

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Christopher Hope, a prisoner at HMP Holme House, on 4 July 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 Christopher Hope was found hanged in his cell at HMP Holme House on 4 July 2015. He was 28 years old. I offer my condolences to Mr Hope's family and friends.

The investigation found that Mr Hope received appropriate treatment for opiate dependency when he arrived at the prison, but no one addressed his withdrawal symptoms from diazepam. Some hours before his death, Mr Hope was taken to the prison's healthcare centre for observation, after he claimed to have taken a new psychoactive substance and appeared to have had a bad reaction. I am concerned that there was no clear strategy to manage and monitor prisoners suspected of taking such substances. However, while Mr Hope began to act strangely and erratically, there was little to indicate that he was at imminent and high risk of suicide and I consider it would have been difficult for staff to have anticipated his actions.

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

March 2016

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Summary

Events

1. On 24 June 2015, Mr Christopher Hope was sentenced to 16 weeks in prison for handling stolen goods and was sent to HMP Holme House. He had been in prison before. He had self-harmed many years earlier, suffered from depression and anxiety and had a history of drug misuse. When he arrived at Holme House, Mr Hope said that he had no thoughts of suicide or self-harm and reception staff did not consider that he was at risk.
2. At an initial health screen, Mr Hope tested positive for opiates and benzodiazepines (used to treat anxiety and sleeping problems). Mr Hope said that, in the community, he bought illicitly obtained buprenorphine (a semi-synthetic opioid used in drug treatment), as his doctor had stopped prescribing it. He said he was prescribed mirtazapine for depression, propranolol for anxiety and pregabalin for neuropathic pain. He received mirtazapine and propranolol after healthcare staff checked with his community GP, but he was not prescribed pregabalin, as the doctor considered this risky.
3. Mr Hope began a methadone maintenance programme for opiate dependence but was not prescribed anything for benzodiazepine withdrawal. Over the next days, the dose of methadone was increased as Mr Hope showed symptoms of withdrawal. At an initial mental health assessment on the morning of 3 July, Mr Hope told a nurse that he was withdrawing from diazepam (a benzodiazepine) and pregabalin and was anxious, shaking, and sweating as a result. The nurse referred him back to the general healthcare team because of his withdrawal symptoms.
4. Later that afternoon, officers asked healthcare staff to examine Mr Hope, who appeared very agitated and confused. His speech was rapid and incomprehensible. Mr Hope's cellmate said that Mr Hope had smoked Spice (a new psychoactive substance - NPS - a synthetic cannabinoid) that morning. A doctor decided that Mr Hope should be moved to the healthcare inpatient unit for monitoring but gave no specific instructions. Nurses checked him in the unit but, apart from a blood pressure reading (which was high) when he arrived, did not take or record his clinical observations. He was later moved from a special observation cell to a standard cell. That evening, Mr Hope began to behave erratically and aggressively. He removed his clothing and flooded the cell.
5. At 12.13am on 4 July, an officer found Mr Hope had hanged himself in his cell using ripped sheets tied to the bed frame. He radioed an emergency and the control room called an ambulance immediately. Staff administered cardiopulmonary resuscitation until paramedics arrived and took over emergency treatment. At 12.52am, a doctor recorded that Mr Hope was dead. Prison staff informed Mr Hope's family shortly after 9.00am that morning.

Findings

6. Mr Hope began a methadone maintenance programme when he arrived at the prison, to alleviate symptoms of opiate withdrawal, but we are concerned that

healthcare staff did not appear to recognise or have a plan to treat Mr Hope for withdrawal from benzodiazepines or pregabalin. Although Mr Hope was moved to the inpatient unit for observation, after his apparent bad reaction to taking a new psychoactive substance, there was no clear plan about what form his observation should take. There was no guidance about how to respond to a prisoner with an apparent bad reaction to taking NPS. It took too long to inform Mr Hope's family that he had died.

