had emotionally unstable personality disorder and had been seen by community mental health services since 2005. He also had a history of self-harm.

31. On 20 August 2018, Mr Maslin was released on licence from HMP Chelmsford. On 24 August, he was found guilty of stealing a handbag and sentenced to 12 weeks in prison for theft. Mr Maslin had served previous sentences at the prison.

HMP Chelmsford

32. At his initial health screen on 24 August, a nurse noted that Mr Maslin had a diagnosis of an emotionally unstable personality disorder, was on a methadone maintenance programme and that healthcare staff had previously seen him. Mr Maslin said that he had used drugs daily and was happy to be back in prison as he had been homeless. The nurse referred him to the prison's Integrated Drug Treatment Service (IDTS) team and to the mental health team's referrals and allocations meeting.

33. A prison GP and a nurse from the prison's IDTS team assessed Mr Maslin. The prison GP noted his history of asthma, epilepsy, mental health and substance misuse, and that he had tested positive for opiates, cocaine, methadone and benzodiazepines. Mr Maslin's immediate opiate substitute needs were considered. He appeared under the influence and said that he had taken pregabalin before coming into prison. Unsure when he had last taken drugs and because of concerns about possible drug interactions and the increased risk of respiratory depression, Mr Maslin was not given methadone. However, the prison GP prescribed medication to relieve the symptoms of drug withdrawal and referred Mr Maslin to the IDTS team and to Full Circle, provided by Phoenix Futures, a psychosocial support team. He was moved to F Wing, the prison's first night centre.

34. On 25 August, a nurse from the IDTS team re-assessed Mr Maslin's methadone needs. He told the nurse that he smoked crack cocaine in the community but preferred PS in prison. The nurse noted Mr Maslin's prescription of pregabalin for pain relief, mirtazapine for depression and clonazepam for epilepsy, although he said that he had not had a seizure for some time. Mr Maslin said that he had no concerns about his mental health and denied thoughts of suicide. He said that the only time he harmed himself was to get what he wanted.

35. A nurse started Mr Maslin on a methadone maintenance programme (where methadone is administered in a slowly increasing dose over five days, from 10mg to 40mg, and is then maintained at that level.) She arranged for the IDTS team to check him twice a day and hold joint reviews with Full Circle after five and 28 days. IDTS staff warned Mr Maslin about the dangers of illicit drug use. The nurse told Mr Maslin that if he was found under the influence, he would be subject to a multidisciplinary team review of his methadone. The nurse noted that the healthcare team would manage his other medication.

36. On 26 August, staff found Mr Maslin under the influence of PS, but he refused treatment. His methadone medication was withheld. Healthcare staff planned for officers to contact the healthcare team if they had concerns and for nurses to check him.

37. On 27 August, a nurse prescriber with the IDTS team, reviewed Mr Maslin's methadone. Mr Maslin told the nurse that he had misused pregabalin and heroin during his release and had not engaged with drug services. The nurse noted that Mr Maslin might have been concealing pregabalin and that his illicit drug use often resulted in an emergency response. The nurse told Mr Maslin that his methadone would be reduced to 25mls and that if he continued to use illicit substances, there would be a further reduction in his methadone. The nurse told him about the risks of accidental overdose by taking illicit drugs. Mr Maslin said that he was unconcerned about the negative effect of PS on his health. The nurse concluded that Mr Maslin remained at high risk of accidental overdose and encouraged him to engage with Full Circle.

38. On 27 August, the healthcare referral meeting discussed Mr Maslin. The following day at a safety intervention meeting, where prisoners with challenging and complex issues are discussed, staff noted that he had settled at Chelmsford and that the mental health team would assess him.

39. On 29 August, a member of staff from Full Circle assessed Mr Maslin who told her that he did not want to work with the substance misuse team as they were no use to him. She told Mr Maslin about the dangers of taking PS and to contact them if he changed his mind about working with them.

40. On 1 September, a nurse prescriber with the IDTS team, completed Mr Maslin's five-day methadone review. She noted that the first nurse had stopped further methadone titration to avoid accidental overdose. Mr Maslin again admitted that he took PS in prison and said that he appreciated that staff were concerned about his safety. Mr Maslin told the nurse that he had withdrawal symptoms and asked for his methadone dose to be increased. The nurse planned to speak to first nurse about Mr Maslin's methadone dosage.

