

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Patrick a prisoner at HMP Lowdham Grange on 31 October 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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

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

Mr Simon Patrick died on 31 October 2015, of the effects of synthetic cannabinoids, while a prisoner at HMP Lowdham Grange. He was 41 years old. I offer my condolences to Mr Patrick's family and friends.

Mr Patrick had longstanding drug problems, mostly involving opiates, and I am satisfied that he received good support and help at the Lowdham Grange to help him deal with his substance misuse problems. He was usually open about his substance misuse and had previously mentioned using new psychoactive substances (NPS) to his drug worker, who had warned him about the dangers of using additional drugs on top of the methadone he was prescribed as treatment for heroin addiction. While I consider it would have been difficult for the prison to have prevented Mr Patrick's death, there is a need for staff to be vigilant for signs of NPS use and proactive in responding to the growing harm it causes in prisons.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

May 2016

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Summary

Events

1. On 17 September 2012, Mr Simon Patrick was sentenced to 15 years in prison. He had been at HMP Lowdham Grange since 16 July 2013. At an initial health screen, a nurse noted that he smoked, used inhalers to treat asthma, and was prescribed pain relief for an old ankle and knee injury. He was on a methadone maintenance programme (a replacement therapy for heroin use) but admitted to using heroin in addition. The nurse referred him to the substance misuse team. He was given a cell in the substance misuse unit. A member of the mental health team reviewed him.
2. A dedicated psychosocial worker helped Mr Patrick with his substance misuse problems. They met at least once a month and Mr Patrick said he was happy with the support he received. However, he found it difficult to stop using illicit substances, including new psychoactive substances (NPS). Mr Patrick's methadone was gradually reduced and he last reported using NPS in February 2015. On 29 October, Mr Patrick told his psychosocial worker that he had no issues and was doing well on his detoxification plan.
3. On 31 October, a friend of Mr Patrick's said he had smoked a large amount of NPS after being offered a large batch free. His friend later found him collapsed and unresponsive in his cell and raised the alarm. Officers and nurses attended quickly and a nurse called an emergency medical code. Nurses tried to resuscitate Mr Patrick until paramedics arrived and took him to hospital. Mr Patrick did not recover and was later pronounced dead at the hospital.

Findings

4. We are satisfied that Mr Patrick received good support for his substance misuse problems in prison. He actively engaged with substance misuse services and usually sought help when necessary. He seemed to be doing well in reducing his dependence on methadone. He had not disclosed any recent use of NPS to his psychosocial worker, who had warned him of the dangers of using NPS and other illicit substances in addition to his prescribed methadone. Lowdham Grange recognises the problems caused by prisoners using NPS and has an appropriate supply and demand reduction strategy. Although we consider that it would have been difficult to prevent Mr Patrick's death, accounts from other prisoners suggest that he had been using NPS for some time, but no one had identified this. We consider that all prison staff need to be extra vigilant for signs of the use of NPS.

Recommendation

- The Director should ensure that all staff are vigilant for signs of prisoners using NPS and are briefed about how to respond when prisoners appear to be under the influence of such substances.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. Two prisoners responded.
6. The investigator visited HMP Lowdham Grange on 10 December 2015. She obtained copies of relevant extracts from Mr Patrick's prison and medical records.
7. NHS England commissioned a clinical reviewer to review Mr Patrick's clinical care at the prison.
8. The investigator and clinical reviewer interviewed five members of staff and two prisoners at Lowdham Grange on 10 December. The clinical reviewer also interviewed a member of staff by telephone on 17 December.
9. We informed HM Coroner for Nottinghamshire and Nottingham City of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
10. One of the Ombudsman's family liaison officers contacted Mr Patrick's sister to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not identify any specific issues for the investigation to take into account.
11. Mr Patrick's family received a copy of the initial report. They pointed out a factual inaccuracy. This report has been amended accordingly.
12. The prison has also submitted an action plan detailing what they have done to address the issues we raised.

