The circumstances surrounding the death of a prisoner from HMYOI Castington, at a hospital on 28 July 2005

Report by the Prisons and Probation Ombudsman for England and Wales

May 2006

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at a hospital on 28 July 2005. Prior to his emergency admission to hospital, the prisoner had been at HMYOI Castington where he was awaiting trial at Newcastle Crown Court. He was found in a collapsed state and near to death in his single cell at Castington at approximately 8:15am that day. The prisoner was pronounced dead at the hospital at 10:20am. He was only 19 years old.

A post mortem examination carried out later that day was unable to confirm the cause of death. However, toxicology reports submitted to the Coroner after the post mortem confirmed that (after lying in a coma for some hours prior to being discovered) the prisoner died as a result of the effects of morphine, likely to be due to his having taken heroin. The evidence suggests that this was an entirely accidental overdose.

The investigation was carried out by my colleague. I also commissioned an independent clinical review of the management of the prisoner's health needs while he was at Castington. This was conducted by a representative of the Northumberland Care Trust. I am grateful to the Care Trust for their work.

I would also like to thank the Governor and staff at Castington for their cooperation during the investigation.

The Prison Service has had some success in recent years in reducing the availability of illegal drugs in prisons. While no measures can be 100 per cent successful, the sad death of this prisoner at such a young age is a reminder of why the combating of drug abuse is so important.

Stephen Shaw CBE **May 2006**
Prisons and Probation Ombudsman

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1. Summary

On 7 April 2005, the prisoner appeared at Newcastle Crown Court charged with obtaining property by deception, kidnapping and conspiracy to supply controlled drugs. He was remanded in custody to await trial. He was taken to Castington YOI that day.

During the reception procedures carried out at the prison, the prisoner admitted that he was a heroin addict and that he had taken an overdose of temazepam six months earlier. He was immediately made subject to formal self-harm monitoring procedures. The prisoner was also placed on a 15-day detoxification programme, and referred to the establishment's Community Psychiatric Nurse, and the CARATs (Counselling, Assessment, Referral, Advice and Throughcare) team. Upon completion of the reception procedures, he was allocated to the Dunstan Unit, where unconvicted young offenders are held. On 14 April, the self-harm monitoring procedures were ended as the prisoner was no longer deemed to be at risk of suicide or self-harm.

Thereafter, he settled well at Castington. He engaged positively with the CARATs team, joined a month-long drug awareness programme, and agreed to undergo regular voluntary drug tests. These indicated an abstention from illicit drugs. He received a positive report on completion of the drug awareness programme. He did well in the education and art classes he attended. He was also employed as a cleaner in his unit where he became very popular.

However, towards the end of May, the prisoner told the Community Psychiatric Nurse (CPN) that he felt depressed. He was therefore referred to a child and adolescent psychiatrist who studied the notes sent to her and concluded that his case would need to be reviewed again by the CPN, to ascertain whether he had any mental health needs. The CPN was advised by discipline staff that not only did they not have any concerns about the prisoner but also that he was doing very well. Consequently, the CPN did not regard him as a priority and did not see him again before he died.

Throughout the majority of his time at Castington, the prisoner gave every indication that he was committed to dealing positively with his heroin addiction. However, on 2 June, a member of staff at Castington received an anonymous telephone call from a woman who claimed that drugs were to be passed to the prisoner during a visit scheduled to take place two days later. The visit took place as planned. Measures were taken to observe the behaviour of both the prisoner and his visitor, but nothing untoward was detected.

On 26 July, the prisoner was visited by his sister and her boyfriend. After he had died, another trainee at Castington alleged that the prisoner had admitted that heroin was passed to him during that visit. However, the procedures for searching visitors, including the use of passive drug dogs, and those in place in the visits room, including CCTV monitoring, did not detect the passage of any drugs. On 27 July, the prisoner's girlfriend visited him. In a statement later given to the police, she said that she was convinced that the prisoner was under the influence of drugs during the visit. However,

the staff on duty in the visits room told my investigator that they had no reason to suspect that he had taken drugs before the visit.

During the evening of 27 July, the prisoner and another trainee asked an officer if they could be locked in the prisoner's cell together for a short period so that they could use the prisoner's Play Station. The prisoner's friend told my investigator that no drugs were used during the 30 minutes they were together. I believe that it was inappropriate for the officer to have allowed the two trainees to be locked in the prisoner's cell together, particularly as the prisoner had in April been assessed as presenting a medium risk to himself and others and as there is no evidence that this assessment had been reviewed.

During the early hours of 28 July, two members of the night staff heard loud snoring coming from the prisoner's cell. Neither had any reason to intervene. At about 7:20am, an officer carried out the first day-shift roll check of Dunstan Unit. When he checked the prisoner's cell, he saw that the television set was on and that the prisoner was lying in his bed with his head towards the cell door as if watching the television. The prisoner appeared to be asleep.

At about 8:15am, two other officers began to unlock the trainees for breakfast. One of them opened the prisoner's cell door and told him to get up. When he did not respond, the officer shook his shoulder but the prisoner still did not respond. There was nothing in his vicinity to explain what had happened to him. The prisoner did not appear to be breathing and he had no pulse. Another prisoner told staff that the prisoner had taken heroin. The emergency first aid given to him by prison staff and paramedics achieved a cardiac output, although the prisoner's heart stopped again when he was lifted on to a spinal board.

The prisoner was taken to the Accident and Emergency Department at a nearby hospital at 9:15am. He was pronounced dead an hour later.

I conclude that the prisoner's addiction to heroin was appropriately assessed and treated at Castington, that his mental health needs were adequately met and that his risk of self harm or suicide was also appropriately assessed and managed.

All the evidence suggests that the prisoner took an overdose of heroin that was too great for his tolerance level to withstand and that his death was therefore an accident. There is no evidence to suggest the prisoner intended to end his life.

The prisoner's death was a tragedy. It is hard to imagine the sense of loss felt by his parents and friends, especially in view of his age. It is a shock to know that it is possible for a person to die of a heroin overdose while in prison. However, it would be very difficult for any prison to be entirely free of illicit drugs. Such a goal would call for draconian measures to be taken, such as intrusive searching or closed visits for everybody, thereby denying physical contact between prisoners and their visitors. A balance has to be struck between deploying robust security measures and maintaining

a humane environment that supports the wider rehabilitation of offenders and the maintenance of family ties.

The investigation found that staff at Castington had no reason to suspect that the prisoner had access to, or that he had taken drugs in the prison. The drug misuse strategies in place in the establishment at the time of the investigation were appropriate.

I commend the efforts made by staff to revive the prisoner after he was found collapsed.

I make three recommendations and two housekeeping points. I also highlight two examples of good practice.

2. Investigation methodology

The investigation was opened on the afternoon of Monday 1 August 2005, when my colleague met with the Governor, the chairman of the Independent Monitoring Board, and the chairman of the local branch of the Prison Officers' Association at Castington. My investigator explained to them the nature and scope of the investigation and the report handling process. That evening, notices were issued to staff and to trainees announcing the investigation and inviting anyone with information relating to the prisoner's death to make themselves known. The following day, my investigator attended the Governor's daily management meeting in order to brief managers on the terms of reference for the investigation.

I commissioned an independent clinical review of the management of the prisoner's health needs while he was at Castington. This was conducted by a representative of the Northumberland Care Trust.

A wide range of discipline, medical and other specialist staff were formally interviewed. So, too, was another prisoner at Castington who was a friend of the deceased. Informal discussions were held with staff and key managers.

My investigator also met with staff who work in the Drug Strategy Unit in the National Offender Management Service Headquarters.

One of my family liaison officers telephoned the prisoner's mother, who expressed a number of concerns she wished to be examined. Later, both my investigator and the family liaison officer met with the prisoner's parents in the company of their solicitor in Newcastle, when further questions were raised by both parents. Their concerns have been fully examined in this report.

3. The deceased

The deceased prisoner was born in January 1986. He is survived by two older sisters. According to his mother, his childhood was happy and uneventful. He left school at the age of 16.

Later, the prisoner managed to secure employment for a short time as a shot-blaster abroad, an occupation that, although short-lived, enabled him to earn a substantial amount of money. On his return to England, he lived in his own flat in Jarrow. He could not find employment and relied on his family to provide him with food. Thereafter, he began to take drugs and became addicted to heroin.

