

**INVESTIGATION INTO THE DEATH OF A MAN AT HMP HULL ON 18 MARCH  
2005**

**REPORT BY THE PRISONS AND PROBATION OMBUDSMAN FOR ENGLAND  
AND WALES**

**January 2006**

This is the report of my investigation into the circumstances of the sad and untimely death of a man in HMP Hull. He died as a result of taking heroin that he had obtained while in prison.

The man's family is understandably devastated by the loss of this popular and likeable young man and I offer my sincere condolences to them. I know that the investigation team have already expressed their condolences to his family, and I hope that this report will answer their concerns.

I have made recommendations in the report to tackle the issue of drugs within prison, record keeping and the notification of families of prisoners following a death. I am happy to report that all of my recommendations have been accepted and HMP Hull has drawn up an action plan for their implementation.

I appointed two colleagues to lead the investigation on my behalf. I am grateful to the individuals and agencies who assisted my investigators and, in particular, to a Principal Officer, who was a most helpful liaison officer.

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

**STEPHEN SHAW CBE  
PRISONS AND PROBATION OMBUDSMAN**

**January 2006**

## **CONTENTS**

Summary	4
The investigation Process	6
Information about the man	7
HMP Hull	8
The events leading up to the death of the man	9
Reports by the Clinical Adviser	13
Issues considered during the investigation:	
Self harm and suicide issues	14
Drugs issues	15
Other issues	17
Conclusions and Recommendations	19

## SUMMARY

- 1 The man was 24 years old when he died in HMP Hull on 18 March 2005. He died of respiratory failure as a result of taking heroin. He had also taken cocaine and some prescribed drugs.
- 2 The man was arrested on 24 December 2004 for burglary offences and, from that date until his death, he was held at both HMP Hull and HMP Doncaster. Following his arrest, whilst held in police custody, the man cut his wrists and was placed under close observation. As a result, when he went to Hull three days later a 'self harm at risk' form was opened and staff monitored the man's safety. He soon progressed onto normal conditions, and he dismissed the self-harm incident as an over-reaction to his arrest. On subsequent occasions in January and February 2005, both prisons again placed the man on self-harm at risk forms when he felt depressed.
- 3 In January, whilst at Hull, the man was suspected of trying to obtain double his prescribed medication. He had previously suffered a back injury from a road traffic accident and was frequently prescribed painkillers. He was also prescribed anti-depressant tablets on occasions, and there is some evidence from other prisoners that the man used the medication as a trading currency within the prison. There is also evidence that he had grown dependent on the painkillers. A medical screening on 13 January identified the back injury but did not find any substance abuse issues.
- 4 On 23 February, the man approached a Senior Officer (SO) to request a move from the wing. He told the SO that other prisoners had taken his medication from him, but he would not identify them. The man was allowed to move wings, although three days later he was transferred to Doncaster. His time at Doncaster was relatively uneventful and, apart from a short spell of depression, the man seemed settled. His attitude was described as polite and he gave staff no cause for concern.
- 5 On 15 March, the man appeared at Hull Crown Court and was then transferred back to Hull prison. This was against his wishes as he preferred to return to Doncaster. He was joined in cell A5-10 at Hull by another prisoner.
- 6 The cellmate described the man who died as frequently being out of his cell trying to obtain drugs from other prisoners. The wing is a reception point for new prisoners and, according to the cellmate, some of the new prisoners brought drugs into the prison. He further stated that the man obtained some crack cocaine and had intended to obtain some more.
- 7 Crack cocaine had in fact been found on the wing the day prior to the man's death in the possession of two other prisoners. All three men have spoken