Background Information

HMP Lowdham Grange

13. HMP Lowdham Grange is a medium secure prison, privately managed by Serco, which holds over 900 men. The accommodation consists of five houseblocks, which typically hold 120-130 men.
14. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare and GP services at the prison, including 24-hour nursing cover, and an out of hours GP service.

HM Inspectorate of Prisons

15. The most recent inspection of Lowdham Grange was in June 2015. Inspectors reported that the range of mental health services and physical services were good but it took too long to see a doctor. There were quick responses to medical emergencies and emergency resuscitation equipment was available on all residential units, and checked frequently. The use of new psychoactive substances (NPS) had increased and quantities of NPS were often found in the prison. Clinical and psychosocial services had started joint working and had positive links with the prison to support prisoners' recovery.

Independent Monitoring Board

16. 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 January 2015, the IMB reported that the clinical services areas had poor ventilation, a lack of light and high room temperatures. Too many drugs were available in the prison, and the IMB noted that the use of NPS was a problem, causing violent and irrational behaviour. The IMB considered that the prison made good efforts to prevent these substances getting into the prison.

Previous deaths at HMP Lowdham Grange

17. Mr Patrick was the fourth prisoner to die at Lowdham Grange since 2012. There were no significant similarities with the circumstances of the other deaths.

New psychoactive substances (NPS)

18. NPS are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting.
19. As well as emerging evidence of dangers to both physical and mental health, it is possible that there are links to suicide or self-harm. Trading in these substances, while in prison can lead to debt, violence and intimidation.

20. In July 2015, we published a Learning Lesson Bulletin about the use of NPS including the dangers to both physical and mental health and the possible links to suicide and self-harm. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

21. On 17 September 2012, Mr Simon Patrick was sentenced to 15 years in prison for violent offences. He had been at HMP Lowdham Grange since 16 July 2013. At an initial health screen a nurse noted that he smoked cigarettes, used inhalers to treat asthma and was prescribed pain relief for an old ankle and knee injury. He was prescribed methadone (an opiate substitute) to treat dependency on heroin but told a doctor that he used heroin as well. The doctor referred him to the substance misuse team and Mr Patrick lived in a unit for prisoners receiving treatment for substance misuse problems. Mr Patrick took mirtazapine to treat depression and a member of the mental health team reviewed him.
22. A member of the substance misuse service was Mr Patrick's designated psychosocial worker. He saw him frequently to support him and encourage him to reduce his use of methadone and illicit substances. They met at least once a month and a doctor reviewed Mr Patrick every 13 weeks, including a urine test for drugs. Mr Patrick's methadone prescription varied over time. On 28 August, he reported that 40ml of methadone was not enough and that he had been using heroin to top it up. A doctor increased his methadone prescription to 50ml. In November, a doctor increased the daily dose to 55ml, as Mr Patrick said he was still craving heroin. For the same reason, doctors increased his methadone to 60ml in December and to 70ml in March 2014.
23. On 24 April, Mr Patrick told the psychosocial worker that he had been using heroin in the past week, on top of his 70ml dose of methadone. He said this was to help his anxiety, panic attacks and mood swings. The psychosocial worker referred Mr Patrick to the mental health team and clinical drug treatment staff. Mental health staff continued to monitor him.
24. On 2 July, Mr Patrick told a prison GP that he had been using heroin but had stopped because he had run out of money. He was having stomach cramps, a symptom of opiate withdrawal. He did not want his methadone to be increased but agreed to take buscopan (to treat stomach cramps). She noted that Mr Patrick had support from substance misuse services at the prison.
25. Clinical staff and drug misuse workers saw Mr Patrick frequently to help address his emotional problems and physical symptoms, but he continued to report using illicit substances on top of his methadone treatment. Mr Patrick said he self-medicated for depression and anxiety. He continued to be prescribed mirtazapine. On 22 July, a doctor increased his methadone dose to 75ml.
26. On 30 October, Mr Patrick told a doctor and the psychosocial worker that he had started to use illicitly obtained diazepam (used to treat anxiety) and had become addicted to it. The psychosocial worker began a care plan to reduce and stop his use of diazepam over time. He warned Mr Patrick that using additional drugs might lead to his death. In November, Mr Patrick wrote a letter to say how thankful he was for the psychosocial worker's help and that he thought his detoxification plan was going to be successful.
27. By 15 December, Mr Patrick had apparently been successful in reducing his use of diazepam. At a review that day, the psychosocial lead told him that ketamine (a short acting anaesthetic which distorts the user's perception of reality) had