The prisoner's parents knew nothing of his addiction until he disclosed this at court. They were shocked to discover that he had been accused of conspiring to supply heroin and a related offence of kidnap for which, in April 2005, he was remanded in custody to await trial at Newcastle Crown Court.

During the four months he spent at Castington prior to his death, the prisoner became popular with staff and other trainees alike.

4. HMYOI Castington

Castington is situated in a rural area near Morpeth in Northumberland and holds up to 240 young offenders aged 18 to 21, and up to 160 juveniles aged 15 to 18. Most of the offenders there are drawn from the north-east, but population pressures elsewhere in the Prison Service occasionally require Castington to take overcrowding drafts from establishments as far away as London.

Three living units hold the juvenile population. Young offenders live in four other units.

Healthcare at Castington is provided by the Northumberland Care Trust. The healthcare centre provides 24 hour nursing and medical care and has inpatient facilities for up to seven trainees.

Castington was last visited by Her Majesty's Chief Inspector of Prisons in June 2003. In the report of that inspection, the Chief Inspector commented that, although systems and procedures needed improvement, it was a credit to staff and managers that Castington was generally a safe environment, grounded in a high level of care for young prisoners, particularly on the juvenile units. The report contained a large number of recommendations to the Governor. The following have some relevance to this investigation:

- The Area Drugs Co-ordinator, and all those involved in determining the aims of the drugs strategy, should review the management of the counselling, assessment, referral, advice and throughcare (CARAT) team and establish priorities for the delivery of its services.
- The Area Drugs Co-ordinator and the Governor should address the issue of an appropriate provider to ensure that all developments in the local drug strategy are in line with the draft national substance misuse strategy.
- The drug strategy group should meet more frequently, and adopt a multi-disciplinary approach that takes account of both alcohol and drug misuse by young people.
- CCTV cameras should be fitted at the gate lodge to permit clear staff observation of the visitors' entrance door.

My investigator found that all these recommendations had been implemented.

In September 2003, Castington underwent an audit by the Prison Service Standards Audit Unit. The establishment's drug strategy was rated as acceptable. Suicide and self-harm prevention was rated as good.

A previous death in custody at Castington occurred on 29 March 2003, when a 20 year old unsentenced young offender hanged himself in his cell. The report of the Prison Service's investigation into this death contained a number of recommendations to the Governor, all of which have been implemented. None of them is relevant to this investigation.

5. Events prior to 27 July

- **Appearance at court**

On 7 April 2005, the prisoner appeared at Newcastle Crown Court charged with obtaining property by deception, kidnapping and conspiracy to supply controlled drugs. He was remanded in custody to await trial. The prisoner was taken to Castington that day, arriving at about 6pm.

- **Reception health screen**

As part of the standard reception procedures at Castington, the prisoner underwent a reception health screen. This was completed by a Staff Nurse. The prisoner told the nurse that he had been in prison before, had not seen a doctor during the previous six months and did not have any outstanding medical appointments. The prisoner also disclosed that he was concerned about pains in his abdomen, back and loins and that he had been vomiting during the previous few days.

The prisoner told the nurse that he had been using 10 bags of heroin and one wrap of crack cocaine per day. He declared that he had last used both drugs on 5 April, only two days prior to his imprisonment. The prisoner said that he was taking DF118 as well as four tablets of subutex daily. These drugs had been prescribed by the police surgeon as initial treatment to contain the symptoms of withdrawal from opiate dependency.

The prisoner also told the nurse that he had never had any psychiatric intervention and had never received medication for any mental health problem. However, he did admit that he had taken an overdose of temazepam and diazepam six months earlier. The prisoner later admitted to a Community Psychiatric Nurse that he had acquired these drugs from someone else. Temazepam is normally prescribed for the short term treatment of insomnia. Diazepam is an analgesic painkiller and muscle relaxant.

- **Detoxification**

The prisoner asked the nurse to be referred to a doctor because he had been feeling unwell for the past few days and because he was addicted to heroin. The nurse recorded that the prisoner should be referred to a doctor in relation to his physical health, the need for detoxification and for appropriate medication to be prescribed. At 8.15pm on 7 April, she faxed a detoxification request form to the on-call doctor after first advising him over the telephone of the prisoner's history. The doctor prescribed a mixture of diazepam and dihydrocodeine (DF118) to be taken individually or together over a period of 15 days commencing the following morning. Diazepam is normally prescribed for the relief of tension and nervousness. Dihydrocodeine is an opioid analgesic painkiller. Neither drug is licensed for detoxification procedures.

- **CARATs referral and first mental health referral**

The nurse also decided that the prisoner should be referred to a Community Psychiatric Nurse because of her concerns about his acute mental health. Furthermore, she decided to refer him to a CARATs worker.

- **Self harm-monitoring: 7-14 April**

The prisoner had been escorted to Castington by Global Solutions Limited (GSL). The Prisoner Escort Record (PER) completed by GSL referred to drugs and alcohol as potential risk factors for the prisoner but did not allude to any risk of self-harm or suicide. However, a GSL custody officer completed a self-harm warning form indicating that the prisoner had taken an overdose of drugs six months earlier and that his solicitor wanted staff at Castington to know that his client was feeling upset at being remanded in custody. GSL rang reception staff at Castington to tell them that the victim of the prisoner's alleged kidnapping was also in custody there. My investigator was unable to establish what, if any, action was taken in the establishment following receipt of this information. Although any failure to act on the information was not material in this investigation, it might be a crucial factor in the future.

Upon receipt of the self-harm warning form on 7 April, a Senior Officer on duty in reception on duty at Castington, decided to open an ACCT (Assessment, Care in Custody and Teamwork) document. This is used as a management tool for those considered to be at risk of self-harm or suicide. The Senior Officer also completed a cell-sharing risk assessment form in which she recorded that the prisoner was concerned about sharing a cell and that, in her view, he presented a medium risk of harming others. At section three of the form, a nurse recorded that she felt there was a clear indication of a high level of risk of the prisoner assaulting a cell mate because of his previous behaviour and because she felt that "something was wrong". The nurse recorded that the prisoner had feelings of deliberate self-harm, had a history of suicide attempts and was withdrawing from opiates. When the risk of self-harm was balanced against that of harming others, staff judged in favour of allocating the prisoner to a single cell for the period of remand. The prisoner was later taken to Dunstan unit, where unconvicted young offenders are held and where, in fact, there are no shared cells.

At 6:30pm, the Senior Officer noted in the ACCT document that the prisoner felt depressed and was currently taking medication prescribed by his GP for heroin addiction. At 8pm, the document was endorsed by the manager of Dunstan Unit who decided that it was appropriate for the prisoner to be allocated a cell fitted with a television set. He also recommended that the prisoner should be granted a free telephone call to his mother and that he should be subject to hourly observations by staff until further notice. The manager noted in the ACCT document that staff had been briefed about the prisoner and that an entry had been made in the Staff Observation Book in Dunstan Unit. The Staff Observation Book is used to record details of

significant events about prisoners that need to be communicated to staff who work with them.

At 9.20am on 8 April, an officer interviewed the prisoner in order to make a detailed assessment of the risk of self-harm he presented. The officer noted that the prisoner felt depressed and low in mood, and that he was worried about his impending trial, being separated from his girlfriend, coming off drugs, being in prison, and being locked in a cell on his own. The officer further noted that the prisoner was next due in court on 14 April. She concluded that he should be offered continued support, especially from the chaplain and his personal officer, should continue his detoxification programme and should maintain contact with his family.

Immediately after this assessment was concluded, a Senior Officer chaired an ACCT case review. This was also attended by an officer and the prisoner. At this review, the prisoner spoke of the issues that were preoccupying him. He was especially worried about a forthcoming visit from his girlfriend and his mother planned for the following day, 9 April. In view of the prisoner’s concerns, the chairman concluded that the risk of the prisoner harming himself had heightened. He therefore decided that the ACCT form was to remain open, and made a routine referral for the prisoner’s mental health to be assessed. He also scheduled a further case review for 14 April, when the prisoner’s next court appearance was due.

The chairman completed a “care map”, in which he set a number of goals to be achieved by the prisoner with the help of staff. These included the completion of the detoxification programme, maintaining contact with his family, settling into Dunstan Unit and preparing for his court case.