41. On 2 September, Mr Maslin was not given his methadone as he was found under the influence of drugs. A nurse prescriber tried three times to speak to Mr Maslin to review his methadone but he refused each time. The nurse concluded that his risk of accidental overdose remained high, even though he was aware of the risks. The nurse concluded that Mr Maslin's methadone reduction should continue as PS interaction with methadone was poorly understood and hard to predict due to varying strengths of PS. The nurse reduced Mr Maslin's methadone dose to 22mls and encouraged him to work with Full Circle for psychosocial support.

42. On 3 September, Mr Maslin was found under the influence of PS. A nurse assessed him and noted that no further action was required, but that officers should contact the healthcare team if they had any concerns.

43. On 4 September, Mr Maslin harmed himself, and staff started suicide and self-harm prevention procedures, known as ACCT. At an ACCT assessment the following day, Mr Maslin said that he used PS, was struggling and that it was affecting his mental health. At an ACCT review with a Supervising Officer (SO), Mr Maslin said

that he could not fight the temptation to take drugs. Later that evening, Mr Maslin self-harmed by cutting his arm. He was taken to hospital for treatment.

44. On 6 September, at a mental health multidisciplinary meeting, two psychiatrists, and a mental health nurse, discussed Mr Maslin. They noted his medication of pregabalin, clonazepam, mirtazapine and methadone, and decided that a prison GP should review his epilepsy and diagnosis and that a psychiatrist should review his other medication.

45. At an ACCT review on 7 September after his move to D Wing, Mr Maslin told a SO that he had felt calmer since moving there. D Wing was a smaller wing which housed prisoners who were difficult to locate elsewhere in the prison. Mr Maslin asked for a review of his IDTS medication. That afternoon, Mr Maslin was seen under the influence of drugs. He refused to be treated by a nurse, who told officers to contact the healthcare team if they had concerns.

46. On 8 September, Mr Maslin asked a nurse to increase his methadone dose, and said that he was struggling. The nurse noted that he was to remain on his current dose. A mental health nurse noted that Mr Maslin had been referred to the mental health team.

47. At an ACCT review that day, Mr Maslin told a SO that he wanted to move to F Wing where he had friends as living on D Wing made him self-harm. Staff moved Mr Maslin to F Wing. Within 30 minutes of returning to the wing, he was seen under the influence of drugs and healthcare staff treated him. He said he was “happy to be back”.

48. On 9 September, a Custodial Manager (CM) told Mr Maslin that he would be moved to C Wing because of his behaviour. Mr Maslin did not object but later that day, he self-harmed, and told staff that the wing was not safe for him.

49. That afternoon, a nurse reviewed Mr Maslin’s methadone medication. The nurse noted that since his last review, he continued to use PS and had often been found under the influence. Mr Maslin told the nurse that he would use PS, despite the risks as he enjoyed taking drugs. The nurse told him that he was concerned for his safety, and that the effects of taking methadone and PS were unknown. He encouraged him to stop taking drugs. The nurse noted that Mr Maslin understood but was not willing to modify his behaviour and had no interest in seeing the substance misuse team. The nurse reduced Mr Maslin’s methadone to 20mls.

50. On 10 September, Mr Maslin missed an ACCT review as he was under the influence of PS, and told a nurse that he had smoked something. Mr Maslin missed a psychiatric assessment as a result. That day, staff moved Mr Maslin to D Wing as he was in debt for PS and D Wing was seen as better able to meet his needs.

51. On 11 September, Mr Maslin was again seen under the influence of PS but refused medical assistance. At an ACCT review, he told staff that he loved taking drugs and would not stop. He dismissed suggestions that his self-harm was linked to his substance misuse. Mr Maslin was put on an alternative regime to other prisoners to try to limit his access to illicit substances.

52. On 12 September, Mr Maslin was moved to the prison's healthcare unit for assessment. The Head of Safer Prisons raised concerns about him at the morning's senior management meeting after discussions with the mental health team.

53. The Governor chaired a Governor Drug Challenge meeting due to Mr Maslin's continued PS use. (The meetings review a prisoner's drug use, identify issues and put in place management plans.) The Head of Reducing Reoffending and an IDTS officer attended. Mr Maslin told them that staff had bullied him to move to the healthcare unit, that he enjoyed taking drugs, did not want to engage with the substance misuse team but felt well supported by staff. They planned to challenge Mr Maslin's use of drugs and support him.