- about the availability of illegal drugs on the wing, but all deny supplying them to the man who died.
- 8 On 17 March, the man and his cellmate watched television and drank tea. During the night the cellmate shook the man because he was snoring loudly. When he got up at 7:45am, he discovered that the man had died. He was understandably shocked by the discovery and immediately rang the cell bell. An officer, who was unlocking prisoners for exercise, opened the door and let the cellmate out of the cell. He then attended to the man but knew immediately that he had died. A prison doctor later formally pronounced death.
  - 9 The duty Governor took charge of events and the cell was sealed to protect it until the police arrived. Support was provided to prisoners and staff who were affected by the death. A police officer was later asked to attend at the family home and inform the family of the sad news.
  - 10 It seems that the man had willingly taken the drugs that ultimately killed him. The importation of drugs into prison creates a problem for the prison authorities and lessons can be learned from this waste of a young life.
  - 11 Post mortem examination and toxicology reports conclude that the man had taken both illicit and prescribed drugs in the time before his death and that he died due to respiratory failure as a result of taking heroin. Cocaine, which had also been found in his body, may well have contributed, but heroin appeared to be the main substance causing death. Care records from the practice in Hull where the man was a patient refer to reported symptoms of heroin withdrawal in November 2004.

## THE INVESTIGATION PROCESS

- 12 The investigators visited Hull on 24 March and were briefed by a senior Governor and a Principal Officer, who also acted as liaison officer. A large number of records were examined which detailed all aspects of the man's time in both Hull and Doncaster prisons.
- 13 The investigators maintained a close liaison with the Police investigation and took care that the criminal investigation was not compromised.
- 14 On 16 May, a nurse manager at a nearby Primary Care Trust (PCT) provided a detailed summary of the major events in the man's medical care whilst he was in custody. On 13 June, the post mortem and toxicology reports were received. On receipt of the post mortem a further report was commissioned from the PCT. This second report, by a clinical adviser, examined the man's clinical management in comparison with normal NHS Primary care provision and the circumstances of his death. The clinical adviser's conclusion was that at times the man's recorded clinical care was not optimal by NHS standards though he added that NHS care itself frequently falls below optimal standards.
- 15 The investigators visited the man's cell on A Wing and interviewed the cellmate who discovered his death. Prison officers involved in the immediate aftermath were also interviewed.
- 16 The man's family expressed their concern in the local newspaper that his death appeared to be drug related, which has been confirmed by my own investigation. Details of the prison's drug policy were obtained and the investigators spoke at length with the governor responsible for implementation of the policy.
- 17 One of my Family Liaison Officers contacted the man's family to establish whether they wished to raise any issues. In a subsequent meeting on 19 April, they spoke of the apparent ease with which illegal drugs were allowed into the prison. They were also concerned by rumours that another prisoner had contaminated the drugs before passing them to the man. Two prisoners, who had been discovered with illegal drugs, were later interviewed.
- 18 The investigation team have been contacted by a solicitor acting for the family, and have provided copies of the custody record and self-harm at risk record relating to the man.

## **INFORMATION ABOUT THE MAN**

- 19 The man was 24 years old when he died. He was born on 26 September 1980 in Hull, and lived in the city all his life. He and his partner had two young children, aged two and four years old. The man had a close relationship with his parents, who are separated. He had been convicted mainly of offences of dishonesty, the first offence occurring in 1997. The man had been known to take crack cocaine. Except for back pain from a road traffic accident, his health was generally good.
  
- 20 After his arrest in December, the man attempted to cut his wrists but later dismissed this as due to frustration because his medication had not been prescribed.

## **HMP HULL**

- 21 HMP Hull was opened in 1870 and is now a Category B local prison serving courts in East and North Yorkshire and North Lincolnshire. Hull receives prisoners, such as the man, directly from court. A major expansion programme, completed in late 2002, added 356 places to the prison's operational capacity (the maximum number of prisoners who can be held) and a further 40 places were added in March 2004. The certified normal accommodation is 812 and the operational capacity is now 1,071.
- 22 The Health Care Centre (HCC) at the prison is a new purpose built two-storey building, which opened in April 2003. The HCC provides 24-hour nursing care with the in-patient unit being located on the upper level of the building.
- 23 Her Majesty's Chief Inspector of Prisons (HMCIP) inspected the prison in 2004. The aspects of the inspection which relate to the prison's Drug Strategy have been examined in detail and form part of this report.

