

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Paul Rishworth a prisoner at HMP Leeds on 23 May 2017

**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.

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 Paul Rishworth died on 23 May 2017 from the effects of a combination of cocaine, synthetic cannabinoid use, diazepam, buprenorphine, mirtazapine, and pregabalin intoxication, while a prisoner at HMP Leeds. He was 31 years old. We offer our condolences to Mr Rishworth's family and friends.

On the day of his death, healthcare staff found Mr Rishworth to be unfit to attend court and suspected him of being under the influence of illicit substances. We are concerned that healthcare staff did not take any physical observations or use a recognised system for assessing the severity of an illness which could have indicated that more frequent reviews and assessments were required.

It is also extremely troubling that Mr Rishworth was clearly able to obtain significant quantities of illicit drugs which, taken with prescription medication, appear to have led to his death.

We are also concerned that no emergency medical code was used when staff discovered Mr Rishworth unconscious in his cell, although we accept that the delay caused was minimal and had no significant impact on the response or the outcome.

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

**Elizabeth Moody**  
**Acting Prisons and Probation Ombudsman**

**May 2018**

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# Summary

## Events

1. On 17 August 2016, Mr Paul Rishworth was recalled to prison having previously been released on licence from a six year sentence. He was sent to HMP Hull. On 16 May 2017, he was transferred to HMP Leeds from where, each day, he attended Leeds Crown Court for trial. Staff at Hull searched Mr Rishworth before he left and he was searched again on arrival at Leeds. He was searched each day before he left for court and again on his return.
2. Mr Rishworth had a history of drug and alcohol misuse. He took painkillers and antidepressants but had no significant long term medical conditions. He was discharged from mental health services at Hull in March 2017. At his initial health screen at Leeds, he told healthcare staff that he had no thoughts of self-harm or suicide. There is no record during the health screen of any discussion about drug or alcohol misuse, although when previously asked at HMP Hull he had declined all offers of help.
3. Mr Rishworth was given a cell in the first night centre. He collected his medication daily and healthcare staff saw him each morning before he went to court to confirm that he was fit to go.
4. On 23 May 2017, a nurse examined Mr Rishworth before he went to court and assessed him as unfit to attend. He appeared to be under the influence of an illicit substance, although he denied taking anything. He said his condition was a result of taking his prescribed medication. He was returned to his cell and a nurse told first night centre staff to contact them if they had any concerns.
5. At about 11.30am, a nurse returned to see Mr Rishworth after a prison officer found him unresponsive on his bed. When the nurse arrived at his cell, Mr Rishworth was out of his cell, pushing a trolley containing his property. Although he still appeared unfit, his condition was much improved. Mr Rishworth was moving to another cell and he refused to allow the nurse to examine him. The nurse arranged to stop his non-essential medication for 24 hours and tasked a substance misuse nurse to assess him. Mr Rishworth moved from the first night centre to a double cell on level four of a standard wing.
6. Shortly after midday, an officer unlocked Mr Rishworth's cell so that he could go and get lunch. Mr Rishworth was lying on his bunk and when the officer asked him if he was going for lunch, he shook his head and stayed in his cell. About 30 minutes later, a second officer checked him through the cell observation hatch when completing the roll check. She did not remember anything untoward.
7. At 3.45pm, a prison officer responded to calls for help from prisoners outside Mr Rishworth's cell. The officer looked through the cell observation hatch and saw Mr Rishworth lying on the bottom bunk. She described his colour as strange and immediately shouted for staff to come and help. Several prisoners had gathered outside the cell and the officer did not open the cell door immediately. She was still on her own and concerned for her safety.

8. More officers arrived quickly and one of them radioed a medical emergency and requested the attendance of healthcare staff. An officer opened the cell door and two officers entered and immediately began cardiopulmonary resuscitation (CPR). Mr Rishworth had no pulse or signs of breathing.
9. Healthcare staff arrived less than a minute later and moved Mr Rishworth onto the floor. They continued CPR and radioed for an emergency ambulance. A nurse arrived with the emergency medical resuscitation bag and defibrillator pads were attached to Mr Rishworth's chest. A nurse put an airway into his mouth and gave him oxygen. The defibrillator did not shock but advised continued CPR.
10. Paramedics arrived at the cell at 3.56pm and took over Mr Rishworth's care. At 4.15pm, they confirmed that he had died.
11. The police later found a mobile phone and inhalers that contained traces of cocaine in Mr Rishworth's cell.
12. The post mortem concluded that Mr Rishworth died from the effects of a combination of cocaine, synthetic cannabinoid, diazepam, mirtazapine, buprenorphine and pregabalin intoxication.