54. On 13 September, Mr Maslin told an officer that he was not happy in the healthcare unit. He told the officer that he took whatever drugs he could to "block things out". However, at an ACCT review, he told a custodial manager, that he felt better in the healthcare unit and recognised the benefit of not being able to get hold of drugs but that he would take them again when moved back to a standard wing.

55. A nurse and an addiction specialist consultant, reviewed Mr Maslin's methadone. Mr Maslin said that he would continue to use PS as much as he could. The nurse noted no symptoms of withdrawal and agreed with the addiction specialist consultant that Mr Maslin's methadone dose should remain at 20mls. They also agreed to request regular drug tests for him although they noted that the prison's drug screening did not test for PS. (Chelmsford does now test for PS.)

56. A prison GP reviewed Mr Maslin during a ward round. He noted that he was disengaged and had mood fluctuations in line with emotional unstable personality disorder. The prison GP prescribed sodium valproate (250mg) to stabilise his mood.

57. Over the following days, Mr Maslin told an officer that he was settled in the healthcare unit, was positive, surprised at how calm the unit was, felt safe and did not have access to drugs.

58. At an ACCT review on 17 September, Mr Maslin told a custodial manager, that he was annoyed at being in the healthcare unit and wanted to return to F Wing. Mr Maslin said that although he was not taking drugs in the healthcare unit, it would not stop him taking them in the future and that staff were, "winding" him up by keeping him in the healthcare unit. Mr Maslin walked out of the review.

59. At an ACCT review on 19 September, Mr Maslin asked a SO if he could move wings. A SO told him that healthcare staff would have to approve any move and a reintegration plan would need to be put in place as he had a history of using PS immediately after moving wings. Mr Maslin agreed that a level of trust was needed on both sides and he denied any thoughts of self-harm. Staff stopped ACCT monitoring.

60. On 20 September, both psychiatrists reviewed Mr Maslin. A psychiatrist noted that Mr Maslin was articulate, denied thoughts of self-harm but would do so if returned to a regular wing. The doctor increased Mr Maslin's sodium valproate to 500mg and noted that he was to remain in the healthcare unit due to his risk of self-harm,

vulnerability and history of drug use. Over the following days, Mr Maslin continued to ask when he could leave the healthcare unit.

61. On 24 September, the Head of Safer Prisons, told Mr Maslin that the decision to move him remained with a psychiatrist.

62. That day, A psychiatrist reported that Mr Maslin had mood swings but had not self-harmed for two weeks. Mr Maslin told the psychiatrist that he wanted to be prescribed medication that would make him numb and emotionless. He denied any thoughts of self-harm. Mr Maslin complained about the side effects of the sodium valproate and the psychiatrist reduced his dose.

63. On 26 September, a mental health nurse reviewed Mr Maslin, and noted his diagnosis of emotional unstable personality disorder. Mr Maslin told the nurse that he would continue to use drugs. She told Mr Maslin a move from the healthcare unit would need to be discussed with a prison GP. She made plans for healthcare staff to support Mr Maslin and assess his mental health regularly. She scheduled a further review for 6 October.

64. On 27 September, a prison GP reviewed Mr Maslin and noted that his mental state was stable and that he denied thoughts of self-harm. The prison GP made plans for him to remain in the healthcare unit. However, in a later entry, the prison GP noted that there was no evidence that Mr Maslin had a mental illness, that his mood was stable and that the risks of using drugs had been discussed with him. The doctor noted that Mr Maslin had the mental capacity to decide whether he wanted to take illicit drugs. Contrary to his earlier entry, the prison GP concluded that Mr Maslin was fit to be moved back to a regular prison wing.

65. During the day, Mr Maslin told a nurse that he was bored and had used another prisoner’s medication for a stimulant effect. He was warned again of the risks of taking medication and PS. When the nurse asked Mr Maslin if he had asked to move wings to so that he could access illicit drugs, he smiled. A nurse noted no signs of withdrawal or intoxication but that Mr Maslin was negative about his recent progress. Because of his continuing use of PS Mr Maslin’s methadone was maintained at 20mg.

66. On 28 September, a nurse from the IDTS team completed Mr Maslin’s 28-day review. The nurse noted no symptoms of withdrawal and told him that his methadone would not be increased. Mr Maslin denied thoughts of self-harm but said that he would damage his cell if he was sent to the “wrong wing”. The nurse arranged for him to have a drug test the following week.

