

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Michael Olsen a prisoner at HMP Swaleside on 11 October 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.

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 Michael Olsen died on 11 October 2017 of morphine poisoning at HMP Swaleside. He was 54 years old. I offer my condolences to Mr Olsen's family and friends.

Mr Olsen had never been prescribed morphine so he clearly obtained this illicitly in prison. There was no indication that he had ever been seen under the influence of an illicit substance during his six months at Swaleside and no intelligence that he was using illicit medication. I am satisfied that, on that basis, staff could not have foreseen his death.

However, I am concerned that Mr Olsen was clearly able to obtain morphine illicitly in Swaleside and have recommended that more should be done to limit the supply and demand for illicit substances.

The investigation also found deficiencies in the roll check process and emergency response, which the prison needs to address.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman

June 2018

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Summary

Events

1. Mr Michael Olsen arrived at HMP Swaleside on 6 April 2017. He had been in prison custody since October 2014 and was serving a 14-year sentence.
2. On 11 October, at 7.20am, an officer conducted a roll check and saw Mr Olsen lying on his back in bed. At around 9am, the same officer conducted a second roll check and noted that Mr Olsen had not moved and looked asleep. Two hours later, he went to collect Mr Olsen for a key work session and noticed that he was still in bed. The officer entered Mr Olsen's cell, noticed that his leg was cold to the touch and called an emergency medical code. Staff responded and started cardiopulmonary resuscitation (CPR). A prison paramedic, who arrived within minutes, assessed that Mr Olsen was dead and asked staff to stop CPR. A prison GP pronounced Mr Olsen's death at 11.25am.
3. The post-mortem report concluded that Mr Olsen had died from morphine poisoning. He had never been prescribed morphine in prison.

Findings

4. Mr Olsen obtained morphine illicitly in prison. There was no evidence that he had ever been seen under the influence of illicit substances at Swaleside and there was no intelligence to indicate that he was using illicit medication. We are satisfied, on that basis, that staff could not have foreseen his death. Self-evidently, the prison needs to do more to reduce the supply and demand for illicit substances and address, in particular, the diversion and trafficking of medication.
5. We are concerned that the officer who performed the morning roll check did not check that Mr Olsen was alive and well.
6. There was a delay of five minutes in control room staff calling an ambulance after the emergency medical code had been called. Although this did not affect the outcome in Mr Olsen's case, it could be critical in future cases.

Recommendations

- The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication.
- The Governor should ensure that staff responsible for completing roll checks satisfy themselves that each prisoner is alive and well.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

The Investigation Process

7. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
8. The investigator obtained copies of relevant extracts from Mr Olsen's prison and medical records.
9. The investigator interviewed one member of staff by telephone on 29 November 2017 and another on 11 January 2018. He interviewed one member of staff at Swaleside on 15 February.
10. NHS England commissioned a clinical reviewer to review Mr Olsen's clinical care at the prison.
11. We informed HM Coroner for Mid Kent and Medway District of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator wrote to Mr Olsen's partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
13. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Swaleside

14. HMP Swaleside, on the Isle of Sheppey, is a long term category B training prison and houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. There is a 17-bed inpatient unit. Minster Medical Group provides GP cover from 9.00am to 5.00pm on Monday to Friday, while Medoc provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Swaleside was in April 2016. Inspectors reported that illicit substances were widely available in the prison, but suspicion tests were not being completed because of the redeployment of testing officers. They reported that the recently reconvened drug strategy committee produced a meaningful ongoing action plan to tackle drugs, but staff from key departments (including security) needed to improve their attendance at the meeting.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 30 April 2017, the IMB reported that there had been a major increase in prisoners being affected by drugs, often prescribed medication. They reported that trading of prescribed medication was made worse by a single hatch on healthcare being the main point of distribution and that they supported the Governor's request for a hatch on each residential wing.

Previous deaths at HMP Swaleside

17. Mr Olsen was the seventh prisoner to die at Swaleside since January 2017. There has been one death since. There are no significant similarities with the circumstances of the other deaths.