Recommendations

- The Head of Healthcare should ensure that clinicians appropriately identify, treat, and monitor prisoners with symptoms of withdrawal from benzodiazepine and other commonly misused medication.
- The Governor and Head of Healthcare should ensure that there is a protocol for managing and monitoring prisoners suffering adverse reactions from suspected use of new psychoactive substances, with clear guidance about the level and type of observations required and when referral to hospital is necessary.
- The Governor should ensure that families are notified about the death of a prisoner without undue delay.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator visited Holme House on 9 June 2015. He obtained copies of Mr Hope's prison and medical records.
9. NHS England commissioned a clinical reviewer to review Mr Hope's clinical care at the prison.
10. The investigator interviewed 13 members of staff and one prisoner at Holme House in September. The clinical reviewer joined him for some of the interviews.
11. We informed HM Coroner for Teesside of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Hope's mother to explain the investigation. Mr Hope's mother wanted the investigation to consider whether Holme House should have watched her son more closely because of his erratic behaviour the night he died. She was also concerned that his cell was not searched for drugs until after he had died.
13. Mr Hope's family received a copy of the initial report. The solicitor representing them wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Holme House

14. HMP Holme House is a local prison holding over 1200 men. Most are on remand, or recently convicted by courts in the local area. G4S provides nursing services and Spectrum CIC provides GP Services at the prison. There is an inpatient unit with 16 beds and palliative care facilities

HM Inspectorate of Prisons

15. The most recent inspection of Holme House was in August 2013. The Inspectorate found the overall quality of healthcare had improved and was good. Patient care was very good. Inspectors found that there had been a significant improvement in the level of misuse of drugs and there was a robust supply reduction strategy. Fewer prisoners than at the last inspection said they had developed a drug problem at the prison. The proportion of prisoners testing positive for drugs was lower than at similar prisons.

Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report, for the year to December 2014, the IMB was concerned that prisoners' use of spice (a new psychoactive substance) was a problem and could not be detected through standard drug tests. The IMB noted that national work was underway to identify reliable testing regimes for new psychoactive substances.

Previous deaths at HMP Holme House

17. Mr Hope was the fifth self-inflicted death of a prisoner at Holme House since the start of 2013. There were no significant similarities with the circumstances of the other deaths.

New Psychoactive Substances

18. New psychoactive substances (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 Lessons 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 23 June 2015, Mr Christopher Hope was arrested with his partner for handling stolen goods. On 24 June, he was sentenced to 16 weeks in prison. The police noted on his Person Escort Record (PER – a document which accompanies all prisoners when they move between police stations, courts and prisons) that he had risk factors including previous self-harm (from many years earlier) drug use (methadone and subutex), concealing drugs and blackouts, depression and anxiety. Mr Hope was sent to HMP Holme House. His partner was also convicted and sent to HMP Low Newton.
22. On the way to HMP Holme House, Mr Hope said he was worried he would be attacked at the prison. The escort officer noted this on his escort record and told reception staff at Holme House what Mr Hope had said.
23. Around 5.40pm, an officer interviewed Mr Hope and noted that he had been in prison before and had been released from Holme House in February 2012. The officer recorded that Mr Hope had a previous offence of arson and had last self-harmed ten years earlier. Mr Hope said he had no current thoughts of suicide or self-harm and no concerns about drugs or alcohol. He had never previously been assessed as at risk of suicide and self-harm in prison. The officer told the investigator that he had had no concerns about him, although he did not record this at the time. He explained the prison rules to Mr Hope and assessed that he was suitable to share a cell.
24. At an initial health screen, a nurse noted in his medical record (SystemOne) at 6.03pm, that Mr Hope said that he had last harmed himself by cutting his wrist in 2008 and had no current thoughts of suicide or self-harm. He said that he was currently prescribed mirtazapine (an antidepressant), pregabalin for neuropathic pain) and propranolol (for anxiety). He said that his GP had previously prescribed subutex (buprenorphine) to treat his opiate dependence but had stopped the prescription. He now bought 18mg of illicit buprenorphine daily. Mr Hope tested positive for opiates and benzodiazepines (used to treat anxiety, and often misused by drug users). She noted that Mr Hope looked relaxed and raised no concerns.
25. A prison GP was present at the health screen and reviewed Mr Hope. He noted that Mr Hope looked well and had no signs of withdrawal or sedation. He decided that, to reduce the risk of overdose, he would not give Mr Hope any medication for drug withdrawal symptoms that night, but would make sure that he was reviewed the next day in the drug and alcohol recovery team (DART) clinic.
26. Around 8.00pm, an officer took Mr Hope to Houseblock 4, the first night and induction unit. He explained the prison regime and induction arrangements to Mr Hope.
27. A healthcare assistant checked Mr Hope for signs of drug withdrawal at 11.45pm that night and at 5.27am the next morning. Each time, he was asleep and his breathing pattern was normal.