## Findings

13. The clinical reviewer concluded that some of the care Mr Rishworth received at Leeds was good and some less so. Mr Rishworth collected medication daily and healthcare staff saw him each morning before he went to court.
14. On arrival at Leeds, healthcare staff assessed Mr Rishworth and identified his previous medical history. They did not complete a full health screen assessment, as was the policy at the time for prisoners transferring in from another prison. There was no discussion about substance misuse and as a consequence no consideration of a referral to substance misuse services (although Mr Rishworth had declined all previous offers made at Hull).
15. Healthcare staff correctly identified that Mr Rishworth was unfit to attend court when he appeared to be under the influence of an illicit substance. However, they did not take or record any physical observations to support their decision. They did not apply a recognised system for assessing the severity of his illness which could have indicated that more frequent reviews and assessments were required.
16. Prison staff did not use an appropriate medical emergency code when they discovered Mr Rishworth unconscious in his cell.
17. Healthcare staff arrived at Mr Rishworth's cell very promptly when he was discovered unconscious. They treated him appropriately until the arrival of paramedics.
18. It is clear that Mr Rishworth died as a result of accessing illicit substances in addition to taking his prescribed medication. It is very troubling that, so quickly after arriving at Leeds, he was able to access such a range of drugs. We continue to be concerned about the availability of illicit drugs at HMP Leeds and

that their policies have not been effective in reducing incidents of illicit substance misuse. Mr Rishworth's death demonstrates these shortfalls.

## Recommendations

- The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that reviews their medical history and identifies any outstanding appointments and relevant conditions in accordance with the standards of PSO 3050 and National Institute for Health and Care Excellence (NICE). The initial health screen should include discussion about substance misuse.
- The Head of Healthcare should review the assessment process used to determine if a prisoner is fit to travel outside the prison, for example to court, to ensure that a robust assessment is completed. The results should be recorded in the medical record to support clinical opinion and a nationally recognised assessment tool, such as NEWS, should be used.
- The Governor should ensure that all staff are aware of PSI 03/2013 and understand their responsibilities during medical emergencies, and in particular the need to use correct medical emergency codes to ensure that staff called to the scene bring the appropriate equipment and there are no delays in calling an ambulance.
- The Governor should review existing policies and their implementation in light of Mr Rishworth's death and the findings of this investigation to ensure they are effective in reducing the supply of and demand for illicit substances.

## The Investigation Process

19. The investigator issued notices to staff and prisoners at HMP Leeds informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
20. The investigator visited Leeds on 1 June. He obtained copies of relevant extracts from Mr Rishworth's prison and medical records and interviewed two members of staff and four prisoners.
21. The investigator interviewed six members of staff when he returned to Leeds on 5 and 6 July. He obtained further statements from staff and prisoners after conducting telephone interviews.
22. NHS England commissioned a clinical reviewer to review Mr Rishworth's clinical care at the prison. The clinical reviewer conducted joint interviews of medical staff with the investigator.
23. We informed HM Coroner for West Yorkshire of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
24. The investigator wrote to Mr Rishworth's mother, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She asked why the prison had not monitored her son more regularly and why they did not call an ambulance after he told them he felt unwell and needed to go to hospital.
25. Mr Rishworth's mother received a copy of the initial report. The solicitor representing her wrote to us and did not raise any further issues, or factual inaccuracies.
26. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS raised points verbally that have been agreed and the report amended accordingly. HMPPS did not raise any factual inaccuracies that changed the context of the report. The action plan has been annexed to this report.

# Background Information

## HMP Leeds

27. HMP Leeds is a local prison holding up to 1,218 men. Care UK runs primary healthcare services. The prison has an inpatient facility with 24-hour nursing care.

