

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ben Hargreaves a prisoner at HMP Humber on 17 January 2016

**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.

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

Mr Ben Hargreaves died on 17 January 2016 while a prisoner at HMP Humber. The post-mortem was inconclusive. He was 37 years old. I offer my condolences to Mr Hargreaves' family and friends.

Mr Hargreaves did not suffer with any physical illnesses while at Humber. He was under the care of the mental health team and they regularly reviewed his anti-depressant medication. Mr Hargreaves' death was sudden, and the coroner has not been able to determine the definitive cause of his death.

However, given the possibility that Mr Hargreaves took non-prescribed drugs in prison, which may have contributed to his death, I believe that the prison needs to address the trading by prisoners of prescribed medication.

Additionally, I am concerned that the officer who performed the morning unlock did not appropriately check on his wellbeing.

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

December 2016

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Summary

Events

1. On 15 August 2014, Mr Ben Hargreaves was sentenced to six years imprisonment for drugs offences. He was moved to HMP Humber on 26 June 2015.
2. At Humber, Mr Hargreaves was placed on a gradual reduction of methadone (an opiate replacement therapy for heroin addicts) and anti-depressant medication.
3. On 29 July, after several missed appointments, a mental health case worker assessed Mr Hargreaves. Mr Hargreaves told her that he felt anxious on the wing due to the noise, and asked for a GP referral to review his anti-depressant medication. The mental health team discharged Mr Hargreaves from their care because they did not identify any mental health needs.
4. A prison GP regularly reviewed Mr Hargreaves and increased his anti-depressant medication, before a decision was made to reduce his dosage and start a different anti-depressant.
5. Mr Hargreaves continued to reduce his methadone intake and, in September, saw a substance misuse worker, as advised by a prison GP. Mr Hargreaves asked the substance misuse worker to refer him back to the mental health team.
6. On 15 October, Mr Hargreaves had a session with a mental health case worker. He told the case worker that he felt low in mood but was otherwise enjoying his prison job and had no thoughts of suicide or self-harm. The mental health worker noted he would review Mr Hargreaves when he had started his new anti-depressant medication.
7. During a mental health session, on 12 November, Mr Hargreaves said he was lacking motivation and had not yet started his new anti-depressant medication. During another mental health session on 11 December, he said he was on his new medication but that he was suffering with side effects. A prison GP prescribed a different anti-depressant.
8. Despite attempts by the mental health worker, Mr Hargreaves did not have a session in January 2016.
9. At 10.46am on 17 January, a prisoner found Mr Hargreaves unresponsive in his cell. Healthcare staff attended and performed cardiopulmonary resuscitation. Paramedics arrived and declared him dead at 11.15am.

Findings

10. The post-mortem examination concluded that the cause of Mr Hargreaves' death was unascertained but found that the presence of mirtazapine (an anti-depressant) and Olanzapine (anti-psychotic medication) in Mr Hargreaves' blood could have caused a sudden cardiac arrest. As Mr Hargreaves had not been prescribed Olanzapine, it is likely that he obtained it from another prisoner; we believe that the prison should act to prevent the diversion of prescribed medication.

11. Given the presence of rigor mortis when Mr Hargreaves was found, we are concerned that the officer who performed the morning unlock did not appropriately check on his wellbeing.
12. We are satisfied that Mr Hargreaves received an appropriate standard of care at Humber, particularly during the emergency response, which was equivalent to that he could have expected to receive in the community. However, we consider that there were delays assessing Mr Hargreaves' mental health and healthcare staff did not appropriately record the reasons why he did not attend mental health appointments.

Recommendations

- The Governor and the Head of Healthcare should review the Drug Supply Reduction Strategy to provide greater emphasis on the risks from prescribed medication and to enable improvements on the diversion of this medication.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Head of Healthcare should ensure that staff follow up and record the reasons for non attendance at healthcare appointments.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Humber informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited Humber on 20 January 2016. She obtained copies of relevant extracts from Mr Hargreaves' prison and medical records.
15. The investigator interviewed two members of staff and a prisoner at Humber on 20 January.
16. NHS England commissioned a clinical reviewer to review Mr Hargreaves's clinical care at the prison.
17. We informed HM Coroner for Hull of the investigation. The investigation was suspended until the coroner was able to give us the results of the post-mortem examination. We regret the consequent delay. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Hargreaves's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She did not have any specific issues she wanted the investigation to consider.
19. Mr Hargreaves's mother received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.
20. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Humber

21. HMP Humber is made up of two former prisons, HMP The Wolds and HMP Everthorpe. The formal merger of the two prisons took place in April 2014. The prison holds up to 1,062 prisoners.
22. City Health Care Partnership provides healthcare services. Onsite healthcare cover is available 24 hours per day, seven days per week

HM Inspectorate of Prisons

23. The most recent inspection of HMP Humber was in July 2015. Inspectors reported that the new health provider had begun to make positive changes and services were generally safe and responsive. The report noted that there was good prioritisation of urgent cases. However, care for prisoners with long-term conditions was developing, and it required a more formal and systematic process in line with community procedures.