been present in his last drug test. Mr Patrick said he was surprised but admitted that he had used NPS in the past week. She said the ketamine might have been an ingredient in the NPS. Mr Patrick said he had no intention of using NPS again and they discussed harm minimisation.

28. From 8 January 2015, doctors gradually reduced Mr Patrick's methadone dose. The psychosocial worker and other members of the substance misuse team saw Mr Patrick frequently and he last reported using NPS in February 2015. Mr Patrick did not report any significant problems with drug use over the following months and none were identified.
29. On 22 October, Mr Patrick told an officer that he was having problems on the wing, but did not disclose any details about what they were. At a substance misuse appointment on 29 October, Mr Patrick told the psychosocial worker that he thought his detoxification treatment was working well, and he reported no issues. At the time, he was prescribed 20mls of methadone daily.

Saturday 31 October 2015

30. A prisoner, who had the cell next to Mr Patrick, told us he was good friends with Mr Patrick and saw him every day. He said he spent the morning of Saturday 31 October in Mr Patrick's cell and Mr Patrick smoked a lot of Spice (a synthetic cannabinoid or NPS) but he did not join in. He told us that someone had offered Mr Patrick a large amount of Spice and told him that if he smoked it all, he could have it for free. He did not say who made this offer. He said Mr Patrick began to behave strangely and said he felt unwell. From about 12.45pm until 4.30pm, the prisoner was locked in his cell as he was on a basic regime.
31. At about 3.30pm, an officer reported a number of prisoners, including Mr Patrick, to the substance misuse team for suspected drug use and asked for them to have drug tests. He stated that Mr Patrick had glazed eyes, was in a strange mood, and appeared disorientated. (When interviewed he told the investigator that this was his standard way of requesting a test but he had not actually considered Mr Patrick was under the influence of drugs. He had been suspicious of the prisoners congregating together.)
32. At about 4.00pm, the prisoner in the next cell said he heard Mr Patrick banging in his cell. He said he saw from his cell door, a friend of Mr Patrick and another prisoner go into Mr Patrick's cell and then leave again. The friend did not give a clear account about events that afternoon but said that when he saw Mr Patrick he had not been making any noise.
33. At approximately 4.30pm, the prisoner in the next cell went into Mr Patrick's cell. Mr Patrick was lying on the floor with a dressing gown over him, like a blanket. He assumed that his friend and the other prisoner had done this to allow him to sleep off the effects of the Spice. (He said this often happened as other prisoners would not want to get someone into trouble by informing officers.) He moved Mr Patrick but could not feel him breathing. He could not rouse him and could not feel any pulse. He called to an officer for help.
34. Two officers went to Mr Patrick's cell and said he was lying on the floor with a towel under his head as a pillow. One officer radioed for healthcare assistance.

A nurse was already on the wing and arrived very quickly. At 4.32pm he radioed a medical code blue (to indicate circumstances such as when a prisoner is unresponsive or not breathing), and began cardiopulmonary resuscitation. Another nurse arrived with an emergency bag and the control room called an ambulance. At 5.51pm, paramedics arrived, took over emergency treatment and then took Mr Patrick to hospital. Mr Patrick did not recover and, at 6.27pm, doctors pronounced him dead.

Contact with Mr Patrick's family

35. A prison counsellor acted as the prison's family liaison officer. She, a prison chaplain and the prison's Director went to see Mr Patrick's mother that evening and informed her of his death, offered condolences and support.
36. Mr Patrick's funeral was on 18 November 2015. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

37. A senior manager 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.
38. The prison posted notices informing staff and prisoners of Mr Patrick's death, and offering support. Staff reviewed all prisoners assessed as at risk of suicide and self-harm, in case they had been adversely affected by Mr Patrick's death.