## HM Inspectorate of Prisons

28. The most recent inspection of HMP Leeds was in December 2015. Inspectors reported that, overall, the prison had not kept up the improvements they had observed in January 2013, but they were confident that good leadership and a positive staff culture would lead to improvements. Inspectors considered that the healthcare services had declined, but outcomes for prisoners remained reasonable. They found that the management of long-term conditions was impressive, prisoners had good access to hospital appointments and liaison with specialist services was effective.

## Independent Monitoring Board

29. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their latest annual report, for the year to December 2016, the IMB raised concerns about high levels of violence and self-harm. They highlighted the damaging impact of new psychoactive substances (NPS) as a factor together with the need to accommodate disruptive prisoners transferred in from elsewhere. Staff shortages and the high number of mobile phones recovered were also highlighted as concerns.
30. The board noted a steady improvement in healthcare services but identified that routine hospital appointments had been missed due to the lack of availability of escort staff. They recognised the extra strain put on healthcare services by the number of NPS related emergency calls.

## Previous deaths at HMP Leeds

31. Mr Rishworth was the twelfth prisoner to die at HMP Leeds since January 2016. Seven of these were from natural causes. There were no significant similarities with the other deaths.

## New Psychoactive Substances (NPS)

32. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

33. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
34. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

## Key Events

35. On 10 March 2013, Mr Paul Michael Rishworth was sentenced to six years in prison for serious assault and was sent to HMP Hull. On 28 April 2016, he was released on licence but on 17 August 2016, his licence was revoked after he was arrested for further offences. He was sent to Hull. On 16 May 2017, he was transferred to HMP Leeds so that he could attend Leeds Crown Court for trial.
36. Staff at Hull searched Mr Rishworth before he left Hull and he was searched again on arrival at Leeds. He was searched each day before he left for court and again on his return.
37. Mr Rishworth had a history of drug and alcohol misuse. While in prison, he refused a number of offers of help from drug treatment services. He signed a disclaimer on each occasion.
38. On arrival at Leeds, Mr Rishworth told a healthcare assistant that he was prescribed mirtazapine (an antidepressant), pregabalin (for pain relief), propranolol (used to treat tremors, angina, high blood pressure and other heart conditions), lansoprazole (used to reduce stomach acid) and fybogel (a laxative). He said he had asthma but did not have an inhaler with him. His medical records showed that he had been discharged from mental health services in March 2017. He said he had no thoughts of self-harm or suicide.
39. A nurse saw Mr Rishworth just over an hour later. He did not express any concerns about his health and confirmed that he had no thoughts of suicide or self-harm. He said that staff at Hull took his medication from him when he left. The nurse arranged for him to have replacement medication prescribed. There is no record during the health screen of any discussion about his previous drug or alcohol misuse or consideration of the offer of a referral to substance misuse services.
40. Mr Rishworth was given a cell in the first night centre. He collected his prescribed medication daily and healthcare staff saw him each morning before he went to court to confirm that he was fit to go.
41. On 22 May, after returning from court, Mr Rishworth's co-defendant managed to get into Mr Rishworth's cell and once inside they shut and barricaded the door. Mr Rishworth was classified as a 'high risk' prisoner and, as such, was not allowed to share a cell. However, a senior prison manager assessed the situation and concluded that any intervention by staff might lead to a negative reaction and possible escalation of the situation. He decided to allow both men to remain in the cell, at least until the next morning, when they were due to go to court.
42. On 23 May 2017 at about 9.35am, two nurses examined Mr Rishworth before he went to court and deemed him unfit to attend. One of the nurses noted in the medical record that Mr Rishworth appeared to be under the influence of an illicit substance. He was unsteady on his feet, slurring his words, his eyes were bloodshot and pupils pinpoint. Mr Rishworth denied taking anything illegal and wanted to go to court. He said that his prescribed medication that he had

collected and taken earlier that morning made him drowsy. The nurses did not take or record any medical observations.