## EVENTS LEADING TO THE DEATH OF THE MAN

- 24 The man was initially arrested by the police over the Christmas period in 2004. Whilst in police custody he cut his wrists, although not seriously. He later dismissed this as “a stupid thing to do.....a one off,” saying that it was because the police medical officer refused to prescribe some painkillers. He was remanded to Hull prison until 13 January when he re-appeared at court. On his return to Hull later that day, the man stated that he had no problems and said that he was not suicidal. He had previously been involved in a road traffic accident and as a result suffered pain to his back for which he needed painkillers.
- 25 At the first health screening the same day, the man spoke about his back pain and his prescription for Kapake (a painkiller). However, his observations record that the man “appears fully mobile. No problems observed re lumber discomfort”. The man was recorded as not having used any drugs or other substances with an added comment on the health screen report that he had spent time in custody at Hull and had only been released that day.
- 26 Two days later, on 15 January, there was a minor incident when the man received two separate warnings from an officer for being at the doors of other prisoners’ cells without permission. As a result, his television was removed for 28 days. A subsequent entry in his record indicated that the prison’s Incentives and Privileges policy had been misinterpreted, and the TV could only be withdrawn for 14 days.
- 27 Following this incident, the man told prison staff that he was having suicidal thoughts and a self harm at risk form was opened. It was closed three days later on 18 January.
- 28 The remainder of the man’s stay in Hull was largely uneventful, although he did complain of anxiety and depression. He was always keen to obtain medication for his back pain, depression and to help him sleep. There is some evidence to support the view that he had differences with some other prisoners. On 29 December 2004 he received a note from another prisoner, warning about the possibility of violence. The names of two cousins, mentioned in this note, who posed a potential threat to the man have not been established. Nonetheless, the man who died seemed to be popular with staff and prisoners alike.
- 29 In the week of 13 February, an intelligence report states that the man had twice tried to obtain a double prescription of medication, by telling healthcare staff that he had not had his previously prescribed painkiller tablets.
- 30 On 23 February, an SO responded to a request from the man to be moved from his current location on C wing. The man told the SO that his prescribed medication had been taken from him by other prisoners, but he would not identify them. He was moved to D wing and remained there until 26 February

- when he was transferred to Doncaster. On that date Doncaster requested a 'one for one' prisoner exchange. Doncaster supplied the transport, on a Saturday, for the movement to take place. This suggests they were more anxious to transfer their prisoner than Hull were to move the man who died.
- 31 The man remained at Doncaster between 26 February and 15 March, and his stay appears to have been quite positive. A Self Harm at Risk Form (F2052SH) was opened when he arrived. This was a precautionary measure because Doncaster had information that the man had cut his wrists nine months previously. He said he had no current thoughts of self harm or suicide. The High Risk Assessment Team at Doncaster considered the man's case on 28 February and decided to close the F2052SH. The record noted that he was "coping all right on the wing and mixes on association. He is eating okay. He has no history of drug or alcohol abuse."
- 32 Staff described the man's attitude as polite and pleasant to staff and other prisoners. He was located on a wing where prisoners are encouraged to sign up for voluntary drug testing, although no tests appear to have been carried out during his short time at Doncaster. He received some medication for depression, but was otherwise fit and healthy. When he left Doncaster to go to court, the man asked if he could return there instead of going back to Hull. He said that his request was because he had been involved in an altercation at Hull.
- 33 Unfortunately for the man, his request was not granted and after appearing in court on 15 March he returned to Hull. When he appeared at court in Hull there was no indication on his documents, especially his Prisoner Escort Record, that he should return to Doncaster. Staff from Global Solutions, the escort company manning the court, took him to HMP Hull because that is the prison which serves Hull Crown Court. There is no evidence that managers at Hull were determined to exclude the man and no steps were taken to transfer him to Doncaster again.
- 34 The last three days of the man's life were spent on A wing, which is used for prisoners new into the prison. No particular concerns for the man's safety were expressed when he returned. A prison officer completed a routine Cell Sharing Risk Assessment of his suitability to share a cell, and decided that the man was at no risk to himself or others. The officer knew him as a popular, if sometimes loud, individual and described him as jovial with no worries or health problems. Prisoners new into Hull undertake an induction process, but because the man had been to Hull previously he only undertook a partial induction.
- 35 The man who died shared a cell with another prisoner. They had known each other outside prison, but not well. According to the cellmate, the man spent a significant amount of time out of the cell going to the cell doors of other prisoners and continually trying to obtain drugs. The cellmate explained that people arriving at the prison after arrest by the police are more likely to be concealing drugs. He said that because A wing is the reception wing for new