Key Events

18. On 6 October 2014, Mr Michael Olsen was remanded to HMP Belmarsh for grievous bodily harm and firearms offences. On 27 March 2015, he was sentenced to 16 years in prison and sent to HMP Thameside. In November, following appeal, his sentence was reduced to 14 years. Mr Olsen had alcohol misuse problems and mental health issues and was often subject to self-harm and suicide prevention measures, known as ACCT. In January 2015, he took an overdose of prescribed medication that he had stockpiled and attempted to hang himself. In July 2016, he overdosed on ramipril (high blood pressure medication) because he was upset with officers and wanted to kill himself. Mental health specialists and the complex care team at Thameside reviewed Mr Olsen frequently and, with support, his mood stabilised.
19. On 6 April 2017, Mr Olsen was moved to HMP Swaleside's psychologically informed planned environment unit (PIPE – a specifically designed environment where staff have additional psychological training to recognise the importance and quality of relationships and interactions). At an initial reception screen, a healthcare assistant noted that Mr Olsen suffered from high blood pressure and was not suitable for in-possession medication. She made a GP referral. On 10 April, a prison GP saw Mr Olsen for a review and recorded that he appeared alert and in a good mood.
20. On 17 May, Mr Olsen told a prison GP that he felt quetiapine (an antipsychotic medication) was causing him to gain weight. The GP noted that Mr Olsen was prescribed quetiapine and mirtazapine (an antidepressant) for low mood and requested a psychiatric medication review. The next day, a substance misuse worker saw Mr Olsen for an initial substance misuse assessment and completed an alcohol specific care plan. Mr Olsen stated that he wanted to focus solely on alcohol as he had not used illicit drugs for over 20 years. She recorded a review date of 6 July, but there is no record a review took place.
21. On 31 May, a prison GP saw Mr Olsen for a review and noted that a consultant psychiatrist had advised to replace his morning dose of quetiapine with citalopram 10mg (an antidepressant) and to continue with mirtazapine. The GP explained the side effects associated with citalopram to Mr Olsen and he agreed to start the medication. Two weeks later, Mr Olsen had a mandatory drug test (MDT) and tested negative. On 28 June, a healthcare assistant reviewed Mr Olsen's in-possession medication risk assessment and assessed him as suitable. Two days later, Mr Olsen told a prison GP that his mood had improved and that he had not had any thoughts of self-harm or suicide. The GP recorded that he looked well and agreed to change his medication to weekly in-possession.
22. On 13 July, a consultant psychiatrist recommended GPs reduce Mr Olsen's mirtazapine to 30mg, with a further reduction to 15 mg, in two weeks. A prison GP saw Mr Olsen for a review the next day, recorded that his mood appeared stable and reduced his mirtazapine accordingly. The psychiatrist monitored the reduction of Mr Olsen's mirtazapine over the next five weeks and considered it reasonable to continue despite him reporting feeling tired. On 30 August, Mr Olsen told a prison GP that he felt fatigued and lethargic having stopped mirtazapine. The GP requested a series of blood tests.

23. Over the next four weeks, Mr Olsen participated in workshops and key work sessions and did not report any thoughts of self-harm or suicide. There is no intelligence to suggest that he was taking non-prescribed medication or that he presented as under the influence of illicit substances. He did however continue to report ongoing tiredness to prison and healthcare staff.
24. On 27 September, a consultant psychiatrist saw Mr Olsen for a review and noted that his mental state remained stable. Mr Olsen reported sleeping too much and the psychiatrist said that he would ask GPs to reduce his evening dose of quetiapine from 150mg, to 100mg, and see him in four weeks. On 9 October, a prison GP saw Mr Olsen for a medication review and noted that he reported a persistent cough. The GP checked Mr Olsen's most recent blood test results, dated 12 September, and a chest X-ray, taken in May, which was normal. He prescribed amoxicillin (an antibiotic) to treat a chest infection and reduced Mr Olsen's evening dose of quetiapine, as advised.

Events on 11 October

25. At 7.20am, while conducting a morning roll check, an officer looked through the observation hatch on Mr Olsen's cell. He told the investigator that he saw Mr Olsen lying on his back, but did not try to get a response from him or check for breathing. At about 9am, after the main prisoner movement, the officer looked through Mr Olsen's observation hatch to conduct a roll check and noticed that he remained in the same position. He told the investigator that he could not see Mr Olsen's face, but from what he saw, he looked asleep. The officer moved onto the next cell.
26. At around 11am, a forensic psychologist approached an officer during the main unlock and asked to see Mr Olsen for a key work session. The officer went to Mr Olsen's cell, looked through the observation hatch and noticed that he was still in bed. He entered the cell calling out Mr Olsen's name and tried to rouse him by touching his leg, which was cold. The officer asked the psychologist to alert nearby staff and, at 11.12am, he called an emergency medical code blue (which indicates that a prisoner is unconscious or has difficulty breathing). Another officer responded immediately, checked for Mr Olsen's vital signs and noted that he was pale and very cold. In the meantime, two prison managers arrived and started cardiopulmonary resuscitation (CPR).
27. A few minutes later, a prison paramedic assessed Mr Olsen and established that rigor mortis was present. He considered that he had died and asked a prison manager to stop CPR. Staff called for an ambulance, but stood it down after they were informed that a prison GP could confirm death. At 11.25am, a prison GP pronounced that Mr Olsen had died.

Contact with Olsen's family

28. At 11.30am, the prison appointed an officer as family liaison officer. The officer and the prison Governor left for Mr Olsen's partner's address at 2pm and arrived at 3.30pm. They broke the news of Mr Olsen's death and offered their condolences and support.

29. The officer provided ongoing support to Mr Olsen's partner until his funeral, which took place on 7 November. The prison contributed towards the cost, in line with national policy.