43. The nurses gave Mr Rishworth a few minutes to see if his condition improved but when it did not, they returned him to his cell. They told prison staff to contact them if they had any further concerns but no follow up plan was agreed or documented.
44. One of the nurses returned to the first night centre to see Mr Rishworth at about 11.30am, after a prison officer could not rouse him. When she arrived, she saw that Mr Rishworth was out of his cell, pushing a trolley containing his property. Although she still considered him to be under the influence, she thought his condition was much improved. Mr Rishworth was moving to another cell and refused to allow the nurse to examine him. A prisoner helped Mr Rishworth to load his property onto the trolley. He described Mr Rishworth as 'ok' but 'a bit the worse for wear'. He said that he was staggering a bit and his face and eyes were red. Mr Rishworth did not say he felt ill.
45. The nurse sent a request to healthcare staff to stop all of Mr Rishworth's non-essential medication for 24 hours, added him to the Integrated Drug Treatment Service ledger for overnight observation and asked a substance misuse nurse to assess him.
46. A prison officer who was working in the first night centre asked a nurse to come and see Mr Rishworth because he had questioned how he would collect his medication that afternoon. The officer told the investigator that although Mr Rishworth's speech was still a bit slurred, he appeared fine.
47. Mr Rishworth was moved from the first night centre to cell D4-14, a double cell (although he was the only occupant) on level 4, D wing. The move involved Mr Rishworth going up several flights of stairs from level 1 to level 4. A prisoner on level 3 said he saw Mr Rishworth from the observation hatch of his cell. He said that Mr Rishworth was clutching his chest and he heard him tell an officer that he needed an ambulance.
48. Another prisoner helped Mr Rishworth to take his property to his new cell. He described Mr Rishworth as 'a bit off it'. He said he asked Mr Rishworth a number of times if he was ok and each time he replied that he was tired. Mr Rishworth did not tell him that he was ill or that he needed a doctor or an ambulance.
49. Shortly after midday, a prison officer began unlocking the cells on the D4 landing to let prisoners out for lunch. When he got to cell 14 he opened the door and went inside. Mr Rishworth was lying on his bunk. The officer told him to go for lunch. He then left to unlock the remainder of the cells on the landing.
50. When the officer returned to lock the prisoners back in their cells, he saw Mr Rishworth still lying on his bunk. He asked him if he was getting up to eat but Mr Rishworth did not say anything, he just shook his head. The officer noticed that all of Mr Rishworth's property was still in bags and had not been unpacked.
51. The officer said he was not concerned as it was not unusual for prisoners to miss lunch, particularly if they had only recently arrived at the prison. He locked the

- cell door, then left to lock the remaining cells before returning to the movement office.
52. At 12.35pm, as part of a routine roll check, a prison officer checked Mr Rishworth through the observation hatch. She did not recall anything out of the ordinary.
  53. The officer did not see Mr Rishworth again until later that afternoon. At 3.45pm, she was standing on the D4 floor landing outside cell D4-05 when she heard prisoners shouting. She heard one of the prisoners say, 'Miss, come here, he's dying' and 'Come on miss, he's my friend and he's dying'. The officer ran to outside cell D4-14 where the prisoners were standing.
  54. The officer looked through the cell observation hatch and saw Mr Rishworth lying on the bottom bunk. She described his colour as strange. She did not have a radio so immediately shouted for staff to come and help.
  55. Several prisoners gathered outside the cell, shouting at the officer to open the door. One prisoner was clearly very upset and the officer described his behaviour towards her as aggressive. The officer did not open the cell door immediately as she was concerned that prisoners could push her inside and trap her in the cell before other officers got there.
  56. Another prison officer got to the cell within a few seconds and more officers arrived quickly afterwards. One of the officers radioed a medical emergency and asked healthcare staff to attend. In the confusion, this call incorrectly mentioned a ligature round a prisoner's neck. An officer opened the cell door and a custodial manager (CM) and an officer went inside. The remaining officers initially stayed at the door to prevent any prisoners from going into the cell.
  57. The CM and officer checked Mr Rishworth for a pulse and signs of breathing. They described his skin as blue/grey in colour and his lips as blue. The CM felt the back of Mr Rishworth's neck. It was warm but the rest of his body was cold. The CM started cardiopulmonary resuscitation (CPR) assisted by the officer.
  58. Two nurses arrived at the cell. They advised the officers to get Mr Rishworth off the bed and onto the floor where they continued CPR. A third nurse made her way to the cell but before she got there, one of the nurses directed her to collect the emergency medical resuscitation bag. Prison and healthcare staff continued to give CPR.
  59. The nurse returned with the emergency bag and another nurse attached defibrillator pads to Mr Rishworth's chest. She also radioed the control room to request an emergency ambulance. A nurse put an airway into Mr Rishworth's mouth and gave him oxygen. The defibrillator did not shock but advised continued CPR. Prison and healthcare staff took it in turns.
  60. Paramedics arrived at the cell at 3.56pm and took over Mr Rishworth's care from prison and healthcare staff. At 4.15pm they confirmed that Mr Rishworth had died.
  61. The police later found a mobile phone and inhalers that contained traces of cocaine in Mr Rishworth's cell.