67. Mr Maslin told an officer from Full Circle that he was bored and fed up on the healthcare unit and that he felt that he was being punished. When asked if he wanted to move so that he could access drugs, Mr Maslin smiled. The officer reminded him of the progress he had made in the healthcare unit, that his drug tolerance levels would have lowered and of the risks of taking drugs. Mr Maslin told the officer that he did not want to engage with the substance misuse team.

68. When staff told Mr Maslin that they were not going to move him to another wing, he damaged his cell and self-harmed. He was moved to the prison’s segregation unit and staff started ACCT procedures.

69. On 29 September, Mr Maslin told an officer at an ACCT assessment that he had self-harmed because he was distressed that he was not allowed to leave the healthcare unit. Mr Maslin denied any intention to take his life and asked for staff to stop ACCT monitoring. He told the Head of Business Assurance, at an ACCT review that he had damaged his cell to manipulate a move to the segregation unit.

70. On 1 October, Mr Maslin was moved to a cell on D Wing. He tested positive for methadone (which was prescribed to him) after a drug test. The following day, he was found under the influence of drugs. Although Mr Maslin was not initially given his medication, staff gave it to him later that day.

71. On 3 October, he told his mother by telephone call that he had damaged his cell in the healthcare unit to get moved but was now not happy on D Wing. He said that he had only agreed to move there to get out of the segregation unit. Mr Maslin told his mother that a prisoner on the wing had said that he was a bad debtor and that prisoners now wanted to assault him. Mr Maslin told her that he would damage his cell if he was not moved to A Wing.

72. A prisoner who lived in the cell next to Mr Maslin, said that he had brief conversations with him. He said that in the early evening, he heard what sounded like Mr Maslin falling in his cell. However, Mr Maslin raised no issues or concerns with staff that evening. In a phone call to his mother at 8.28pm, in which they discussed domestic and family issues, Mr Maslin's speech was slow and slurred.

73. At 9.10am on 4 October, Mr Maslin left his cell and went downstairs to the ground floor and played chess with an officer. He returned to his cell at 9.40am. The officer said that Mr Maslin was not under the influence of drugs at the time.

74. At 9.41am, Mr Maslin left his cell and walked up the landing, holding what appeared to be an e-cigarette. At 9.50am, a prisoner, Prisoner A, dragged Mr Maslin, clearly unconscious, down the wing and into the cell next to his own, before leaving.

75. At 9.51am, an officer went to the office next to Mr Maslin's cell. He left a minute later and glanced into Mr Maslin's cell as he walked past. He walked past the cell next to Mr Maslin's cell into which Mr Maslin had been dragged.

76. At 9.52am, another prisoner, Prisoner B, walked with Prisoner A to the cell where Mr Maslin was. At 9.54am, while Prisoner B stood outside, Prisoner A dragged Mr Maslin into his own cell before leaving with Prisoner B. At 9.59am, Prisoner A returned to Mr Maslin's cell, went in for a few seconds before leaving and then returned a minute later, going in and leaving again.

77. At 10.02am, an officer went to Mr Maslin's cell to ask him if he wanted to exercise. He found Mr Maslin unconscious, and called a medical emergency code blue, indicating that a prisoner is unconscious or having difficulties breathing. Two nurses responded and found Mr Maslin, sitting on the floor and making grunting noises. The nurses helped Mr Maslin to his bed but he was agitated and refused to be treated. A nurse said it appeared that Mr Maslin had been tearing pages out of his Bible to smoke, and that the cell had a "burning, woody, sweet smell". The nurses left the cell and told officers that they should contact the healthcare team if they had any concerns.

78. A trusted prisoner who knew Mr Maslin, offered to "keep an eye" on him. A Supervising Officer (SO) accepted the offer and told the trusted prisoner that he should tell staff immediately if he had any concerns about Mr Maslin. The SO told the investigator that the offer of assistance was accepted, with the acknowledgment that Mr Maslin remained the responsibility of staff. The trusted prisoner remained with or near Mr Maslin for around half an hour, during which time they chatted.

79. A nurse later returned to the wing. Although she did not go to see Mr Maslin, the trusted prisoner told her that he was fine.