Support for prisoners and staff

30. After Mr Olsen's death, a prison 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.
31. The prison posted notices informing other prisoners of Mr Olsen'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 Olsen's death.

Post-mortem report

32. The post-mortem report identified toxic levels of morphine in Mr Olsen's blood and found that he had died from morphine poisoning. Quetiapine, citalopram, mirtazapine and low levels of alcohol were also identified. The report noted that morphine poisoning involves suppression of the respiratory drive, causing the deceased to lapse into coma from reduced consciousness.

Findings

Clinical care

33. Mr Olsen had a history of self-harm and mental health issues that had stabilised in the months leading up to his death. Prison GPs liaised with mental health specialists who reviewed Mr Olsen frequently and recommended appropriate changes to his psychiatric medication. Healthcare staff often asked Mr Olsen about his mental wellbeing and there is no evidence that he ever presented as under the influence of illicit substances or that he reported concern about his drug use. The clinical reviewer considered that the prison's mental health team assessed Mr Olsen regularly and that there was no indication in his electronic medical record to suggest he presented at risk of self-harm or suicide.
34. We are satisfied that Mr Olsen received a good standard of clinical care at Swaleside, equivalent to that which he could have expected to receive in the community.

Illicit drugs

35. The post-mortem gave Mr Olsen's cause of death as morphine poisoning. The drugs quetiapine, citalopram and mirtazapine, as well as a low level of alcohol were also found in his blood. Mr Olsen's mirtazapine prescription was stopped for at least a month before he died and he was not prescribed morphine at Swaleside. We conclude therefore that Mr Olsen had obtained mirtazapine and morphine illicitly.
36. Swaleside's Drug Ingress Policy for 2017, states that drugs including heroin cannabis and prescribed medications, particularly mirtazapine, were all readily available on the wings. To tackle the availability of illicit substances entering the prison the policy focuses on drug dealing, visits, drones, packages over the wall and mail. The policy does not contain any reference to the risks presented by diverted medication and methods to reduce their supply. During interview, the head of security told the investigator that he did not know of a local policy for preventing prisoners from diverting their prescribed medication. However, he said the prison has a system in place to ensure that healthcare staff issue medication to one prisoner at a time from an enclosed hatch on the wing, with an officer present.
37. The Head of Security told us that Swaleside has introduced a dedicated search team and that searching is primarily intelligence led. He said that because of this, prisoners who are well behaved and discreet are less likely to be searched. Although Mr Olsen had used illicit drugs and overdosed on prescribed medication in the past, there was no intelligence to suggest that he was using illicit drugs at Swaleside.
38. The presence of non-prescribed drugs in Mr Olsen's blood clearly suggests weaknesses with the prison's drug supply and demand reduction strategy. Specifically, while we recognise that the prison's Drug Ingress Policy is relatively detailed, we are concerned that the policy does not cover the risks from diverting prescribed medication and that there is not a separate policy to cover this. We

consider that further work is required to reduce the availability of illicit drugs and diverted medication.

39. We make the following recommendation:

The Governor should ensure that there is an effective supply and demand reduction strategy to reduce the availability and use of illicit drugs and diverted medication.

Roll check

40. The purpose of a roll check is to ensure that all prisoners are accounted for, but also to check that they are alive and well. When an officer carried out a roll check at around 7.20am, he noted that Mr Olsen was in his cell, but he did not check for signs of life. The officer told the investigator that his understanding of the roll check procedure at that time was to check prisoners had not escaped. He said that he would only try to get a response from a prisoner and check for signs of life if they were subject to ACCT procedures.

41. We are concerned that the officer missed a second opportunity to check on Mr Olsen's welfare when conducting a further roll check at around 9am. The officer told us that Mr Olsen appeared asleep, although he could not see his face and did not attempt any form of interaction. He said that he did not have any concerns about Mr Olsen's wellbeing, as he often slept through the morning and had recently complained about a change of medication making him sleep a lot.

42. While we cannot be sure whether more thorough checks on Mr Olsen's wellbeing at 7.20am and 9am would have affected the eventual outcome, it is possible they may have done. We make the following recommendation:

The Governor should ensure that staff responsible for completing roll checks satisfy themselves that each prisoner is alive and well.

Emergency response

43. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Swaleside's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

44. We are satisfied that the officer responded quickly when he found Mr Olsen unresponsive and that he used an appropriate emergency medical code. Statements written by staff involved in the emergency response state that the code blue was called at 11.12am. However, an ambulance was not called immediately. Despite, the control room log showing that an officer called an ambulance at 11.12am, the ambulance log states they received the call at 11.17am. At interview, the officer told the investigator that he used his wrist watch to check the time instead of the control room clock and that the time may have been incorrect. We consider that the ambulance log is the more reliable

and we conclude therefore that there was a delay of five minutes between the calling of the code blue and calling for an ambulance.

45. While the immediate calling of an ambulance would not have changed the outcome for Mr Olsen, in other emergency situations it could be crucial. We therefore make the following recommendation:

The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

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