## Contact with Rishworth's family

62. On 23 May at approximately 4.30pm, the prison appointed a family liaison officer (FLO). Mr Rishworth had previously named his mother as his next of kin and at about 5.30pm, the FLO and a senior prison manager left the prison to go to her home.
63. The FLO and senior manager arrived at the home address at about 6.25pm. There were several people outside. They confirmed their arrival with the prison control room but a member of staff told them that the police had advised not to enter the address without police support.
64. The FLO and senior manager went instead to the local police station to get more information. They eventually returned to the home address just before 9.00pm. Two police officers accompanied them to the area but kept a discreet distance from the address.
65. Mr Rishworth's mother invited the FLO and senior manager into the premises. She said that prisoners on the wing had already telephoned the family and told them about Mr Rishworth's death. There were also messages posted on social media. She asked why the officers had driven away earlier and the FLO explained that this was on the advice of the police. The FLO and senior manager offered their condolences and explained the procedures that would follow.
66. Mr Rishworth's mother said Mr Rishworth had telephoned her that morning and told her that he did not go to court because a nurse had decided that he was not fit. She said he told her that he felt unwell and had asked to see a doctor. (Mr Rishworth's prison phone record does not show any calls to his mother that day.)
67. The FLO and his deputy stayed in contact with Mr Rishworth's mother. On 26 May, the FLO returned Mr Rishworth's property to her.
68. Mr Rishworth's funeral was held on 14 June 2017. The prison contributed towards the cost in line with prison service policy.

## Support for prisoners and staff

69. After Mr Rishworth's 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. Two officers were unable to attend the debrief but confirmed that they had been offered support. Another officer did not attend the debrief and did not receive immediate support. He was contacted at home by a member of the care team later that evening.
70. The prison posted notices informing other prisoners of Mr Rishworth's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Rishworth's death.

## Post-mortem report

71. A post-mortem examination concluded that Mr Rishworth died from the effects of a combination of cocaine, synthetic cannabinoid use, diazepam, mirtazapine,

buprenorphine and pregabalin intoxication. (Mr Rishworth was prescribed mirtazapine and pregabalin.)

# Findings

## Clinical care

72. The clinical reviewer concluded that some of the care Mr Rishworth received at Leeds was of a good standard, being equivalent to that which he could have expected to receive in the community, but other aspects of his care less so.
73. On arrival at Leeds, healthcare staff completed an initial health screen that identified Mr Rishworth's medical conditions and medication but a full healthcare assessment did not take place. There was no discussion about his previous drug or alcohol misuse or consideration of the offer of a referral to substance misuse services. The deputy head of healthcare explained that the practice at Leeds is not to do a full health assessment for prisoners transferred in from other prisons because one has been completed at the previous establishment.
74. Prison Service Order (PSO) 3050, Continuity of Care, states that for a prisoner's first reception into custody, an initial assessment of the healthcare needs of all newly received prisoners of the healthcare team should be undertaken within 24 hours. Additionally, the National Institute for Health and Care Excellence (NICE) introduced updated guidance NG57 in November 2016. The purpose of this assessment is to identify any existing problems and to plan any subsequent care recognising the importance of continuity in the success of clinical interventions and treatment.
75. The deputy head of healthcare acknowledged that the procedure at Leeds is not best practice and said that Care UK are in the process of developing a revised reception screening tool to be used at all prisons where they provide healthcare. Although in the case of Mr Rishworth the initial assessment identified his previous medical conditions and medication, this might not always be the case. We agree with the clinical reviewer that a more robust process is needed. We make the following recommendation:

**The Head of Healthcare should ensure that all newly arrived prisoners have an appropriate health screen that reviews their medical history and identifies any outstanding appointments and relevant conditions in accordance with the standards of PSO 3050 and National Institute for Health and Care Excellence (NICE).**