Independent Monitoring Board

24. 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 the last annual report for the year to December 2015, the IMB noted that when City Health Care Partnership took over in December 2014, there was an initial decrease in staff and the number of complaints increased. Since then, an increased presence of nurses has meant that minor problems are dealt with quickly and non-urgent requests for appointments were dealt with within a week. The IMB noted that a coroner's report raised concerns about the appropriate use of ACCTs and that more training should be in place to ensure staff across the prison recognise and understand the signs that the mental health of a prisoner is a concern.

Previous deaths at HMP Humber

25. Mr Hargreaves was the third prisoner to die from natural causes at HMP Humber since November 2015. There are no similarities with the circumstances of the other deaths.

Key Events

26. On 15 August 2014, Mr Ben Hargreaves was sentenced to six years imprisonment for drugs offences and sent to HMP Woodhill. He moved to HMP Humber on 26 June 2015.
27. On 26 June, a nurse assessed Mr Hargreaves. He noted that Mr Hargreaves was on 14mls of methadone (an opiate replacement therapy for heroin addicts) and 150mg of sertraline (an anti-depressant). He referred Mr Hargreaves to the mental health team, although there was a delay as the referral was not entered in Mr Hargreaves' medical record until 4 July.
28. On 7 July, Mr Hargreaves made a self referral to the mental health team. A mental health worker noted in the referral that Mr Hargreaves had thoughts of self-harm and that he was struggling on his wing. She made an appointment as an amber referral (of moderate urgency) and sent an appointment letter to Mr Hargreaves for 14 July.
29. On 14 July, Mr Hargreaves did not appear for his mental health assessment with the mental health worker. She telephoned the wing and Mr Hargreaves was on the wing. She noted in her record that Mr Hargreaves had probably not been told about his appointment and re-scheduled it. Mr Hargreaves did not attend re-scheduled appointments on 16 and 21 July, though no one recorded the reasons for his non-attendance. On 24 July, a mental health worker tried to visit Mr Hargreaves on his wing, but he was not there.
30. On 29 July, Mr Hargreaves attended an appointment with the mental health worker. During the meeting, he told her he often felt anxious when he was in large groups or on the wing, because it was loud. She referred this matter to wing staff. Mr Hargreaves asked for a GP appointment to review his anti-depressant, as he felt it was not effective, though his mood deteriorated if he did not take it.
31. On 5 August, a prison GP examined Mr Hargreaves. He advised Mr Hargreaves to consider the DARS (drug and alcohol recovery service) and counselling. He increased his sertraline prescription from 150mg to 200mg per day.
32. On 18 September, a substance misuse worker assessed Mr Hargreaves. He told her that he was currently on 7mls daily of methadone and he did not feel settled. He said he had aches in his legs, stomach cramps, and problems sleeping. He asked to be seen by the mental health team.
33. On 1 October, a prison GP reduced Mr Hargreaves' sertraline prescription back to 150mg per day to prepare for a change to citalopram. On 12 October, the GP reduced his sertraline dosage to 100mg per day and, in preparation for a change to citalopram two weeks later.
34. On 5 October, a prison GP reviewed Mr Hargreaves. He noted he was reducing his methadone dose well, and advised Mr Hargreaves to attend the gym as part of his detox.

35. On 15 October, Mr Hargreaves had an appointment with a drugs worker. Mr Hargreaves said he had clinical depression and was low in mood, but acknowledged that it was probably due to the reduction in sertraline. Mr Hargreaves said he enjoyed his job in the bike shop and was on 3mls of methadone from 70mls per day. Mr Hargreaves declined the offer of talking therapy as he had not found it useful in the past. He also denied any current thoughts of self-harm or suicide. The drugs worker noted he would check on Mr Hargreaves progress once he has started his new citalopram medication.
36. On 29 October, the drugs worker prescribed Mr Hargreaves with a 14 day supply of sertraline and a 14 day supply of citalopram, before starting a 20mg prescription for citalopram on 24 November.
37. The drugs worker saw Mr Hargreaves on 12 November. Mr Hargreaves said he was tired by 10.00pm but felt scared to fall asleep due to the nightmares he was suffering about his time at HMP Stocken. Mr Hargreaves said he was lacking motivation on the wing and at work, but he did not feel suicidal or have thoughts of self-harm.
38. During their appointment on 11 December, Mr Hargreaves told the drugs worker that he did not think the citalopram was helping him. He said he felt light-headed, had a dry mouth, could not sleep, and felt dizzy. He said that he wanted to discuss his medication with a prison GP. The drugs worker made an amber referral for a GP appointment. Mr Hargreaves told him that he had no thoughts of self-harm or suicide.
39. On 17 December, a prison GP examined Mr Hargreaves and changed his anti-depressant medication immediately from citalopram to a 30mg dose of mirtazapine (an anti-depressant).
40. On 31 December, a mental health worker sent an appointment letter to Mr Hargreaves for 6 January 2016. On 6 January, he was not able to see him because the wing was on lock down. The following day, he went to the wing again but Mr Hargreaves had gone to work. He asked wing officers to keep him back from work after lunch, but the officers did not tell Mr Hargreaves and he returned to work that afternoon.