- prisoners drugs are widely available. Some support for his statement is contained in the account of another officer who, during the afternoon of 17 March, discovered crack cocaine in the possession of two other A wing prisoners.
- 36 The cellmate said that the man managed to obtain crack cocaine from another prisoner in the exercise yard during the morning of 17 March. He said that the man smoked it in their cell during the morning, and said that the man intended to get some more. The cellmate was not certain whether he managed to do so. He said that the man usually obtained drugs, such as crack cocaine, by trading drugs prescribed either to him or to other prisoners. Also he said that some tablets had been left in the cell by a previous occupant.
- 37 Other prisoners also spoke to the investigators about the drug culture in the prison. The two prisoners found with crack cocaine were subject to an adjudication (disciplinary charge). It seems likely that the man obtained his drugs from someone on the wing, but no reliable information about their source has been given to the investigation team. The cellmate and the other two prisoners deny giving drugs to him, and all of them have their own theory about how the man managed to obtain the drugs.
- 38 On the evening of 17 March, the cellmate said that the man seemed more like his old self. He watched television and they drank tea together. Later, the cellmate heard him shouting to other prisoners through the window. Between midnight and 2:00am, the cellmate said he shook the man because he was snoring. He said the man was awakened by being shaken, but immediately drifted back to sleep.
- 39 The following morning, the cellmate got up and made tea for the man and himself. He then approached the man and noticed that he was blotchy and felt cold to the touch. He said he tried unsuccessfully to find his pulse, and then realised that the man had died. The cellmate rang the cell bell to call staff.
- 40 At approximately 8:45am, a regular A Wing officer was unlocking cells to carry out a fabric check (a check on the locks and bars). He heard the bell from A5-10 and responded to it. He immediately opened the door as the cellmate was screaming that the man had died. The officer asked the cellmate to sit outside the cell while he went to look at the man.
- 41 The officer saw the man lying in the bottom bunk bed, facing towards the cell door. He appeared to be asleep, except that his skin was purple/blue in colour. The officer felt for the man's pulse and instinctively knew that the man had died. He knew that a prison doctor was on his morning visits and, instead of using his radio, he ran to the Healthcare Centre and requested that the doctor come to the cell. He estimated that the doctor arrived about 40 seconds later and this is confirmed in the interview with another officer. The doctor pronounced that the man had died at 8:50am.

- 42 Steps were taken to provide security and privacy to the scene of the death and to inform the relevant staff. The duty governor was informed and came to the cell to take charge. The cell was sealed pending the arrival of the police. The cellmate, who was shocked by the man's death, was supported, as were other prisoners deemed to be at risk. Later, the cellmate was moved for his own safety to the Segregation Unit as rumours began to circulate that he had supplied drugs which killed the man.
- 43 The police arrived and commenced enquiries into the death under the direction of a Detective Inspector from Humberside Police. A police officer later went to the man's home to inform his mother and partner of his death. The prison subsequently arranged to pay some of the funeral costs.
- 44 Staff at the prison who had been involved were provided with care and support to help them come to terms with events.