80. At 11.08am, Mr Maslin was given his lunch before an officer locked his cell door. An officer checked Mr Maslin again at 11.25am and at 11.49am, he briefly spoke to Mr Maslin who said he wanted to sleep.

81. Two officers spoke to Mr Maslin at 1.37pm. An officer said that Mr Maslin accused staff of stealing his e-cigarette and asked for teabags. The officer told him that she could not give these to him as he would smoke them. Mr Maslin asked the officer for tea bags again at around 2.00pm for teabags. To placate Mr Maslin, an officer told him they had run out of teabags but that she would get him some later. The officer said that Mr Maslin's requests for teabags continued over a period of a couple of hours. She said that Mr Maslin did not appear under the influence of drugs during her contact with him.

82. At 2.10pm, Mr Maslin telephoned his mother. The recording of the call indicated that his speech was slow and slurred. Mr Maslin told his mother that he might "smash" his cell up as he was stoned. He said that he had smoked a spliff and complained that he had not been given his methadone. Mr Maslin told her that he had been put on D Wing to stop him getting stoned but that he got stoned anyway. Mr Maslin's mother told him that the prison should do something about his mental health. They briefly talked about medication.

83. At 2.28pm, Mr Maslin asked an officer for a cup of tea. At 2.42pm, a prisoner, Prisoner C, appeared to talk with Mr Maslin through his cell door observation panel. Around 20 minutes later, the trusted prisoner also appeared to talk to Mr Maslin at his cell door. At 3.08pm, an officer checked on Mr Maslin in his cell but reported no concerns.

84. At 3.16pm, two officers carried out a brief search of Mr Maslin's cell. An officer B said that she could not recall speaking to Mr Maslin at that time and did not recall how he was. Two minutes later, the officers left the cell and locked the door.

85. At 3.37pm, both officers checked on Mr Maslin. An officer said that she took a toilet roll with her as an excuse to interact with him because she was concerned that he might be aggressive as he had been refused teabags.

86. A prisoner, Prisoner D, said that another prisoner on the wing was giving out PS to prisoners to watch their reaction. He said that this is how Mr Maslin would have got his PS. He said that prisoners would go to the prisoner's cell and come out "stoned".

87. At 4.00pm, Prisoner C looked into Mr Maslin's cell before moving away. At 4.17pm, another prisoner, Prisoner E, looked in the cell before moving away, smiling. A

minute later, Prisoner E returned with Prisoner C. Both prisoners stood outside the cell door, periodically looking in and laughing.

88. At around 4.23pm an officer was on the landing below Mr Maslin's cell when Prisoners C and E shouted to her that Mr Maslin had, "keeled over". The officer ran to Mr Maslin's cell. Another officer followed. The first officer said that when she arrived at the cell, Prisoners C and E were laughing.

89. The officer shouted for assistance and immediately went into Mr Maslin's cell, followed by the second officer. The officers found Mr Maslin, sitting slumped in a chair. The officer said that Mr Maslin was light blue in colour. She thought that he was dead and lifted his head, at which point she said that he caught his breath. The officers laid Mr Maslin on the floor in the recovery position.

90. The second officer tried to radio an emergency code blue call but was unable to do so because of other radio traffic. He left the cell to find a general alarm button but could not find one. The second officer again tried to radio a code blue but remained unable to do so because of staff talking over the radio. He shouted for assistance and that there was a code blue emergency. An unknown member of staff then activated the general alarm and the second officer eventually radioed an emergency code blue, and an ambulance was called immediately.

91. At 4.28pm, two nurses arrived at the cell. Both nurses said that there was a strong smell of smoke. Mr Maslin was breathing, and the nurses continued to take observations until paramedics arrived at 4.38pm, and took over Mr Maslin's care. Soon afterwards, Mr Maslin stopped breathing and the health professionals present started cardiopulmonary resuscitation. Mr Maslin was stabilised and taken to the critical care unit at a hospital in an induced coma at 5.07pm.

92. A cigarette butt found in Mr Maslin's cell was tested but the results were inconclusive. Later that afternoon, two prisoners on the wing were heard to say how "potent" the "gear" was that they were smoking, and that it was "two puffs and its man down."

93. On 17 October, Mr Maslin died in hospital after a period of palliative care.

94. After his death, Mr Maslin's family forwarded some letters and poems that he had sent them. Some are undated but appear to have been written during his previous periods in custody. In some of them, Mr Maslin discusses his feelings of wanting to die and the reasons for his use of PS.