Thursday 25 June

28. A nurse examined Mr Hope in the DART clinic the next morning. Mr Hope said that he had no health problems, but that since his community GP had stopped prescribing him buprenorphine, he had been using illicit buprenorphine (18mg) and diazepam each day. He said he was also taking pregabalin (for pains in his hands caused by burns), mirtazapine and propranolol. (He had not yet been prescribed these at the prison, as they had not been confirmed with his GP.) Mr Hope repeated that he had self-harmed by cutting his wrists in 2008 and had no current thoughts of suicide or self-harm. She noted that Mr Hope was showing some signs of withdrawal from drugs and that a doctor would assess him that afternoon.
29. That afternoon, a prison GP examined Mr Hope and noted he was agitated, had dilated pupils and his colour was poor. He recorded that Mr Hope was suffering from withdrawal symptoms and prescribed methadone, an opiate substitute, starting at 20mls daily and rising to 60mls daily between 25 June and 30 June. He asked that an opiate withdrawal observation measurement scale reading (a standard method of assessing withdrawal symptoms) should be carried out regularly and checked by a member of the DART team. He made no plans about Mr Hope's withdrawal from benzodiazepines. Mr Hope's community GP records had been received and these confirmed that he had been prescribed mirtazapine, propranolol and gabapentin. He noted that he wanted to discuss safer prescribing alternatives and decided to review Mr Hope the next day.

Friday 26 June

30. A nurse checked Mr Hope twice during the night and identified no concerns. A prison GP examined Mr Hope in the afternoon of 26 June and noted that he had withdrawal symptoms. His colour was poor and his pupils were dilated. The GP increased the dose of methadone to 40ml and prescribed propranolol.

Saturday 27 – Sunday 28 June

31. There were no recorded concerns about Mr Hope over the weekend of 27 – 28 June.

Monday 29 June

32. On the morning of 29 June, a nurse saw Mr Hope in his cell for a five-day review assessment, as part of the DART program. She told the investigator that Mr Hope had engaged well and had raised no concerns. She recorded that she had discussed his current drug treatment and checked that he was aware of reduced drug tolerance levels and the increased risk of overdose if he used illicit drugs in the prison. Mr Hope said he wanted to be referred to the mental health team because he was suffering from anxiety and depression, which she agreed to do.
33. A prison GP examined Mr Hope that afternoon. Mr Hope said that his methadone prescription was having only a small positive effect. The GP noted that Mr Hope was irritable, his colour was poor, and his pupils were dilated. He increased the dose of methadone to 50ml.

Tuesday 30 June

34. On 30 June, a nurse referred Mr Hope to the mental health team. A doctor reviewed Mr Hope, who said that he was still suffering from withdrawal symptoms. She noted that his colour was poor and his skin looked clammy. She increased the dose of methadone to 60ml as planned. She arranged a further review for 3 July.

Wednesday 1 July

35. On 1 July, after receiving information from Mr Hope's hospital consultant, a prison GP prescribed him mirtazapine. He did not record why he decided against prescribing pregabalin at the time. When interviewed, he explained that he was following guidance about the need for caution when prescribing pregabalin for people taking methadone, because of the risk of overdose. The plan was to wait until Mr Hope stabilised and possibly try a safer alternative.

Thursday 2 July

36. On 2 July, Mr Hope attended a harm minimisation group therapy class. This was a support and information group for prisoners who wanted to address their drug and alcohol issues. It was recorded that Mr Hope participated and engaged well and showed a good understanding about the risks of overdose and taking illicit drugs.