On 8 April, a psychology assistant carried out an assessment of the prisoner’s resettlement needs. The prisoner participated fully, although the psychologist noticed that he seemed “fairly down”. The prisoner told her that he had considered harming himself because he felt that he was not coping well with imprisonment and that a major problem for him was “not having his drugs”. The psychologist made a note of the details of her conversation with the prisoner in the ongoing record in the ACCT form, as well as in his core record.

The prisoner was also seen by a doctor that day. The doctor noted in the prisoner’s medical record that he had commenced his detoxification programme, but was not sleeping well. He did not change the prisoner’s medication.

Between 8 and 14 April, staff observed the prisoner at regular intervals. After seeing him on 9 April, the Chaplain also recorded that the prisoner was not sleeping well. No information was recorded in the ACCT form or elsewhere about the visit planned for that day. On 12 April, the prisoner had a further visit from his girlfriend. That same day, an Officer noted that the prisoner felt that he was “getting better”. The prisoner had seemed pleased to discover that the Officer was one of his personal officers. On 13

and 14 April, the prisoner appeared at court and returned to Castington in relatively good cheer. He was remanded to reappear on 20 June.

At 6.10pm on 14 April, a Senior Officer convened the further ACCT case review that he had planned on 8 April. Only the prisoner and the Senior Officer were present. The Senior Officer noted that the prisoner had settled well on Dunstan unit, was happy with developments at court, and was feeling much better as a result of his detoxification programme. The prisoner told the Senior Officer that he had been visited by his girlfriend and mother and was planning further visits. The Senior Officer noted that, throughout the review, the prisoner had maintained very good eye contact and had remained in good humour. The Senior Officer therefore decided that it was appropriate to close the ACCT form.

- **CARATs assessment**

On 15 April, an Officer completed a CARATs assessment with the prisoner in response to referrals from a nurse on 7 April and from a psychological assistant on 11 April. During the assessment interview, the prisoner was polite and cooperative though slightly nervous, a factor the Officer attributed to the prisoner's withdrawal from drugs. The prisoner told the Officer that he was not guilty of the offences of which he had been accused and that he was confident that his parents would remain supportive of him in his attempts to change his drug habits. The prisoner said that he had been placed on a detoxification programme and that he was also agreeable to engaging with a short duration drug treatment programme. This month-long course is aimed at those trainees who, by virtue of their sentence length or their remand status, might not spend sufficient time in prison to engage in the longer duration rehabilitation programmes that are available. In addition, the prisoner indicated a desire to work with the Drug Interventions Programme (DIP) for which he was referred on 18 April.

- **Voluntary drugs testing programme**

On 3 May, The prisoner agreed to join the voluntary drugs test programme in his unit. This required him to undertake regular drugs tests and to remain clear of drugs. The documentary evidence presented to my investigator showed that the prisoner was tested on 20 May, 1 June and 7 July. All test results were negative. In a Personal Officer report submitted to the Governor after the prisoner's death, an Officer mentioned that the prisoner had excelled on the programme and had gained a silver grade certificate, one of only three awarded in 2005. This suggests that the prisoner had probably undergone more than three tests.

- **Incentives scheme**

On 10 May, the prisoner applied to be considered for the enhanced level of privileges. In his application form he wrote,

> "My behaviour is exceptional towards staff and other trainees and I am very polite. I attend all education classes in which I am getting a certificate for level 1 cooking and I will receive an award at the end of my 4 week course. My personal hygiene is exceptional and my cleanliness around the jail is also ok. I respect all rules and expectations of the prison. I am a perfect candidate for enhanced. Plus I asked for a cleaning job but I am already attending education."

The prisoner's application was considered and approved on 17 May.

- **Progress in education classes**

On 5 May, an instructor in Information Technology, wrote in the prisoner's file that his behaviour and attitude in education classes was excellent. He was working towards the word processing unit of CLAIT. The instructor noted that she thought the prisoner was a very capable young man and was a pleasure to have in class.

On 20 May, an art teacher, wrote in the prisoner's file that he had worked hard in art lessons, was polite and well-mannered and had a mature attitude towards his work.

- **Second mental health referral**

On 9 May, an Officer carried out an assessment of the prisoner prior to his commencement of the short duration drug treatment programme. During the assessment, the prisoner expressed feelings of paranoia and anxiety. He told the Officer that he felt particularly bad when he was locked in his cell. The Officer therefore referred him to a Community Psychiatric Nurse (CPN).

- **Mental health assessment**

The CPN saw the prisoner on 20 May. He made the following entry in the prisoner's medical file:

> "Seen today on D Wing.
>
> Complaining of being depressed all the time. Was self medicating on the outside £100 a day of heroin - smoking it. Had money saved up - has no savings left now. Been on heroin for 18 months - heavy use 6 months.
> Started off on heroin - no other drug use.
> Currently on remand - due in court 20/6/05 for pleas and directions.
> Charged with kidnapping - could be looking at 8 years. Spent 5 days in prison 2 years ago (driving offences).
> Couldn't face visit yesterday. Last had drugs day he came in.
> Has had a detox programme. No physical withdrawals.
> Feels that he can't remember anything then starts to feel depressed.
> Sleep 1am-6am.

Appetite ok.
Sometimes has thoughts of self-injury. Took an overdose 7 months ago temazepam. Got from someone else.
No auditory/visual hallucinations. Gets on okay with peer group. Comes out for association.
Doing drugs course. On morning education. Sometimes can't concentrate in education. Feels that situation is worse when he can't concentrate.
Has visits from family - feels as if he doesn't know them - I am getting to know them again.
Problems have started since he came off heroin.
Has been seeing CARATs worker who put him on the course.
Episodes of depersonalisation.
Motivation is there to do things but doesn't as he "isn't me".
Night time and mornings worst time.
Has nightmares of being stabbed. Dreamt girlfriend's ex was killing him.
Been with girlfriend for one and a half years. Ex is the type who would stab someone - but no contact for 18/12.
To refer to a psychiatrist for her advice and opinion."

The CPN followed up this consultation by writing to Castington's Clinical Director, on 23 May. The CPN concluded his letter as follows:

> "The prisoner stated that by talking about his experiences often causes him to dwell on the things he finds problematic. I have therefore given him the option of contacting our service if he feels that he requires any further input from myself. However, because of the nature of some of his disclosures, I have informed him and he has agreed to see my colleague for her advice and opinion."

At interview, the psychiatrist explained that she did not see the prisoner in response to the CPN's referral. After she had read the notes on the prisoner, she came to the conclusion that no significant mental health issues had been found. She therefore replied to the CPN on 5 July as follows:

> "I had an opportunity to review your letter regarding the prisoner and his IMR (Inmate Medical Record) when last at Castington. Reading though the history and given that you did not believe that there was any indication for ongoing involvement of the in-reach mental health team, I am unclear as to the indication for assessment by me. I would be grateful if you would review the prisoner and whether he has any present mental health needs and then discuss this referral again with me.

The psychiatrist told my investigator that, when she returned from a period of leave on 15 August, she asked the CPN what had happened subsequently. She said that the

CPN told her that he had spoken to a number of discipline officers at Castington about the prisoner's progress. They told him that there were no concerns about him and that he was doing very well. At interview, the CPN confirmed to my investigator that he received the reply from the psychiatrist but did not regard the prisoner as a priority. The CPN did not see the prisoner again.

- **Short duration drug treatment programme**

The short duration drug treatment programme began on 9 May and lasted a month. The prisoner's end of course report indicated that he had achieved a great deal in managing to overcome his addiction and to remain free from substances during his time in custody. The report said that, following his release, it would be important for him to focus on the behaviours and life style that he had held prior to his substance misuse. This would involve him occupying his time effectively and returning to work so that he could earn money in a safe and legal manner. By so doing, the prisoner would be able to distance himself from high-risk situations and reduce the likelihood of any relapse or re-offending.

The report went on to say that the prisoner was fortunate in having a strong support network consisting of family, friends and his girlfriend following release. It was important for him to maintain these positive relationships if he was to lead a substance free life. The prisoner had developed a good awareness of the situations that could put him at risk of using further drugs. He was concerned by the effects that his drug abuse had on others in spite of the fact that he had kept his behaviours secret from most friends and family members.