Contact with Mr Maslin's family

95. The Head of Safer Prisons contacted Mr Maslin's family that afternoon to tell them that he had been taken to hospital and offered to get them a taxi to get to the hospital quickly. Mr Maslin's sister was present at his bedside in hospital when he died.

96. A CM and an officer were appointed as family liaison officers (FLO). Chelmsford contributed to the costs of Mr Maslin's funeral in line with national instructions

Support for prisoners and staff

97. The Governor debriefed the 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.

Post-mortem report

98. A post-mortem and toxicology examination found that Maslin died from bronchopneumonia and hypoxic brain injury, the cause of which was unascertained.

99. Post-mortem toxicology tests taken from hair samples showed no signs that Mr Maslin had misused drugs or used PS recreationally. However, no pre-admission bloods were taken when Mr Maslin was admitted to hospital which meant that full toxicology testing could not be undertaken after Mr Maslin's death.

Findings

Psychoactive substance availability at Chelmsford

100. HMIP reported that 40 per cent of prisoners at Chelmsford said that it was easy to get illicit drugs at the prison. Inspectors noted that organised crime was responsible for much of the supply of drugs and that although managers had taken sensible steps to address the supply, it was not enough.

101. Staff and senior managers at Chelmsford knew that Mr Maslin frequently used PS. Despite being warned about the dangers of its use, he continued to take them and told staff that he enjoyed taking drugs and would not stop.

102. Chelmsford has a substance misuse strategy, issued in April 2018, and the prison holds monthly drug strategy and PS meetings. The strategy aims to ensure that there is an effective, integrated approach to substance misuse and includes increasing access to substance misuse interventions, reducing supply, strengthening continuity of care between custody and community and targeting prisoners misusing drugs.

103. In February 2016, Chelmsford started an action plan to combat the availability and use of PS in the prison, with the aim of addressing its supply and demand. The PS action plan is updated at monthly meetings and includes ongoing actions intended to reduce the supply of the drug.

104. The PPO's Learning Lessons Bulletin on PS, issued in July 2015, highlighted that PS was a source of increasing concern in prisons and that PS use had a profoundly negative impact on the physical and mental health of prisoners. Mr Maslin's death is an example of the dangers of PS and illustrates how prisons must do all they can to eradicate its use.

105. We are satisfied that Chelmsford continue to make efforts to challenge the availability and demand of PS. However, given the continuing availability of PS at the prison, more needs to be done to reduce both the supply and demand for PS. This includes the regular searching of the cells of prisoners known to use illicit substances regularly.

106. Drug taking and trading is a serious problem across much of the prison estate and Chelmsford is not alone in facing this problem. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies, as Chelmsford has.

107. In April 2019, HM Prison and Probation Service published the National Drug Strategy. It set out their plans to reduce substance misuse in prisons by providing direction to assist all stakeholders and detailed guidance for prisons to help them identify issues and share best practice.

108. In relation to reducing the supply of drugs, the HMPPS 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."

We therefore recommend that:

The Governor should ensure that the key drug issues at Chelmsford are identified and that the prison's local drugs strategy is promptly revised to address these key issues

Tackling Mr Maslin's PS use

109. Mr Maslin had a prolonged and significant history of using PS while in custody and he was frequently found under the influence of PS. He was offered support from the substance misuse team on numerous occasions but consistently refused to work with them. The IDTS team regularly advised him of the risks to his health of taking PS with methadone and his medication and how to reduce his risk. Despite this, Mr Maslin continued to use PS, telling staff he knew about the dangers and would not stop as he enjoyed taking it.

110. During his time at Chelmsford staff tried to address Mr Maslin's substance misuse. He was the subject of multidisciplinary reviews and the Governor reviewed him during a drug challenge meeting. Mr Maslin was put on an alternative regime to other prisoners, and he was moved from wings where drugs were thought to be more prevalent, before the decision was taken to move him to the healthcare unit for closer monitoring and assessment.

111. Despite Mr Maslin's refusal to address his substance misuse, we are satisfied that Chelmsford offered him the appropriate support and guidance and that staff generally responded appropriately when he was found under the influence of drugs.