Friday 3 July

37. In response to the mental health referral, a nurse from the mental health team saw Mr Hope at 10.30am on 3 July, for an initial mental health assessment. Mr Hope said that he was used to taking a lot of pregabalin and diazepam in the community and now had withdrawal symptoms. He said he was feeling anxious, shaking and sweating. She noted he had these symptoms during the assessment. She decided that the mental health team did not need to provide any further input into Mr Hope's care and she sent a referral request back to the primary healthcare team to address Mr Hope's withdrawal symptoms. A nurse recorded in Mr Hope's medical record that he had received the mental health nurse's referral and noted that Mr Hope was due to see a doctor later that day.
38. Mr Hope's cellmate told us that Mr Hope had left their cell during the morning association period, between 10.00am and 11.00am. When he came back, he said that he looked agitated and stressed. He was talking a lot and loudly. Mr Hope told him that he had taken 'Spice' a new psychoactive substance (NPS), that he had obtained from another prisoner.
39. Around 2.15pm, an officer responded to Mr Hope's cell bell and said that Mr Hope was sitting up in his bed, talking but not making much sense. Mr Hope was adamant that he had one arm longer than the other. The officer told us that he thought that Mr Hope was under the influence of drugs but Mr Hope denied this, when he asked him. The officer said he was worried about Mr Hope and locked the cell door and asked nurses on houseblock to see him.
40. The officer went back to Mr Hope's cell and told him that a nurse would see him shortly. Mr Hope then tried to get out of bed. He was naked and the officer told

him to wait in the bed until he got his clothes together for him. The officer searched Mr Hope's clothing for drugs before giving them to him, but found nothing. He said Mr Hope was still in a confused state.

41. At 2.35pm, a nurse arrived at Mr Hope's cell, followed by another nurse. The nurse recorded that Mr Hope appeared to be under the influence of an illicit substance and might have taken Spice or another NPS. She tried to examine Mr Hope, but was unable to get temperature, blood pressure, or oxygen saturation readings, as he was so agitated and confused. His pupils were dilated and he was warm. When he spoke, Mr Hope did not make any sense and he said that he could not hear because the cord from his trousers was not connecting to his ear.
42. A prison GP arrived a few minutes later. He took Mr Hope's pulse (which was within the normal range) while the nurses tried to calm him down. The GP noted that his colour was good but his speech was repetitive. A nurse told us that Mr Hope appeared to be hallucinating and it was difficult to engage with him. Mr Hope did not say that he had taken any illicit substances. The GP said that nurses should remove his medication and withhold his dose of methadone that day. Mr Hope's cellmate gave the nurses a tobacco packet, which contained a quantity of small tablets inside, and half a tablet wrapped in cellophane from Mr Hope's locker.
43. The prison GP told us that he did not think Mr Hope was at immediate risk. He decided he should be moved to the inpatient unit for observations where he expected that the staff would monitor him for any deterioration in his health and check his observations (temperature, pulse rate, blood pressure, and oxygen saturations). He did not specifically request this or specify the frequency, as he considered this would be standard practice. He noted that staff should call him or the out of hours service if they had further concerns about him or his level of consciousness reduced.
44. A nurse phoned the inpatient unit and told Nurse A that Mr Hope was being admitted for observations, as they believed he had taken spice. Around 3.00pm, an officer escorted Mr Hope to the inpatient unit. Mr Hope's cellmate said Mr Hope was not happy about leaving the cell and said he would not "make it though the night without him". The officer said Mr Hope was compliant and caused no fuss.
45. Two nurses told us that the inpatient unit was busy that evening. All the prisoners were locked in their cells because there was a shortage of prison officers. The only officer in the unit at the time was constantly supervising a prisoner who was considered at high risk of suicide.
46. Mr Hope was located in cell eight, which was usually used for prisoners being constantly observed, as it had a perspex door. This made it easier for staff to monitor his safety. Nurse A said that Mr Hope was inebriated, talkative, laughing, and joking. She told us that there was no standard protocol for monitoring and taking clinical observations for prisoners in the unit because they were suspected of being under the influence of illicit substances. She said she took Mr Hope's clinical observations, when he arrived, and said they were all within normal limits.