The concluding remarks in the report were:

> "Throughout the programme, the prisoner has displayed a sound understanding of the negative aspects associated with his previous substance using and offending behaviours. As a result, he has developed a great deal of motivation to make the appropriate changes in order to return to a drug and crime-free life. He is eager to increase and enhance his knowledge and understanding during his time within custody and is likely to participate well in any further course offered him. In relation to his substance misuse specifically, it is felt that continued support from CARATs while in custody and from a local substance misuse team/DIP following release will provide sufficient encouragement and guidance for the prisoner to achieve and maintain his goals."

Anonymous telephone call

On 2 June, while the prisoner was engaged on the drug programme, a member of staff received an anonymous telephone call at the prison, from a woman claiming to be the mother of a trainee. She claimed that drugs were to be passed in to the prisoner by "a female on a visit scheduled to take place on 4 June. The member of staff who received the call recorded the details on a security information report. Although the information was graded as very unreliable, it was nevertheless decided that the visit should take place in an area of the visits room that could be closely observed by a CCTV camera. The visit took place, but nothing untoward was detected. However, my investigator was told that no drug dogs were available that day. No further security information reports about the prisoner were forthcoming until after he had died.

Social visits: 23-27 July

On 23 July, the prisoner was visited by his girlfriend and her friend. The girlfriend visited the prisoner again on 27 July, this time alone. In a statement given to the police after the prisoner's death, she described how the visit with the prisoner on 23 July was received. She said that he was "on really good form" and that he "had his ups and downs but for the most part he was up and cheerful".

She described the visit on 27 July differently. She said in her statement,

> "I knew straightaway when I saw the prisoner in visits that he had taken something. His pupils were like pin pricks and he had burst blood vessels under his eyes as if he had been vomiting. His skin looked pasty and he was really laid back. He admitted to me that he'd had some gear that morning. He had been sick and crying that he had let everyone down. He said that he had smoked a few lines of heroin……but he promised that he was never going to take drugs again.……..
>
> The day before my visit, the prisoner's sister had been in to visit with her boyfriend. I knew that he used drugs and he wasn't particularly a friend of the prisoner's so I wondered why he would go up to see him. We had a tiff but we made it up before I left the visit.
>
> The prisoner phoned me later that night and we ended up having an argument about him using. He promised he would never take it again. He was sorry. The conversation ended with me trying to end the relationship. The prisoner had phoned me back a couple of times but then the credit went off. I would love to know who supplied him with the drugs that killed him. "

Another trainee and a friend of the prisoner's, told my investigator that the prisoner had used heroin before his visit with his girlfriend on 27 July and that he had told him how he

had acquired the drug. According to the prisoner's friend, the prisoner had said that it had been brought in on a visit the prisoner received from his sister and her boyfriend on 26 July. It had apparently been wrapped in cling film and secreted in the visitor's throat. The visitor then regurgitated the package and put it in a hot drink bought from the canteen in the visits room. The hot drink was then passed to the prisoner, so that he could secrete the package in his mouth or throat until he could regurgitate it in his cell. The prisoner's friend explained that by this means, all the systems in place for the detection of illicit drugs could be by-passed. He gave no indication as to whether the prisoner had admitted which visitor had allegedly passed the heroin to him.

Some credence was given to this information in a security information report submitted by a member of staff some time after the visit had taken place on 26 July. It was reported that another trainee had said that heroin had found its way to a prisoner in C Wing following that visit.

The prisoner's visits record shows that he was, indeed, visited by his sister and her boyfriend on 26 July. In a statement later given to the police, his sister said,

> "Whilst the prisoner was in prison I visited him regularly. I went to the prison on Tuesday 19 July 2005 with my mother. As far as I can remember, the prisoner was in good spirits. He had gone through the detox programme and was doing really well…….
>
> I visited the prisoner again on Tuesday 26 July with my then boyfriend. He had known the prisoner for about a year before he was sent to jail. I had been going out with my boyfriend for about two weeks before the visit. He said he would come along with me to see the prisoner. I knew that the prisoner wouldn't mind. We were not there long. The prisoner had already gone back to his cell because he thought we weren't coming. The prisoner seemed more quiet than usual and didn't eat much of the food which he always enjoyed. We just talked for a bit and then it was time to go.
>
> Although I knew that my boyfriend has been into heroin in the past, I would never have agreed to him taking anything in to the prisoner. We both had to go past the dog and were both searched. I never took any drugs in to the prisoner, nor did I see my boyfriend take anything in or ever mention that he would. "

Records show that on both 26 and 27 July, the prisoner was seated at table 10 which is located no more than four feet from the central podium in the visits room and about ten feet from the nearest CCTV camera. Two members of staff are normally seated, back to back, on the podium to observe the visits rooms. My investigator was told that on both days the prisoner underwent the normal searching procedures prior to, and immediately following, the visits. My investigator was also told that on both days each of the prisoner's visitors were subjected to a "screen" by a passive drug dog followed by

a rub down search by staff prior to the visit. There was no indication from the drug dog, nor any other evidence to suggest that any of the prisoner's visitors was carrying or attempting to pass drugs on either day. At interview, a Senior Officer confirmed that, in his capacity as Visits Manager on 27 July, he had cause to speak to the prisoner's girlfriend on two occasions after noticing that she was seated on the prisoner's lap. On neither occasion did the prisoner appear to him to be under the influence of drugs or to be showing the physical symptoms described by his girlfriend in her statement to the police. Neither did the Senior Officer have any reason to suspect that drugs were being passed during that visit. Unfortunately, the CCTV footage of the visits that the prisoner had received had been taped over before the investigation began. Thus, potentially important information and evidence was lost. However, in a statement later given to the police, the Security Senior Officer at Castington said that he had viewed the videotape immediately after the prisoner's death and could detect nothing untoward on the part of the prisoner or his visitors.

6. Events on 27 and 28 July

Events during the evening of 27 July

On 27 July, an Officer supervised the prisoner as he spent time in the afternoon completing his cleaning duties. The Officer reported that the prisoner was "his usual happy self". During the evening, the prisoner took part in association with other trainees, after serving the tea meal at 5pm. Another Officer who was on duty in Dunstan Unit that evening told my investigator that he remembered speaking to the prisoner that evening as he came out of the showers. That Officer, too, said that the prisoner was "happy enough".

At 7.30pm, the prisoner and his friend asked an Officer if they could be locked in the prisoner's cell together so that they could play on the prisoner's Play Station. The Officer agreed to their request. At interview, he told my investigator that it was not unusual to lock two trainees in the same cell if they could be trusted.

At interview, the prisoner's friend initially denied being locked in with the prisoner that evening. Later, he offered my investigator a statement in which he admitted that this was not true. He said that he had lied because he was concerned that the Officer would get into trouble for locking them in together, and that it would be assumed that he and the prisoner had asked to be locked in together to smoke heroin. In his statement, the prisoner's friend said that "in the short time we were locked up together, there was no heroin smoked".

At about 8pm, the Officer unlocked the prisoner's cell to allow the prisoner's friend to return to his own cell in time for the evening lock up. The Officer did not notice anything unusual about either trainee. In his view, the prisoner did not appear to be emotional, subdued, or preoccupied. In fact, the Officer thought that he seemed healthy, normal and quite cheerful. He later offered the prisoner some hot water for a cup of tea as he completed the evening roll check, but the prisoner declined.

According to the prisoner's friend, the prisoner shouted to him from his cell at about 8.15pm to tell him that he had taken his cigarette lighter. The prisoner's friend told my investigator that he shouted back to the prisoner to tell him to look around his cell for the lighter. The prisoner's friend said that he did not hear from the prisoner again.

At about 8.40pm, a Night Patrol Officer commenced his shift in Dunstan Unit. He carried out a roll check in order to satisfy himself that the number of trainees in the unit tallied with the roll given to him by the off-going day shift. The roll was correct. At interview, he could not remember which cell the prisoner was in that night or the manner in which he checked the prisoner's cell.