## REPORTS BY THE CLINICAL ADVISER

- 45 A further report was requested from the local PCT once the post-mortem report with its reference to a heroin overdose had been received. This second report was prepared in November 2005 by the doctor who is Clinical Adviser (Medical) for the PCT. The clinical adviser criticises the way in which the man's case was managed when he complained of depression at Doncaster. He also observes that the management of the man's chronic back pain was not optimal as compared with normal NHS care.
- 46 The clinical adviser writes that it is not clear whether the man had a history of substance misuse. He adds:  
"The fact that the man may have been an infrequent and inexperienced drug user with low tolerance may have considerably increased his risk of death from overdose."
- 47 In the summary at the end of his report the clinical adviser writes that at times either the clinical care or at least the recorded clinical care given to the man was not optimal by NHS standards. He notes that the records written by the doctor are poorly legible, the author is not clearly identified "and in all they would not be defensible in terms of the quality of recording of the history, examination and management plan."
- 48 In January 2006 the clinical adviser was able to obtain the man's Primary care records. These records provide information about contacts between the man and his GP. The clinical adviser then wrote to my investigator about one reference to heroin use in the Primary care records. He notes:  
"There is a computer based record of a telephone consultation on 11.11.2004 with a doctor at the man's GP practice relating to reported symptoms of heroin withdrawal. The man who died told the doctor that he had used heroin up to three days previously. The doctor gave advice regarding the appropriate way to seek further help, in this case he was advised to see another doctor in the practice at that time who was experienced in dealing with substance misuse. Some mild symptom relief was prescribed for the withdrawal symptoms."
- 49 The reported heroin use does not appear to have been confirmed by urinalysis and the telephone advice does not appear to have been followed.
- 50 In summary, there is little additional information in the primary care notes, there is a suggestion of previous heroin use based on a telephone discussion but not confirmed by urinalysis."

## **ISSUES CONSIDERED DURING THE INVESTIGATION**

- 51 There are several issues concerning the man's care and custody, and two in particular deserve to be examined in greater detail. These relate to self harm issues identified while he was in prison, and the availability of illegal drugs which ultimately proved fatal for the man.

### **Self Harm and Suicide Issues**

- 52 When the man was arrested by police in December, he had scratched his wrists. As a result, he was placed under closer supervision when he arrived at prison. He later told prison officers that the injuries were an overreaction to his arrest, and that he was no longer at risk of suicide or self harm. It seems that he disliked being closely supervised and preferred to be treated like other prisoners.
- 53 However, on 15 January 2005 the man expressed further feelings of self-harm and depression. His feelings appeared following a disciplinary matter and his television being withdrawn under the Incentives and Privileges scheme. They were dealt with appropriately and he was offered help and support by the prison. A form F2052SH was opened and, for the next three days until 18 January, he was closely observed by staff. There was no medical confirmation that the man was unwell, although he did complain that he had been sick and might have suffered a fit. By 18 January, the man said that he felt much better. Following a review, the F2052SH was closed and he returned to normal conditions in the prison.
- 54 When the man transferred to Doncaster on 26 February, the F2052SH was reopened. This appears to have been due to the incident when he was in police custody that had been recorded as a suicide attempt.
- 55 Whilst there is some evidence that the man did, from time to time, feel depressed, there is nothing to suggest that he ever intended to take his own life or cause himself serious injury. When he expressed any intention to harm himself or said that he felt depressed, the prison authorities acted appropriately, considered any risk to him, and correct procedures were properly followed.