76. Nurses examined Mr Rishworth each day to assess his fitness to attend court. On 23 May, two nurses correctly decided that he was unfit to attend court when he appeared to be under the influence of an illicit substance. The nurses recorded that he was unfit in the medical record but did not take or record any physical observations (pulse, blood pressure, temperature etc) to support their views.
77. The clinical reviewer considers that if the National Early Warning Score (NEWS – a system for assessing the severity of an illness) had been used, it would have indicated that more frequent reviews and assessments were required, particularly given the range of prescribed medication taken by Mr Rishworth and the potential impact of taking such medication with illicit substances. We agree with the clinical reviewer and make the following recommendation:

**The Head of Healthcare should review the assessment process used to determine if a prisoner is fit to travel outside the prison, for example to court, to ensure that a robust assessment is completed. The results should be recorded in the medical record to support clinical opinion and a nationally recognised assessment tool, such as NEWS, should be used.**

78. The clinical reviewer has made other recommendations about healthcare staff's knowledge of guidance about the appropriate use of CPR and the impact of the concurrent use of multiple medication and substance misuse. We do not repeat these in this report but draw them to the attention of the Head of Healthcare.

### **Emergency response**

79. Prison Service Instruction (PSI) 03/2013 requires Governors to have a two-code medical emergency response system that ensures an ambulance is called immediately when staff have serious concerns about the health of a prisoner. It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that access to both the prison and the individual prisoner is not delayed.
80. HMP Leeds has a two-level code system that differentiates between a blood injury and all other injuries. They use 'Code Red' for blood, burns and fractures and 'Code Blue' for symptoms including breathing difficulties, unconsciousness and collapse.
81. The issue of a medical emergency code should initiate several mandatory actions, which include the communication or control room automatically calling an ambulance straight away and the immediate attendance at the scene of the duty nurse together with the necessary equipment.
82. The first officer to respond to Mr Rishworth's cell did not carry a radio and shouted for staff to assist her. When other staff arrived, an officer radioed a 'medical emergency' but did not specify code red or code blue. In the initial confusion, the officer incorrectly mentioned a ligature around Mr Rishworth's neck.
83. Healthcare staff were at the cell very quickly but did not know the type of incident they were responding to and so did not bring the emergency resuscitation equipment. However, officers began CPR immediately when they entered the cell and when the first nurse arrived she radioed for an emergency ambulance and requested the emergency resuscitation equipment.
84. The clinical reviewer said it was unlikely that the short delay in calling an ambulance and the arrival of emergency resuscitation equipment would have affected the eventual outcome for Mr Rishworth. However, we are concerned that in other circumstances such a delay could be crucial. We make the following recommendation:

**The Governor should ensure that all staff are aware of PSI 03/2013 and understand their responsibilities during medical emergencies, and in particular, the need to use correct medical emergency codes to ensure that staff called to the scene bring the appropriate equipment and there are no delays in calling an ambulance.**

## Substance misuse

85. It is clear that Mr Rishworth died because he used illicit substances in addition to taking his prescribed medication. A prisoner told the investigator that Mr Rishworth might have swallowed drugs. He was not sure if Mr Rishworth was referring to himself or someone else. The investigation chose not to rely on this information because it could not be ascertained whether they were genuine reflections of what had happened and because of the limited information that he provided. We continue to be concerned about the availability of illicit drugs at HMP Leeds. The incidents where Mr Rishworth was suspected to be under the influence of drugs were dealt with in line with the prison's NPS policy, but it is hard not to conclude that the prison's demand and supply reduction policies have not been effective in reducing incidents of Illicit substance misuse including NPS. We make the following recommendation:

**The Governor should review existing policies and their implementation in light of Mr Rishworth's death and the findings of this investigation to ensure they are effective in reducing the supply of and demand for illicit substances.**

## Support for staff

86. After Mr Rishworth's death, a senior manager held a debrief for staff involved in the emergency response. This is good practice. However, it is unfortunate that neither the officer who was the first officer on scene, nor the CM and officer who gave initial first aid, could attend. We appreciate the difficulties and are satisfied that the officers received appropriate support. However, in future we would encourage senior managers, who conduct debriefs after such incidents do so at a time when the officers involved can attend.

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