Events during the night of 27/28 July

The Night Patrol recalled that at about 4am on 28 July, as he was patrolling the unit, he heard loud snoring noises coming from the cell in which, unbeknown to him, the prisoner was located. He approached the cell and looked through the observation panel in the door. He saw that the television set was on, giving light into the cell. The Night Patrol told my investigator that the occupant was in his bed with only his head and shoulders visible. He was lying on his left side, facing towards the television set. He did not attach any significance to the snoring and so he left the cell to continue with his duties. At about 5am, as he was patrolling the unit, he again heard snoring noises coming from the same cell. He did not check to see which trainee was in the cell. It was not until he was later told that the prisoner had died that he realised that he was the one in the cell. At interview, he told my investigator that on one of the visits to this cell, he gave the door "a little nudge" with his foot to see if he could waken the occupant out of his deep sleep, but could not recall whether he did this on the first occasion or the second. He gained no response from the occupant. He thought that he looked through the observation panel on the second occasion but could not remember whether the occupant was in the same position as before. Soon afterwards, another officer, the Assistant Night Orderly Officer (A/NOO) joined him in the unit office. The Night Patrol asked the A/NOO to "have a listen to that lad down there snoring". The A/NOO did as requested at about 5.30am and confirmed that he could hear loud snoring coming from the cell. Like his colleague, the A/NOO did not attach any significance to the snoring.

Shortly afterwards, the Night Patrol carried out a roll check prior to the arrival of the day shift. At interview, he could not recall how he checked the prisoner's cell. He told my investigator that he could not remember whether the occupant had changed position in the bed, or whether the television set was still on. However, he did recall that the only noises he heard in the vicinity were those of other trainees' radio and television sets. He completed his roll check and went off duty at about 7.40am.

At about 7.20am, an Officer carried out a further roll check in Dunstan Unit in order to satisfy himself that the check that had already been carried out by the Night Patrol was correct. At interview, he told my investigator that, prior to carrying out the roll check, he spoke to the night staff to discover whether there had been any problems during the night. He was told that there had been none. He said that his practice during roll checks was first to check the security of each cell door. He would then look through the observation panel in each door and check to see whether there were "any signs of problems or distress". Finally, he would satisfy himself that there was some sign of life or movement from the occupant. He told my investigator that this was how he conducted the roll check in Dunstan Unit on this particular occasion. Unlike the Night Patrol, the Officer knew which cell the prisoner was in. He remembered looking into the prisoner's cell and seeing him lying under his duvet on his left side with his left hand on his cheek. The prisoner's head was nearest to the cell door. The Officer could not see the prisoner's face because he was looking towards the television set which was at the far end of the cell. He remembered that the television set was on. He also said that, at the time, he thought that the prisoner appeared to be asleep but breathing. He said he

thought that he saw the prisoner's shoulder move and that he took a breath. Later, he admitted that, with hindsight, he wondered whether the prisoner was breathing. Thinking that the prisoner was "ok", the Officer did not speak to him. He then went on to complete the roll check of the rest of the unit.

The discovery of the prisoner in a collapsed state

At about 8.15am, two Officers began unlocking trainees for breakfast. One of them unlocked the prisoner's cell and saw him lying on his bed as if watching television. The Officer stood at the doorway and asked the prisoner to get up to collect his breakfast. When he did not respond, the Officer approached the prisoner and shook his shoulder. There was still no response from the prisoner. The Officer thought this was unusual as the prisoner was normally out of bed by this time. He then gave the prisoner another shake and said to him, "Come on, get up". He then saw that the prisoner had been sick and that his lips were blue. He also thought that the prisoner's eyes were closed. There was nothing visible in the prisoner's vicinity to suggest what had happened to him. As he was not equipped with a radio, the Officer told his colleague to raise the alarm. His colleague pressed a nearby alarm bell and then helped the Officer to turn the prisoner on his side in order to try to clear the blockages from his mouth. They moved the prisoner onto his back in order to check for a pulse in his neck and to commence cardio-pulmonary resuscitation (CPR). There was no trace of a pulse. The Officer massaged the prisoner's chest while his colleague attempted to remove fluid from his airway without any protective gloves or equipment. In view of the fact that the bed provided a rigid surface on which to attempt resuscitation, they judged that it was not necessary to move the prisoner onto the floor.

In response to the alarm bell, a Senior Officer ran to the landing and into the prisoner's cell. He immediately sent a 'Code Blue' message to the communications room by radio to alert staff to the discovery of a life-threatening incident. The records show that this message was received at 8.16am. In a statement later submitted to the Governor, the Senior Officer described the prisoner as warm and pale. He too said that he could find no pulse.

The Orderly Officer of the day three members of staff applying CPR techniques. He noticed that the prisoner was on his bed and was unresponsive.

Meanwhile, two nurses, who had been administering treatments on the main prison corridor, and who heard the emergency message given over the radio, went straight to the prisoner's cell. They arrived at the same time as a discipline officer who had collected emergency equipment, including an ambu-bag, and oxygen. No defibrillators were available at Castington at the time. Another nurse, who had been administering treatments in another unit, also joined her colleagues at the scene.

At about the same time, the prisoner's friend became aware of the fact that there was an emergency in the prisoner's cell. He approached an Officer who was on the landing

at the time, and said to him, “You need to know it’s heroin.” The Officer then ran down the landing to tell the healthcare staff who had arrived at the cell.

Between them, the staff now in attendance continued to apply CPR techniques in rotation. At 8.16am an emergency ambulance was called. A paramedic crew arrived at the scene at about 8.30am. They applied a cardiac monitor and emergency drugs, including narcan (to counter the effects of heroin) and adrenaline. At one stage, these resuscitation attempts achieved a cardiac output, and so the prisoner was placed on a spinal board to enable him to be moved to the ambulance. However, as he was moved, his heart stopped again.

By this time, Castington’s Clinical Lead Director and the clinical team leader were at the cell. They accompanied the prisoner in the ambulance, together with a Senior Officer and an Officer, as the prisoner was taken to the Accident and Emergency Department at a nearby hospital, leaving the prison at about 9.15am.

The prisoner did not respond to any further attempts to save his life. He was pronounced dead at the hospital at 10.17am. Later, during an examination of the prisoner’s cell, the police found a biro that appeared to have been used for smoking drugs.

A governor at Castington attempted to contact the prisoner’s mother at home by telephone. He wanted to arrange a face to face meeting with the family so that the news of her son’s death could be disclosed personally. However, there was no reply. As no other contact numbers were available, the governor rang the prisoner’s Probation Officer who gave him a work telephone number to try. As time was passing by, and as the governor was also concerned about the possibility that the prisoner’s mother might hear about his death from another source, he decided to ask the police in South Shields for their assistance. They readily agreed to contact the family themselves. Later that day, the governor and the establishment liaison officer visited the family in person in order to explain to them the circumstances of the prisoner’s death. The prisoner’s parents told my investigator and Family Liaison Officer that they were told differing accounts of the manner in which the prisoner was discovered on 28 July, and that they had been very upset by this.

On 29 July, a memorial service was held at Castington. This was attended by members of the prisoner’s family and by a number of trainees from Dunstan Unit. After the service, the Governor spent some time with the family in his office.

The prisoner’s funeral took place in South Shields on 5 August. A number of staff from Castington attended.

Later, the prisoner’s mother wrote a letter to the Governor in which she expressed her appreciation for the support shown by him and his staff to her family.

7. Consideration of issues arising from the investigation

When the prisoner was found in a collapsed state in his cell on 28 July, there was no clear evidence to suggest what had happened to him. His friend told staff that the prisoner had taken heroin. It was later confirmed in the toxicology reports sent to the Coroner that the prisoner had died after being in a coma for some hours following his use of heroin. Although neither my investigator nor the police have been able to prove conclusively how the prisoner acquired the drugs that killed him, the evidence suggests that, shortly before his death, he was passed a quantity of heroin by visitors.

The investigation attempted to answer the following questions:

- Did the prisoner mean to end his life, or did he die as a result of an accidental overdose of heroin? Was his risk of self-harm or suicide and general mental health properly assessed and managed?
- Was the prisoner's heroin addiction properly assessed and treated at Castington?
- Were staff at Castington aware of the means by which the prisoner acquired heroin shortly before he died? If so, could they have prevented his possession of the drugs?
- Could staff on duty in Dunstan Unit during the night of 27/28 July have known that the prisoner was using drugs in his cell? Could they have intervened to prevent his death?
- Are there effective policies and procedures in place at Castington for:

- the reduction of the supply of drugs?
- the reduction of the demand for drugs?
- the throughcare of drug users?