However, she only recorded his blood pressure (148/97HHmg, which is above the normal range). She said she had no concerns about Mr Hope.

47. Nurse B said that they asked an agency healthcare assistant (whose name is not known) to watch Mr Hope, to talk to him and settle him down. She had hoped that healthcare staff would be able to take a urine test once Mr Hope had settled. However, he fell asleep for most of the afternoon. Her shift finished at 5.00pm, around the same time as the agency healthcare assistant.
48. Nurse A said Mr Hope woke up around 6.00pm. He said he had no recollection of the afternoon and last remembered being on the exercise yard that morning and being given a cigarette by another prisoner. She told him what had happened and where he was.
49. A custodial manager was the orderly officer in charge of the prison that night. At 7.15pm, he received a handover from the outgoing orderly officer. The orderly officer told him about the situation with Mr Hope and that he was being monitored, but was not considered to be at risk of suicide or self-harm.
50. Around 7.55pm, Nurse A went to Mr Hope's cell because he was shouting. She said he did not want anything specific and it appeared that he just wanted to talk to someone. He spoke about his plans to see his partner and children but appeared a little confused, as he still did not know where he was.
51. Before her duty finished, at around 8.00pm, Nurse A briefed Nurse C, the night nurse, about Mr Hope. A healthcare assistant and an officer also started night duty in the inpatient unit, around this time.
52. Shortly after 8.00pm, Nurse C and the healthcare assistant checked Mr Hope, who was pacing around in his cell talking and shouting to himself. Occasionally, he lashed out in a kung-fu type move. The nurse did not have any serious concerns about Mr Hope, as she understood him to be under the influence of an illicit substance. She said she checked him about four times an hour throughout the evening, at random intervals, but did not take any clinical observations. She told us that they had felt it unsafe to go into Mr Hope's cell to check his medical observations because of his unpredictable behaviour.
53. Around 9.00pm, staff moved Mr Hope from the constant observation cell to a standard cell in the inpatient unit, as the cell was needed for a prisoner who had been assessed as at high risk of suicide or self-harm. Nurse C said that they continued to monitor Mr Hope, using the observation panel on the cell door. Mr Hope was no problem when he was being moved to the new cell, but once he was locked in, he started shouting, banging and kicking the door.
54. The healthcare assistant said that as the evening progressed, Mr Hope became more aggressive and disruptive. Around 10.00pm, Mr Hope flooded his cell and water was running underneath the door into the corridor. He phoned the custodial manager, who told him to turn the water off and place towels at the bottom of the door.
55. Nurse C noted in his medical record that Mr Hope had been talking to himself, shouting and banging the cell door. He was standing in the middle of the cell

with no clothes on, surrounded by water. The healthcare assistant said that Mr Hope was abusive when they tried to speak to him.

56. The healthcare assistant cleared up the water in the corridor. The custodial manager went to the inpatient unit with an assistant orderly officer. He said they removed some furniture from the cell, including a table that Mr Hope had damaged. The custodial manager said that he appeared unable to engage in any meaningful conversation, which he thought was because Mr Hope was under the influence of spice that he had taken earlier. He said he did not consider that Mr Hope was at risk of suicide and self-harm.
57. The healthcare assistant checked Mr Hope at around 11.30pm. He was naked, shouting and walking around his cell. At 11.45pm, an officer noted that Mr Hope was sitting on his bed with the sheet wrapped around him. Mr Hope told the officer that he was okay and then started talking to himself.