Post-mortem report

39. A post-mortem examination concluded that Mr Patrick had died of the effects of synthetic cannabinoids (found in NPS). Medication in his system was at expected therapeutic levels and had not caused or contributed to Mr Patrick's death. The post-mortem report noted that the effects of synthetic cannabinoids were not well known but they were recognised to cause sudden death, seizures, and to stop breathing.

Findings

Substance misuse

40. Mr Patrick had long standing drug problems and we are satisfied that he received appropriate support for these problems at Lowdham Grange. Staff from substance misuse services saw him frequently and he saw staff from mental health services when required.
41. Mr Patrick had a good relationship with his psychosocial worker and had usually been open about his misuse of substances to him in prison. In November 2014, he had thanked him for helping him try to become drug-free. Two days before Mr Patrick died, he saw the psychosocial worker and reported that his methadone replacement therapy was going well and he had no concerns. He did not tell him that he was using NPS and there was no other intelligence at the time to indicate that Mr Patrick was using NPS. When Mr Patrick had previously admitted using NPS, substance misuse staff had warned him about the risks and we are satisfied that he was aware of the dangers.
42. A prisoner told us that NPS was easily available on the wing and that Mr Patrick had been smoking it for a while. He said that Mr Patrick had smoked considerably more than usual on 31 October, because he had been offered some free. He told us that the most common way to get NPS into the prison was on letters to prisoners which were sprayed with liquid NPS; this was torn up and mixed with tobacco.
43. An officer told us that he had been suspicious about Mr Patrick and other prisoners that day because of the way they were congregating together but not because they appeared to be under the influence of drugs. He said that, although he had recorded that Mr Patrick had glazed eyes, this was the standard way he had been trained to ask for suspicion drug tests, but he did not think that Mr Patrick was actually under the influence at the time or that he appeared unwell. (As this was just a short time before, the drug tests had not taken place by the time Mr Patrick was found collapsed and in any event would not have detected NPS.) The officer said Mr Patrick had come to the wing office sometime between 12.00pm and 1.00pm for a routine enquiry and there was nothing about his behaviour which had concerned him.
44. In our Learning Lessons Bulletin on NPS, published in July 2015, we noted that prison staff needed to be aware of the signs that prisoners are using NPS and that prisons needed to have effective strategies to reduce supply and to treat prisoners who used NPS. At the inspection of Lowdham Grange in June 2015, HM Inspectorate of Prisons noted that there was increasing use of NPS at the prison but there was a comprehensive drug strategy and the prison was trying to educate prisoners during their induction about the risks.
45. Lowdham Grange implemented an NPS pathway by Nottinghamshire NHS Foundation Trust on 26 June 2015. It states that if a prisoner has a significant event, such as collapsing or an emergency admission to hospital, as a result of taking NPS, they should be referred to see the drug workers within 48 hours. Harm minimisation advice should be offered and the option to work with the

services to prevent the prisoner using NPS, or other substances. Leaflets and posters in the prison warn against the effects of such illicit substances.

46. Lowdham Grange revised their drug and alcohol strategy at the same time to recognise that NPS was the substance of choice among prisoners because it is difficult to detect. The revised strategy contains information on searching, assessing and reducing the supply of substances. We welcome the work already undertaken but we are concerned that no member of staff had apparently identified that Mr Patrick had been using NPS either on 31 October or earlier. As there was no evidence that Mr Patrick had suffered ill effects from NPS before, he had not been referred for services through the NPS pathway. We consider that all staff need to be vigilant for signs of prisoners using NPS and should not wait until prisoners suffer severe ill effects before intervening. We make the following recommendation.

The Director should ensure that all staff are vigilant for signs of prisoners using NPS and are briefed about how to respond when prisoners appear to be under the influence of such substances.

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