## Drugs issues

- 56 There is evidence that the man acted on occasions to obtain prescribed or illicit drugs. He frequently referred to a back injury sustained in a road traffic accident for which he was prescribed pain killing tablets, either diclofenac, kapake or co-codomol.
- 57 The officer who was urgently directed to the man's cell on the day he died states that, in January, the man appeared desperate to obtain prescribed drugs. Later that month, there is a medical record entry that he had become dependent on painkillers. He continued, however, to receive medication for pain relief and depression whilst he was at Doncaster, and on 9 March was given his last prescription of trazadone and co-codomol.
- 58 There is evidence from other prisoners and an unsubstantiated intelligence report that the man used and traded drugs while he was in prison. He had apparently used crack cocaine before being remanded in prison, but he had no drug related convictions and he did not say to staff that he was using drugs in the community.
- 59 The toxicology report finds that, when he died in March, the man had taken heroin, cocaine and several other drugs, some of which may have been prescribed to him. As he had been in prison custody for the previous three months, I believe that the illegal drugs were obtained in either Hull or Doncaster prisons. It is more likely that Hull was the source of the drugs. At Doncaster the man was on a wing where prisoners were encouraged to sign up for voluntary drug tests. His time at Doncaster was uneventful. The man transferred from Doncaster to Hull on 15 March. It is probable that he obtained and used heroin very shortly before his death. It is unusual for prisoners to hide drugs about their person or in their cell for substantial periods of time. The danger of detection by prison staff or robbery/theft by other prisoners is too great.
- 60 At Hull the man was on a wing for newly received prisoners where men arrived in large numbers each day from the outside community. The Intelligence Officer's assessment in response to a Security Information Report written by a SO on 18 March was that there were "numerous reports of drugs on A Wing."
- 61 Throughout this investigation, the man's family have expressed their concern and anger at the apparent ease with which prisoners can obtain dangerous drugs. This critical issue has been raised with the Governor at Hull. The prison's drug strategy policy, which was written and implemented in August 2004, has also been examined in detail.
- 62 A governor was appointed as Drug Strategy Co-ordinator (DSC) in January 2005, and is responsible for the policy. He made some minor changes to the policy, but none that affected its overall effectiveness. Essentially, the policy has objectives including helping prisoners to resist using drugs, overcome their addiction and stifle the availability of drugs in the prison. The two issues that

- concern this investigation are the availability of drug services to help the man with any drug related problems, and the measures to stop drugs coming into the prison.
- 63 During an inspection of Hull in March 2004 by Her Majesty's Chief Inspector of Prisons (HMCIP), certain aspects of the drug policy were criticised. Whilst the policy was said to be clear and based on national and operational instructions, it "lacked a clear focus as to how the relevant procedures were managed and co-ordinated". In particular, HMCIP observed that the policy "did not clearly differentiate between the treatment needs of the prison population; for example, the specific needs of young adults with substance misuse problems were not addressed". In response, the DSC has stated that the prison is now actively engaged in producing a policy to deal with this omission and it will be completed by the end of 2005.
- 64 The DSC also informed my investigators that there are two substance misuse nurses employed by the prison to deal with the needs of any prisoner found to have a drug misuse problem. Prisoners can refer themselves to the service. The prison also has a Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team which operates with a community based drug agency to provide drug treatment to prisoners. Currently the CARAT team has ten staff and they are soon to be joined by two more.
- 65 Other criticisms in HMCIP's report include a lack of structured training and development for staff in drugs issues. I am not able to comment on the extent to which the recommendation has been acted upon. However, the investigation team found evidence of wing officers' vigilance about drugs. There was certainly no evidence that staff "turned a blind eye" to drugs. It is difficult to ask officers to take on the mantle of trained drug workers. However, I would like to see more staff aware of the wider issues of drug misuse such as when prisoners are found in possession of illegal drugs or they try to obtain more than their prescribed dose of medication.
- 66 Prisoners new to Hull are 'screened' for drugs, as the man was when he arrived. The 'screening' consists of a single question to the prisoner about their substance use during the past month. HMCIP commented that, whilst all prisoners were screened, not all were tested for drugs. The DSC states that it is not possible to test all prisoners for drugs on reception, but those who give cause for concern, and agree, are routinely tested.
- 67 The prison and PCT hope to publish a joint policy regarding prescribing medication for prisoners. At the time of the man's imprisonment, all decisions rested with the doctor. The doctor would prescribe medication, and also decide whether the prisoner could have it in his own possession or was required to take it under supervision. The decision about holding medication would depend on various factors, such as whether it was a controlled or dangerous drug, whether the prisoner could be subject to 'taxing' or having it taken off him by other prisoners, or might use it himself as currency.