Saturday 4 July

58. At 12.13am, when the officer looked through the observation panel in Mr Hope's door, he was lying on the floor with a noose made from bed sheets around his neck and attached to the bed frame. He radioed a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and the control room operator immediately called an ambulance. The healthcare assistant, who was nearby, ran to collect the emergency medical bag.
59. The custodial manager, who was on the landing above, arrived at Mr Hope's cell within 20 seconds. He and the officer went into the cell, closely followed by Nurse C. The officer cut the noose from around Mr Hope's neck. Mr Hope was not breathing, had no pulse and showed no signs of life. The custodial manager started chest compressions and the nurse ensured Mr Hope's airway was clear.
60. The healthcare assistant brought the emergency bag and passed an airway tool to the nurse, who inserted it into Mr Hope's mouth. The healthcare assistant then took over chest compressions from the officer. Mr Hope showed no signs of life. As the cell floor was wet, they thought it was unsafe to use the defibrillator (a life-saving device that can re-start the heart by giving an electric shock in some cases of cardiac arrest), so they continued chest compressions.
61. Paramedics arrived at 12.27am and took over emergency treatment. More paramedics and a doctor arrived at 12.40am. At 12.52am, the doctor pronounced Mr Hope dead.

Contact with Mr Hope's family

62. The duty governor arrived at the prison around 12.50am. He said he had been unable to contact a family liaison officer, until around 6.00am, when he spoke to one of Holme House's family liaison officers. The family liaison officer went to the prison and, at 8.30, she and the duty governor went to inform Mr Hope's mother that he had died. They arrived at his mother's home around 9.15am, explained what had happened, and offer condolences and support. At the same time, staff at HMP Low Newton broke the news to his partner. In line with Prison Service instructions, the prison contributed towards the cost of Mr Hope's funeral, which was held on 16 July.

Support for prisoners and staff

63. After Mr Hope's death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and offered his support and that of the staff care team.
64. The prison posted notices informing other prisoners of Mr Hope'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 Hope's death.

Post-mortem report

65. The post-mortem examination found that the cause of Mr Hope's death was hanging. Toxicology tests showed traces of methadone. The toxicology tests did not include tests for synthetic cannabinoids, such as Spice.

Findings

Assessing the risk of suicide and self-harm

66. Prison Service Instruction (PSI) 64/2011, which governs safer custody procedures and PSI 7/2015, which covers early days in custody, indicate that depression, substance misuse or detoxification and a history of suicide and self-harm are factors that might increase a prisoner's risk of suicide and self-harm. An officer said that he read Mr Hope's PER and was aware of his offence, that he last self-harmed many years earlier and that this was not his first time in prison. There were no current risk warnings of suicide and self-harm. The officer's judgement was that Mr Hope was not at risk of suicide or self-harm and did not need to be monitored.
67. A nurse and a prison GP also recorded Mr Hope's risk factors and spoke to him about his mental health, his medication, and his illicit drug use. Mr Hope was adamant he was not at risk of suicide or self-harm. Initially, he said he did not have a problem with drugs and showed no signs of withdrawal, although tests confirmed he had been using opiates, buprenorphine, and benzodiazepines. Holme House identified that Mr Hope would need to undergo a drug detoxification programme. Staff did not identify any other significant problems and Mr Hope did not raise any other concerns when he first arrived at Holme House.
68. When he arrived at the prison, Mr Hope's physical and mental health issues had been identified and were being addressed. We are satisfied that there was no reason for staff at Holme House to be concerned that he was at risk of suicide and self-harm when he first arrived.
69. Mr Hope subsequently exhibited out of character and strange behaviour on the night of 3 June. Prison staff attributed this to the effects of a substance Mr Hope had taken and did not consider that this meant he was at risk of suicide and self-harm. While Mr Hope acted as if he was intoxicated, there was nothing in his behaviour or what he said that indicated he had any suicidal intentions. We do not consider that the staff could have anticipated his actions.

Clinical care

70. The clinical reviewer concluded that the clinical care Mr Hope received at Holme House was mostly comparable to that he could have expected in the community. However, he had some concerns about the lack of monitoring for symptoms of withdrawal from benzodiazepines and the lack of clear monitoring plans when he was admitted to the healthcare unit as an inpatient.

Substance misuse treatment

71. A nurse completed the reception healthcare screening on 24 June along with a prison GP. Mr Hope had a history of drug misuse and tested positive for buprenorphine and benzodiazepines. Although he disclosed he used 18mg buprenorphine daily, they did not record any details about his use of diazepam (a

benzodiazepine) and, in the following days, he was not monitored for signs of withdrawal from benzodiazepines.