- Can more be done at Castington to prevent a similar tragedy happening in the future?

Did the prisoner mean to end his life, or did he die as a result of an accidental overdose of heroin? Was his risk of self-harm or suicide and his general mental health properly assessed and managed?

When the prisoner was taken to Castington from Newcastle Crown Court on 7 April, a member of the escort staff from Global Solutions Limited noted that he had taken an overdose of drugs six months earlier. This information was imparted to the reception staff at Castington by means of a self-harm warning form. The reception staff acted upon this warning immediately by opening an ACCT document - a tool by which those prisoners who are considered to be at risk of self-harm or suicide are managed, monitored and reviewed. In this document, a note was made of the fact that the prisoner felt depressed and was taking medication prescribed by his GP for heroin addiction. Arrangements were made for the prisoner to be placed on a detoxification

programme.

The following day, the prisoner was seen by an Officer who carried out a more detailed assessment of the risk of self-harm he presented. She noted that the prisoner felt depressed and worried about his impending trial, being separated from his girlfriend, withdrawing from drugs, being in prison and disliking the experience of being locked in a cell on his own. These are the sorts of worries that many prisoners are likely to feel when they first arrive in prison, especially if they, like the prisoner, are withdrawing from drugs. In the prisoner's case, it is clear that staff interpreted these worries as indicators of a risk of self-harm and therefore made him subject to formal self-harm monitoring procedures by opening an ACCT document. This remained in force for a week, during which time the prisoner showed signs that he was settling well in his living unit, coping better with developments at court and feeling better as a result of his participation in the detoxification programme. On 14 April, it was decided that, as the prisoner's risk of self-harm had reduced, it was no longer necessary for the self-harm monitoring procedures to remain in force.

Thereafter, the prisoner's mental state was primarily monitored by a Community Psychiatric Nurse. Although the prisoner was not considered to be at risk of self-harm at any other time at Castington, there were nevertheless concerns about his general mental health. He had been referred for mental health assessment by a nurse during the reception procedures. The prisoner was also referred a month later by an Officer prior to commencing the short duration drug treatment programme. When the CPN saw the prisoner on 20 May, he took a history of his drug related problems and decided to refer him to a Consultant Child and Adolescent Forensic Psychiatrist. At interview, the CPN told my investigator that his main concern was the prisoner's "depersonalisation" (defined as an abnormal state of mind in which the subject feels unreal and detached from himself and the world). He therefore wanted the psychiatrist to see if he had missed anything major in his own assessment of the prisoner. After studying the referral notes, the psychiatrist came to the conclusion that no significant mental health issues were evident. She wrote back to the CPN during the first week in June to ask him to review the prisoner again and to discuss the case with her at a later date. As staff had told the CPN that the prisoner was doing very well at this time, he did not consider him to be in need of urgent prioritisation. The CPN therefore did not formally assess the prisoner again before he died.

In the report of the independent clinical review of the management of the prisoner's health needs at Castington, the reviewer concludes that the CPN's interventions with the prisoner "represented good and careful assessment and management".

In relation to the management of the prisoner's risk of self-harm, the reviewer concludes as follows:

> "There was little to suggest the likelihood of deliberate self-harm, although I believe that the reception nurse was correct in opening an ACCT form since the prisoner had a history of overdose, was detoxing

> and did divulge that he had considered harming himself. I am equally sure that the ACCT form was closed in response to a satisfactory risk assessment and there was nothing to suggest the ongoing likelihood of self-harm."

I agree with the reviewer's conclusions.

Following the closure of the ACCT form on 14 April, the prisoner's state of mind seemed to improve and he began to adopt a positive approach to his imprisonment. On 15 April, he was assessed for his suitability for engagement with the CARATs service at Castington. His employment at the kitchen servery kept him busy and in contact with a wide range of peers and staff. He became very popular. On 4 May, the prisoner agreed to join a voluntary drugs test programme in his unit. On 9 May, he started a month-long drug treatment programme during which he earned a positive report. On 10 May, he applied for promotion to the top-most level of the incentives and earned privileges scheme. A week later his application was approved. On two occasions in May, the prisoner attracted glowing reports from the education department. In the early stages of his time at Castington, the prisoner disclosed that he was worried about his relationship with his parents and with his girlfriend and about the length of sentence he was likely to be given. These worries may well have continued to occupy his mind at times when, outwardly, his morale seemed to have improved. However, on no occasion after the closure of his ACCT form in April did the prisoner display behaviours that would indicate he was suicidal.

I believe that the assessment and subsequent monitoring of the risk of self-harm the prisoner presented in the earliest stages of his time at Castington was entirely appropriate. I agree with the Clinical Reviewer's conclusion that the assessment and management of the prisoner's mental health was also appropriate. I also agree that there was nothing to suggest an ongoing likelihood of self-harm. The investigation found no evidence to suggest that the prisoner took drugs on the night of 27/28 July because he wanted to end his life. In the absence of such evidence, it is most likely that the prisoner died as a result of an accidental overdose of heroin, at a time when, by virtue of his recent abstention from its use, his tolerance level would have been low.

Was the prisoner's heroin addiction properly assessed and treated at Castington?

When the prisoner arrived at Castington on 7 April, he declared his heroin addiction to reception staff. As a consequence, he was immediately placed on a detoxification programme and referred to the CARATs team. Neither DF118 nor diazepam is licenced or approved for detoxification. The local policy for detoxification should be reviewed and brought in line with the national guidelines as stated in the Orange Book: Drug Misuse and Dependence – Guidelines on Clinical Management, Department of Health, 1999.

The prisoner initially refused to engage with CARATs. He was persuaded to do so by a psychology assistant who interviewed him as part of his induction programme and by

the good auspices of the prisoner's CARATs officer. On 15 April, the Officer saw the prisoner and arranged for him to join a short duration drug treatment programme. On 4 May, the prisoner agreed to join a voluntary drugs testing programme. The tests he underwent during the programme consistently showed that he was clear of drugs. The drug treatment programme commenced on 9 May and ended a month later. During this programme, the prisoner's knowledge and attitudes of drug abuse issues were frequently assessed. His final report concluded as follows:

> "Throughout the programme, the prisoner has displayed a sound understanding of the negative aspects associated with his previous substance using and offending behaviours. As a result, he has developed a great deal of motivation to make the appropriate changes in order to return to a drug and crime-free life. He is eager to increase and enhance his knowledge and understanding during his time within custody and is likely to participate well in any further course offered him. In relation to his substance misuse specifically, it is felt that continued support from CARATs while in custody and from a local substance misuse team/DIP following release will provide sufficient encouragement and guidance for the prisoner to achieve and maintain his goals."

Before the prisoner was found collapsed in his cell on 28 July, there was nothing in his behaviour that might have suggested to staff that he was no longer motivated to avoid drugs. On the contrary, everything about him suggested the opposite. His engagement with CARATs, with the voluntary drugs testing programme, and with the short duration drugs awareness course were all seen as signs that the prisoner was earnest in his desire to bring his addiction to illegal and harmful drugs under control.

The claim made by an anonymous telephone caller on 2 June that drugs were to be passed to him during a visit two days later was properly followed up by the security department. The visit took place. Nothing untoward was detected. However, no drug dogs were available on that day.

That said, the investigation uncovered some evidence to suggest that the prisoner may not have been entirely sincere about his motives for engaging so positively with the drug misuse interventions available to him. My investigator was told by a prisoner that the prisoner was keen to demonstrate that he was adopting a mature attitude to his drug addiction, in the hope that the courts would act leniently when sentencing him. Of course, this claim cannot be substantiated. Notwithstanding that caveat, I judge that the prisoner's heroin addiction was appropriately assessed and treated at Castington and that he was offered every encouragement and assistance to remain drug - free.

Were staff at Castington aware of the means by which the prisoner acquired heroin shortly before he died? If so, could they have prevented his possession of the drugs?

Could staff on duty in Dunstan Unit during the night of 27/28 July have known that he was using drugs in his cell? Could they have intervened to prevent his death?