- 68 The PCT and prison would like to achieve a system that mirrors the way in which medication is dispensed in the community. However, as already indicated, there are some difficulties and currently individual decisions are made about the arrangements for each prisoner.
- 69 The policy about drugs entering the prison emphasises the risk of visitors bringing them in and provides clear instructions for staff dealing with the problem. This issue quite rightly causes concern, and the policy is right to highlight the risk. However, it has become apparent in the course of this investigation that appreciable quantities of drugs may be brought into the prison by new prisoners. The policy fails to grasp this issue in the same way. This is a difficult problem for the prison and one that should be tackled jointly with healthcare and the police. It should be prioritised, as drugs continue to be taken into the prison and, some prisoners would say, arrive in large amounts.

### **Other Issues**

- 70 The Prison Service Order 'Follow Up to Deaths in Custody' instructs that, unless there are very good reasons not to do so, the notification of a death to the next of kin should be conducted by the prison Governor or deputy. In this case, although the man's family lived only a short distance away, the police went to inform the family. I am critical of this decision and cannot see any reason why the prison acted in this way. I understand that the prison was uncertain of the family address, but I cannot see why the details of the address were not simply obtained from the police. However, I am aware that, after the family were informed, a senior governor maintained regular contact with the man's father.
- 71 The initial clinical review states that, in relation to healthcare records, "the standard of record keeping could be improved upon in respect of each entry being timed, dated and signed with printed name and designation, entries require being in sequence and the use of abbreviations should be discouraged".
- 72 The further review supplied in November 2005 by the clinical adviser criticises some aspects of the clinical care the man received during his time in prison. The clinical adviser notes that the man told the prison doctor at Doncaster that his father had committed suicide and his mother was suffering from cancer. The clinical adviser comments that the man's depression and bereavement were not managed adequately. I am happy to report, however, that the information given by the man to the doctor at Doncaster was incorrect. The man's father met my investigator and FLO in January 2006 and soon afterwards the family solicitor assured my investigator that his mother is not suffering from cancer.
- 73 The letter subsequently written by the clinical adviser in January 2006 refers to reported symptoms of heroin withdrawal in 2004. On 11 November 2004 the man told one of the doctors with whom he was registered in Hull that he had

symptoms of heroin withdrawal after using heroin up to three days previously. It is therefore possible that the man had used heroin in the community prior to his reception into prison in late December 2004. The clinical adviser concludes his letter with a careful summary, as follows:

“There is a suggestion of previous heroin use based on a telephone discussion but not confirmed by urinalysis.”

## **CONCLUSIONS AND RECOMMENDATIONS**

- 74 The man died because he obtained and used heroin in prison. He also used cocaine and some prescribed medication. The evidence appears to suggest that the man was a willing participant in this drug taking, and it seems that he would actively seek drugs from other prisoners. However, Hull's duty of care includes, so far as possible, maintaining an environment where drugs are not freely available and where prisoners can live, should they wish, free from the constant temptation of drugs.
- 75 To say the least, this is a very difficult task. The threat from drugs is ever constant and the means by which they enter prison forever changing. The tactics needed to counter this need to be equally resourceful and innovative.
- 76 Hull now has a new Clinical lead and the Primary Care Trust has undertaken to write a health improvement plan for the prison. This plan will incorporate drug and substance misuse issues. It is hoped, therefore, that procedures for identifying and dealing with prisoners who display drug dependency problems are appropriately dealt with.

**I recommend that the new Clinical lead, as a matter of urgency thoroughly reviews the procedures within the prison to identify and treat prisoners on reception with actual or suspected substance misuse problems.**

**I recommend that record keeping procedures in healthcare are reviewed to improve their quality and thoroughness.**

- 77 The Drug Strategy is in need of a thorough review with particular regard to the way in which policy effectively reduces the supply of drugs into the prison.

**I recommend that the Prison and local Drug Action Team undertake an urgent and thorough review of the Prison Drug Policy, with particular regard to the issue of drugs being imported into prison by prisoners.**

**I recommend that the relevant recommendations from HMCIP's inspection in March 2004 are immediately implemented.**

- 78 On the issue of notifying the family of the death, clear instructions already exist within Prison Service Orders and it is important that these are followed.

**I recommend that the Governor at Hull ensures that published national procedures are followed in the event that a prisoner dies in custody.**