Emergency response

112. An officer said that he tried several times to radio a code blue but was unable to do so as other staff were talking over the radio. He left the cell to look for a general alarm but could not find one and still unable to call a code blue, he shouted to colleagues for assistance before an emergency code blue was called.

113. The officer should have called a code blue immediately. He did not need to wait for other members of staff to stop talking over the radio before radioing the emergency code. The delay in calling a code blue led to a delay in calling an ambulance. Although the delay in calling an emergency code is unlikely to have made any difference to the outcome for Mr Maslin, it may be critical in another emergency. We therefore make the following recommendation:

The Governor should remind all prison staff to radio an appropriate emergency code as soon as they find a prisoner in a life-threatening situation, even if the prison radio is busy.

Attendance of function heads at drug strategy meetings

114. The investigator identified that the Head of Healthcare and pharmacy lead failed to attend any of the drug strategy meetings between April 2018 and Mr Maslin's death. We note that Chelmsford had raised non-attendance at these meetings as a concern since February 2018, and that they had noted that it needed immediate action to resolve in the six months leading to Mr Maslin's death.

115. Chelmsford's drug strategy meetings are an essential forum for prison managers to discuss and formulate policy and strategy to improve the delivery of drug services and to review other areas of their drug strategy, including security. We make the following recommendation:

The Governor should ensure that all heads of function attend all drug strategy meetings or send a representative in their absence.

Clinical care

116. The clinical reviewer concluded that overall, the care given to Mr Maslin was not equivalent to that which he could have expected to receive in the community, but that there were aspects that were equivalent. The Head of Healthcare will need to address the conclusions of the clinical review and the Root Cause Analysis completed by NHS East of England Specialised Commissioning Group (EESCG).

Notifying interested clinicians of prisoner substance misuse

117. The clinical reviewer reported that Mr Maslin was not always appropriately monitored when he was found under the influence of illicit substances. This was partly due to his lack of co-operation and that not all interested clinicians were notified of such incidents, although they were sometimes shared with IDTS and mental health teams. Consequently, the clinical reviewer concluded that the procedures for notifying interested parties were not sufficiently robust, and that healthcare staff over-relied on recording incidents of substance misuse in Mr Maslin's SystmOne electronic medical notes. The clinical reviewer noted that the use of other communication, monitoring and referral systems did not result in all clinical staff, including the prison pharmacist and psychiatrists, receiving critical information about prisoners.to all clinical staff.

118. The clinical reviewer suggested that healthcare staff complete a simple checklist after prisoners are suspected of drug use to set out the frequency of observations, the duration of checks and the scheduled time for a member of healthcare staff to visit. She also said that healthcare staff should use the "tasking" function on SystmOne (which is similar to email) to ensure that relevant clinicians are notified and allocated appropriate actions. In light of the clinical reviewer's findings, we make the following recommendation:

The Head of Healthcare should ensure that all clinical services at Chelmsford are aware of the treatment that prisoners using illicit substances receive to enable them to assess and review treatments and prescribed medications and their potential interactions with illicit substances.

Caring for prisoners under the influence of illicit substances

119. The clinical reviewer noted that communication could be improved between the different clinical services and prison officers about the care of prisoners found under the suspected influence of drugs. For example, she noted that on 4 October, two code blue incidents were called for Mr Maslin after suspected PS use, but the attending nurses did not give the prison officers clear guidance about how often Mr Maslin should be checked or when to contact them. A nurse told the investigator that when nurses treated a prisoner under the influence of drugs, they would ask staff to check on him and only return if staff thought it necessary.

120. The clinical reviewer noted that as Mr Maslin was being monitored under ACCT procedures, staff assumed that these checks were sufficient to monitor his health needs. She concluded that as Mr Maslin was well known for substance misuse and self-harm, healthcare staff should have considered setting the frequency and duration of additional checks and that it would have been good practice for a nurse to have returned to the wing to check on Mr Maslin. We note that on some previous occasions, when Mr Maslin had been found under the influence of drugs, there was no evidence that nurses had returned to check on his welfare.

121. Although a full healthcare team is not always available at Chelmsford, there is no joint protocol or guidance between the healthcare team and prison staff about managing prisoners suspected of taking or treated for using PS or other illicit substances.

122. Although Mr Maslin was checked regularly on 4 October and a formal agreement between healthcare staff and officers is unlikely to have changed the outcome for him, it might be critical for a prisoner found under the influence of drugs but not managed under ACCT procedures. We therefore make the following recommendation:

The Governor and Head of Healthcare should ensure that a formal system is implemented so that healthcare staff advise officers how to monitor prisoners found under the influence of illicit substances.