Events of Sunday 17 January 2016

41. On the morning of Sunday 17 January, between approximately 5.30am and 6.00am, an Operational Support Grade carried out the morning roll check. He told the investigator that through the cell flap he saw Mr Hargreaves lying on his bed.
42. At approximately 9.00am, an unidentified officer unlocked the cells. We cannot be sure that the officer checked on Mr Hargreaves' welfare and that he was alive at this point.
43. Later that morning, a prisoner went to Mr Hargreaves' cell to ask for a cigarette. When he entered the cell, he found Mr Hargreaves laid down and unresponsive. He immediately pressed the cell buzzer, at 10.46am, and looked for an officer. An officer responded to the cell buzzer, found Mr Hargreaves unresponsive and placed him in the recovery position. A senior manager also arrived at the cell

and called a code blue (which indicates that a prisoner is unconscious or not breathing) at 10.49am.

44. A nurse heard the code blue and arrived at Mr Hargreaves' cell at 10.50am. She noted that he had no pulse, was not breathing, had fixed and dilated pupils and there were signs of rigor mortis. She fitted a defibrillator but it advised not to shock. She performed cardiopulmonary resuscitation (CPR) until a paramedic arrived at the scene at 11.14am. The paramedic pronounced Mr Hargreaves dead at 11.15am.

Contact with Mr Hargreaves's family

45. On 17 January, the prison appointed an officer as the family liaison officer. At 4.00pm, he and another family liaison officer visited Mr Hargreaves' mother at her home to inform her of his death, and offer their condolences.
46. The officer maintained contact with Mr Hargreaves' mother and provided continued support.
47. Mr Hargreaves funeral was held on 3 August. In line with national policy, the prison contributed to the costs.

Support for prisoners and staff

48. After Mr Hargreaves death, 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.
49. The prison posted notices informing other prisoners of Mr Hargreaves's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Hargreaves' death.

Post-mortem report

50. The post-mortem concluded that the cause of Mr Hargreaves' death was unascertained. However, the forensic pathologist did state in the post-mortem report that mirtazapine and olanzapine (anti-psychotic medication) were found in Mr Hargreaves' blood at therapeutic concentrations. The pathologist stated that the prolonged use of these two drugs can cause sudden cardiac arrest.

Findings

Drug supply reduction policy

51. The post-mortem examination revealed olanzapine, a non-prescribed drug, in Mr Hargreaves' blood. We cannot rule out that he may have obtained this and other drugs while in prison, resulting in him suffering a sudden cardiac arrest.
52. The prison's Drug Supply Reduction Strategy, dated March 2015, focuses on illicit drugs, though it contains a small section on displacing the supply of prescribed medication. The Strategy stated that the diversion of prescribed medication can be limited by monitoring prescriptions for saleable medication, reviewing the current prescription list and replacing those drugs that are tradable, managing prescribed and in-possession medication, and providing training so that staff can identify medication types when conducting cell searches.
53. A nurse told us that healthcare staff complete a full risk assessment for all prisoners to decide whether or not they are suitable for medication in their possession and that all medications that could be fatal in small doses can only be taken under supervision. She also confirmed that a prisoner suspected of trading or inappropriately using his medication should face searches from healthcare and prison staff.
54. The presence of a non-prescribed drug in Mr Hargreaves' blood demonstrates a failure with the current process. We consider that Humber need to review their Drug Supply Reduction Strategy to contain greater emphasis on the risks involved from prescribed medication. The focus should include closer supervision of the administration of prescribed medication and a need to educate prisoners and staff about the risks involved from prescribed medication. We make the following recommendation:

The Governor and the Head of Healthcare should review the Drug Supply Reduction Strategy to provide greater emphasis on the risks from prescribed medication and to enable improvements on the diversion of this medication.

Unlock procedures

55. When Mr Hargreaves was found unresponsive at 10.46am, the nurse noted the presence of rigor mortis. This would indicate that Mr Hargreaves had been dead for some time. We are concerned that the officer who performed the morning unlock, at approximately 9.00am, did not check Mr Hargreaves' wellbeing when they unlocked his cell.
56. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

57. Additionally, Prison Service Instruction 75/2011 states that “there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process”.
58. We do not know if checking on Mr Hargreaves during the unlock process might have prevented his death. It meant, though, that staff missed an opportunity to check his wellbeing and resulted in another prisoner finding him dead. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Clinical care

59. We agree with the clinical reviewer that the care Mr Hargreaves received at Humber was equivalent to that he could have expected in the community, particularly the emergency response when he was found unresponsive.
60. However, it is concerning that it took more than a month for Mr Hargreaves to be referred and assessed by the mental health team. Additionally, Mr Hargreaves did not attend five mental health appointments, though healthcare staff have not documented the reasons why Mr Hargreaves missed some of them. Although there is no evidence that these missed appointments contributed to Mr Hargreaves’ death, we expect the prison to be able to document that a prisoner made the decision not to attend an appointment. We make the following recommendation:

The Head of Healthcare should ensure that staff follow up and record the reasons for non attendance at healthcare appointments.

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