The method by which drugs may have reached the prisoner

The only evidence presented to my investigator about the method by which the prisoner may have come into possession of heroin was that which suggested it was probably passed to him in the visits room at Castington shortly before his death. This information came from two sources. The first was a security information report submitted by a member of staff on 26 July in which it was recorded that a trainee at Castington had said that heroin had found its way to a prisoner on C Wing. My investigator was told that security information reports are normally submitted, in the first instance, to the security department where an assessment is made of the reliability of the information recorded. Thereafter, they are passed to a senior manager who decides what action to take. This process is completed, if possible, on the same day the information is submitted. If that is not possible, the process is invariably completed the following day. My investigator was unable to ascertain how long the process took or what follow-up action was taken. However, the security information report did not name the prisoner as a recipient of the drugs. Staff therefore had no reason to take action against him.

The second source was a trainee who told my investigator that the prisoner had admitted to him that heroin had been passed to him in the visits room on 26 July. The information from the trainee was offered after the emergency in the prisoner's cell had been discovered on 28 July.

Neither the police nor my investigator were able to test the veracity of the information gleaned from the two sources. Evidence offered to my investigator by staff present on duty in the visits room shows that both members of staff were confident that neither the prisoner nor his visitors showed any sign that they were passing drugs on 26 July, nor that the prisoner displayed unusual behaviour during his visit the next day.

The security procedures in the visits complex involve the searching of visitors and trainees before and after each visit. My investigator spoke to the dog handler who was on duty in the visits complex on 26 July. He confirmed that his dog had undergone training the previous day and was therefore likely to be particularly effective on 26 July. The dog handler told my investigator that some visitors had in the past scented drugs and, in such circumstances, the ability of drug dogs to detect drugs could be impaired. His dog gave no indications that day.

Some of the evidence above casts doubt on the theory that the prisoner was passed drugs during his visits on 26 July. However, it is my belief that if, as the prisoner's friend

suggests, it is possible for determined drug suppliers and users to by-pass the normal detection methods in place in the visits complex at Castington, it is equally possible that drugs were passed to the prisoner.

I am satisfied that there were no indications to staff on 26 July to suggest that drugs had been passed to the prisoner during the visit he received that day. I draw the conclusion that, if drugs were brought in during the visit, it would be unreasonable to expect staff to have prevented the passing of the drugs or to be aware that the prisoner had received them.

The extent to which it was reasonable for staff to suspect the prisoner of being in possession of drugs before he died.

The prisoner gave no signs before 28 July that he was obtaining or using drugs. Only one security information report was submitted about him. This was in relation to the anonymous telephone call made on 2 June in which it was claimed that drugs were to be passed to the prisoner during a visit planned to take place two days later. Although the information was graded as very unreliable, measures were put in place to observe the visit. Nothing untoward was detected, although no drug dogs were available on that day. The prisoner's overt behaviour was exemplary. He had gained the trust of staff. They therefore had no reason to suspect him of drug misuse at any time before his death.

The significance of the fact that the prisoner spent 30 minutes locked in his cell with another trainee during the evening before his death. Should this have been allowed?

The investigation discovered that, during the evening of 27 July, an officer allowed the prisoner and his friend to spend about 30 minutes together in the prisoner's cell with the door locked. At interview, the prisoner's friend initially denied that this occurred, but later handed in a statement in which he admitted lying. He said that no heroin was smoked during the time he spent with the prisoner. The officer who gave them permission to be together in the prisoner's cell told my investigator that he trusted them both and he therefore felt justified in allowing them to be together.

Both the prisoner and his friend were heroin addicts and both were in prison charged with drug related offences. These facts alone provide insufficient grounds for keeping them apart. The officer who locked them in together had no reason to believe that either trainee wished to use the 30 minute period in question to smoke heroin. Indeed, he told my investigator that neither trainee looked under the influence of drugs when he separated them at 8pm. Although heroin may not have been used during the time that the prisoner and his friend were together that evening, quantities of the drug may nevertheless have passed between them. My investigator was told by a senior manager that it is not the Governor's policy that trainees should be locked in the same cell together. The officer should, therefore, not have allowed the two trainees to be locked in the prisoner's cell together. Furthermore, the cell sharing risk assessment

carried out on his reception into prison identified the prisoner as a medium risk to himself and to others.

I make no formal recommendation but the Governor will wish to remind staff of the policy regarding trainees being locked in cells together.

Should the night staff have intervened when they heard unusually loud snoring noises coming from the prisoner's cell in the early hours of 28 July?

The Night Patrol recalled that at about 4am on 28 July, as he was patrolling the unit, he heard loud snoring noises coming from the cell in which, unbeknown to him, the prisoner was located. He approached the cell and looked through the observation panel in the door. He saw that the television set was on, giving light into the cell. He told my investigator that the occupant was in his bed with only his head and shoulders visible. He was lying on his left side, facing towards the television set. He did not attach any significance to the snoring and so he left the cell to continue with his duties. At about 5am, as he was patrolling the unit, he again heard snoring noises coming from the same cell. He did not check to see which trainee was in the cell. It was not until he was later told that the prisoner had died that he realised that he was the one in the cell. At interview, the Night Patrol told my investigator that on one of the visits to this cell, he gave the door "a little nudge" with his foot to see if he could waken the occupant out of his deep sleep, but could not recall whether he did this on the first occasion or the second. He gained no response from the occupant. He thought that he looked through the observation panel on the second occasion, but could not remember whether the trainee was in the same position as before. Soon afterwards, the Assistant Night Orderly Officer, joined the Night Patrol in the unit office. The Night Patrol asked his colleague to "have a listen to that lad down there snoring". The Assistant Night Orderly Officer did as requested at about 5.30am, and confirmed that he could hear loud snoring coming from the cell. Like the Night Patrol, the Assistant Night Orderly Officer did not attach any significance to the snoring.

Shortly afterwards, the Night Patrol carried out a roll check prior to the arrival of the day staff. At interview, he could not recall how he checked the prisoner's cell. He told my investigator that he could not remember whether the occupant had changed position in the bed, or whether the television set was still on. However, he did recall that the only noises he heard in the vicinity were those of other trainees' radio and television sets. He completed his roll check and went off duty at about 7.40am.

Given the circumstances at the time, neither member of staff had any reason to enter the prisoner's cell in order either to check why he was snoring so loudly or to try to stop him snoring. The prisoner's snoring could be taken neither as an indication that there was something wrong with him nor that it might be a nuisance to other trainees. I therefore raise no criticisms against either member of staff for not intervening.

Should the Officer have obtained a response from the prisoner when he checked his cell as part of the roll check he carried out at the beginning of his shift on 28 July?

At about 7.20am, an Officer carried out a roll check in Dunstan Unit in order to satisfy himself that the check that had already been completed by the Night Patrol was correct. At interview, the Officer told my investigator that, prior to carrying out the roll check, he spoke to the night staff to discover whether there had been any problems during the night. He was told that there had been none. He said that his practice during roll checks was first to check the security of each cell door. He would then look through the observation panel in each door and check to see whether there were "any signs of problems or distress". Finally, he would satisfy himself that there was some sign of life or movement from the occupant. He told my investigator that this was how he conducted the roll check in Dunstan Unit on this particular occasion. Unlike the Night Patrol, the Officer knew which cell the prisoner was in. He remembered looking into the prisoner's cell and seeing him lying under his duvet on his left side with his left hand under his cheek. The prisoner's head was nearest to the cell door. The Officer could not see the prisoner's face because he was looking towards the television set that was at the far end of the cell. The Officer remembered that the television set was on. He also said that, at the time, the prisoner appeared to be asleep but, because he thought he saw his shoulder move, he was breathing. Later, the Officer admitted that, with hindsight, he wondered whether the prisoner was breathing. However, thinking that the prisoner was "ok", the Officer did not speak to him. He therefore went on to complete the roll check of the rest of the unit.

My investigator was shown a copy of Castington's Local Instruction 2.73 which sets out the Governor's policy for the completion of roll checks. In relation to those checks that are to be carried out at the beginning of each day, the instruction says,

> "Oncoming day staff must carry out a full roll check before the night patrol leaves the unit. (Staff must see the face of, or obtain a verbal response from, every prisoner at this check.)"