Management of multiple prescribers

123. At Chelmsford, Mr Maslin was prescribed medication from three sets of clinicians: the IDTS team, psychiatrists and the prison GP. The clinical reviewer found that overall, the multiple medications that these clinicians were not managed to consider drug interactions or the co-morbidities of substance misuse, pain and mental health.

124. Although Mr Maslin was reviewed in multidisciplinary and complex case meetings, no clinician had overall responsibility for managing his medication. The GP did not have any influence over the medication prescribed by the psychiatrists and although the IDTS team were made aware of incidents when Mr Maslin used illicit drugs so that they could review his methadone prescription and withhold the drug when necessary, they too had no influence over the GPs and psychiatrists who continued to dispense prescribe medication.

125. The clinical reviewer found that although the review of Mr Maslin's methadone was documented, reviews of the other sedating medicines prescribed for Mr Maslin were

not recorded and it is not clear if other medicines were withheld. She concluded that Mr Maslin's medication, regardless of who prescribed them, were not always appropriately reviewed or withheld in the context of his repeated substance misuse. Even though there were multidisciplinary team case reviews, a full holistic review of all Mr Maslin's medication and the risks of the polypharmacy were not recorded.

126. The clinical reviewer reported that HMP Berwyn have a policy of withholding all non-essential medication from prisoners suspected of taking illicit drugs for 24 hours and until a doctor can review the prisoner's medication. This is to avoid any adverse effects of taking prescribed and non-prescribed drugs together. Chelmsford does not have such a policy and although on occasions, Mr Maslin's methadone was withdrawn, there was no formal review of his medication by a GP or pharmacist to review any possible contraindications between his medications and continuing use of PS. We make the following recommendation:

The Head of Healthcare and other clinical leads should ensure that a process is implemented to give a named individual responsibility to oversee medications prescribed from multiple prescribers.

Mental health

127. The clinical reviewer reported that the involvement of both the prison's mental health team and prison psychiatrists in Mr Maslin's care was appropriate. She noted that healthcare staff saw Mr Maslin within appropriate timescales, that mental health care plans were implemented and that a prison GP had confirmed that his mental health medications were appropriate, including the prescription of sodium valproate as a mood stabiliser. The clinical reviewer concluded that overall, the different elements of Mr Maslin's mental healthcare were equivalent to that which he could have expected to receive in the community.

128. However, the Root Cause Analysis completed by EESCG concluded that Mr Maslin should have had a full mental health assessment when he arrived at Chelmsford. However, he was not assessed until 26 September, and he was not allocated a mental health nurse or key worker to offer him regular support. The Root Cause Analysis also noted that Mr Maslin may have benefited from a more formal talking therapy. However, Chelmsford had no counselling service available at the time. We repeat two of the recommendations made from the Root Cause Analysis:

The Head of Healthcare should ensure that prisoners with mental health issues and who self-harm are given a full mental health risk assessment on arrival at prison and that those who meet the criteria for secondary mental healthcare receive a comprehensive assessment within 72 hours of arrival, a care plan and risk assessment is put in place and a keyworker identified.

The Head of Healthcare should ensure that talking therapies are available to prisoners in HMP Chelmsford.

Substance misuse

129. The clinical reviewer concluded that Mr Maslin's methadone treatment programme at Chelmsford was appropriate and equivalent to that which he could have expected

to receive in the community. She noted that his methadone medication was reduced or withdrawn when he was thought to be under the influence of drugs and that the withholding of this medication was in line with community and prison procedures.

130. The Root Cause Analysis completed by EESCG concluded that Mr Maslin was given a high level of care by the prison's IDTS team and it was noted that they were responsive to his needs and held regular reviews.

Other healthcare needs

131. The clinical reviewer reported that Mr Maslin's other health needs were appropriately met and equivalent to that which he could have expected to receive in the community.

Sharing our report with staff

132. We consider that it is important for staff who were involved in Mr Maslin's care to see the findings of and learn lessons from our investigation. We make the following recommendation:

The Governor and Head of Healthcare should ensure that any staff named in this report are given the opportunity to read the report at the draft stage in line with paragraph 1.11 of PSI 58/2010.

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