72. The clinical reviewer noted that although staff monitored and treated Mr Hope for signs of opiate withdrawal, they do not seem to have considered whether he might also have been withdrawing from benzodiazepines or pregabalin, both of which he said he used. Withdrawal from pregabalin can cause symptoms such as anger, anxiety, depression, dizziness and panic attacks while diazepam withdrawal can cause symptoms such as tension, tremor, restlessness, abnormal movements, confusion and, in extreme cases, sensitivity to sound, light and personal contact, hallucinations or seizures which can be life-threatening. We consider that healthcare staff should have recognised that Mr Hope might be at risk of withdrawal from benzodiazepines and pregabalin and monitored him accordingly. We make the following recommendation:

The Head of Healthcare should ensure that clinicians appropriately identify, treat, and monitor prisoners with symptoms of withdrawal from benzodiazepine and other commonly misused medication.

New psychoactive substances and monitoring Mr Hope

73. As in many prisons, the use of “Spice”, a synthetic cannabinoid and one of a range of new psychoactive substances (NPS), is a problem at Holme House. The Independent Monitoring Board flagged this up in its most recent report. Such substances are currently not detectable by prison drug tests and it does not have the characteristic smell associated with cannabis. Its use can produce a wide range of reactions including bizarre, aggressive behaviour and hallucinations.
74. In July 2015, we issued a Learning Lessons 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.
75. On 3 July at 2.35pm, Mr Hope told his cellmate that he had taken Spice, although this was not identified in the toxicology results. He was confused and agitated making it difficult for a nurse to assess him fully. A prison GP told us that he asked that Mr Hope should be admitted to the inpatient unit, where he would be monitored. He noted in the medical record that Mr Hope should be observed, and that a doctor should be called if staff had further concerns about him or his level of consciousness reduced. The GP told the investigator that, had he known that nurses would not take regular clinical observations, he would have considered sending Mr Hope to hospital.
76. Nurses A and B told us that there was no protocol for managing prisoners suspected of taking NPS, although they had started to discuss the issues with the prison’s safer custody department. They said that they now take observations every half-hour and, if they consider that the prisoner has deteriorated, they send them to hospital.
77. The staff observed Mr Hope frequently when he was in the inpatient unit. Although they did not take his clinical observations, this would not have identified

him as at risk of suicide. The clinical reviewer commented that, had Mr Hope been in the community and apparently under the influence of an illegal substance, it is likely that he would have taken to his GP or to hospital. We note that the GP reviewed Mr Hope and decided he should be monitored as an inpatient in the prison. We consider this was a reasonable response. While Mr Hope later behaved erratically and aggressively, there was nothing to indicate that his physical health was deteriorating and little to suggest that he needed to be taken to hospital. However, we consider there needs to be a clear joint healthcare and prison protocol about how to respond to and monitor, prisoners suspected of taking NPS. We make the following recommendation:

The Governor and Head of Healthcare should ensure that there is a protocol for managing and monitoring prisoners suffering adverse reactions from suspected use of new psychoactive substances, with clear guidance about the level and type of observations required and when referral to hospital is necessary.

Informing Mr Hope's family of his death

78. Prison Rule 22 requires that the governor should inform families "at once" when a prisoner dies. Prison Service Instruction 64/2011, requires that wherever possible, the family liaison officer and another member of staff must visit in person the next of kin or nominated person to break the news of the death. It notes that time will be of the essence in order to try to ensure that the family do not find out about the death from another source.
79. Mr Hope was pronounced dead at 12.52am, on 4 July. The duty governor said that despite attempts he was unable to appoint a family liaison officer until around 6.00am. He and an officer left the prison around 8.30am to break the news to Mr Hope's mother. They informed her shortly after 9.00am. His partner was informed at the same time. This was a lengthy delay.
80. Holme House has seven trained family liaison officers but does not appear to have a system to ensure that one is always available to break the news of a death at the prison at short notice, including at night. If it is not possible for a family liaison officer to attend, then the visit should not be unnecessarily delayed. We make the following recommendation:

The Governor should ensure that families are notified about the death of a prisoner without undue delay.

**Prisons &
Probation**

Ombudsman
Independent Investigations