The Officer freely admitted at interview that he could not see the prisoner's face when he checked him. With the benefit of hindsight, one might judge that he should have made sure that he did so. However, he did see the prisoner's head. He was therefore able to confirm, purely from a security point of view, that he was present in the cell. He gained the impression that the prisoner had fallen asleep while watching television. I believe that, given what he saw, the Officer was following the spirit of the Governor's instruction in not seeking to gain a verbal response from the prisoner. I therefore raise no criticism against him for the manner in which he conducted the roll check.

However, I am conscious that the requirement for staff either to see the face of, or to gain a verbal response from, every prisoner at the morning roll check is based on security grounds. I am concerned that prison staff, can, under this policy, fail to check the wellbeing of each prisoner.

My investigator consulted Security Group in Prison Service Headquarters and the Prison Service's Standards Audit Unit on this point.

He was advised by Security Group that the Prison Service's National Security Framework sets out general security guidance, but devolves to Governors and Directors of prisons the responsibility for drawing up specific security policies for their own establishments. Where roll checks are concerned, the National Security Framework states the times at which they should be carried out. It does not offer guidance about how each check should be completed. Security Group did, however, offer the comment that the Governor's instruction for the completion of roll checks at Castington was appropriate. So too did Standards Audit Unit.

However, both departments agreed that the policy places more emphasis on the security of trainees than on their well - being. Both also recognised that it is possible for prison staff to fail to spot prisoners who are either dead, dying or unwell in their cells, if no verbal response is demanded by staff during roll checks as a matter of routine.

I therefore recommend that the Governor of Castington should consider what benefits there might be in changing his policy for the conduct of morning roll checks so that the security and health requirements can both be met.

Are there effective policies and procedures in place for drug misuse? Can more be done at Castington to prevent a similar tragedy happening in the future?

The drug misuse strategy in place at Castington when the prisoner was there had been agreed by the Area Drug Coordinator in 2004, and was revised in August 2005. The principal elements of the 2004/2005 strategy seek to:

- reduce the supply of drugs.
- reduce the demand for drugs.
- reduce the harm from illegal substances by offering advice, support, counselling, treatment and throughcare.

Reducing the supply of drugs

Methods for reducing the supply of drugs comprise:

- mandatory drug testing.
- searches of the perimeter, buildings and cells, incorporating the use of drug dogs.
- routine and random searches of staff.
- searches of trainees and young offenders and their property on reception and after their return from community visits, work placements and periods of temporary release on licence.
- searches of trainees and young offenders returning from visits.
- targeted searches of trainees and young offenders following receipt of information or intelligence.
- searches of visitors and the visits complex.

Mandatory drug testing

Mandatory drug testing is regarded by the Prison Service as an effective method of deterring prisoners from using illegal drugs while in custody. Prison Service Order (PSO) 3601 requires Governors to ensure that an agreed percentage of the prisoner population is tested for drugs on a random basis each month. At Castington, the 2004/2005 target was for between 5% and 10% of trainees to be tested each month, of which 14% were to be tested at weekends. Those who test positive face a disciplinary hearing at which various sanctions can be imposed. Those found guilty of misusing Class A drugs are also automatically placed on a frequent testing programme. In addition, all trainees who test positive for any type of illegal drug are also automatically referred to the CARATs team.

Searching

(i) *Searching of visitors*

On arrival at Castington, visitors pass through to the visits room via a route that is separate from that used by staff to enter the prison. Visitors are logged in and their visiting orders are validated. They are required to place in lockers any items of property that are not essential to the visit, retaining the key to the locker used. Visitors then pass through to the search area carrying a minimum of items.

Visitors then have two searches. The first is conducted by a drug dog. Visitors are lined up at the doorway of the search area where a dog handler is stationed. If the dog does not indicate, the visitor is passed through to a search room where the second search takes place. If the dog does indicate, the visitor is placed in a line with other visitors so that the dog can carry out a second check. If the dog indicates again, the visitor is asked to enter an interview room.

The second search takes the form of a visual check of the mouth, and a rub-down search carried out by a member of staff of the same sex as the visitor. If it is suspected that the visitor is in possession of an illicit item, he or she is placed in an interview room. Otherwise, the visitor is allowed to pass on into the visits room.

In the interview room, the visitor is told that he or she is suspected of carrying an illicit item and is offered a closed visit or the option of leaving the prison. It is open to the Governor to bar such a visitor from further visits for up to three months. If an illicit item such as a quantity of drugs is found, the police are called. No visitor is strip-searched at the prison.

(ii) *Trainees*

Trainees are subject to a rub-down search prior to each visit and are always placed at a table in the visits room before their visitors arrive in the room. Each trainee is seated in a dedicated chair at a table appropriate to his risk. Those considered to present a

higher risk of a security breach, such as drug misuse, are placed at a table most easily monitored by a CCTV camera. There are six staff on duty in the visits room as well as a visits manager and a dog handler. During each visit, officers regularly patrol the room. Another officer in an adjacent room observes a bank of CCTV monitors that oversee the activities of those in sight of each camera. If something is seen, staff in the visits room challenge the visitors or trainees and take appropriate action, such as terminating the visit or, if necessary, involving the police. At the conclusion of each visit, trainees are given a further rub-down search, and 10% are given a strip-search on a random basis. Those trainees whose behaviour during visits arouses suspicion are automatically strip-searched.

(iii) *Searching of the visits room*

The visits room is searched before and after every visits session. The area is cleaned every day by civilian cleaners, who have no direct contact with trainees.

Reducing the demand for drugs

The main element of Castington's 2004/2005 strategy for reducing the demand for drugs by trainees and young offenders is the voluntary drug testing programme. This is supported by a positive approach at the establishment to the use of compacts. These require trainees to agree to certain standards of behaviour. Also in place is a rewards and sanctions initiative, by which trainees are given incentives to improve their behaviour, such as increased privileges, and sanctions if their behaviour deteriorates.

Reducing the harm from illegal substances by offering advice, support, counselling, treatment and throughcare.

Closely allied to the strategy for reducing the demand for drugs is the strategy for reducing the harm the use of illegal drugs can cause. The principal ingredient of this strategy at Castington is the provision of the CARATs service. Those trainees who wish to use the service are offered a standard assessment that seeks to identify their care and support needs. As a result of the assessment, they are then offered counselling, group work, healthcare and detoxification, rehabilitation and harm minimisation education.

Trainees who volunteer for the CARATs service are expected to agree personal goals and outcomes, and set targets for the management of their substance misuse. Regular reviews of their progress are undertaken. In order to provide post-release support, CARATs staff establish release plans with each trainee. These involve referrals to appropriate community based agencies to support the trainees after their release from prison, especially through engagement in the Drug Interventions Programme.

My investigator discussed Castington's drug misuse strategy and visits searching policies with the Drug Strategy Unit in National Offender Management Service (NOMS) Headquarters. He was advised that the drug strategy in place at Castington at the time

of the investigation was acceptable and was entirely consistent with the three key strands of the NOMS drug strategy: supply reduction, demand reduction and throughcare.

Drug Strategy Unit commented that it would be very difficult for any prison to be entirely free of drugs. Such a goal would call for draconian measures to be taken, such as intrusive searching or closed visits for everybody, thereby denying physical contact between prisoners and their visitors. A balance has to be struck between deploying robust security measures and maintaining a humane environment that supports the wider rehabilitation of offenders and the maintenance of family ties.

Drug Strategy Unit offered the view that the following additional measures could be considered for implementation at Castington:

- more use should be made of the national Supply Reduction and Good Practice Guide and that this document should be reflected in the establishment's drug strategy.

- consideration should be given to the use of clear plastic cups in the visits area in order to make the potential for passing drugs more difficult. (See recommendation 15:53 of the Good Practice Guide.)

- PE and visits staff should be included in drug strategy meetings, as they, like the Chaplaincy staff who are already included, can be sources of useful information about potential drug misuse or attempts to supply illicit drugs.

I see these as housekeeping points for the Governor to consider in conjunction with the Area Drug Co-ordinator when reviewing the local drug misuse strategy.

Attempts to resuscitate the prisoner

The attempts by staff to resuscitate the prisoner are worthy of praise, especially the two Officers who, in very harrowing circumstances, did their best to remove blockages from the prisoner's airway without any protective gloves or equipment.

Absence of defibrillators

In the clinical review, the author says,

> "I do not believe that having a defibrillator in the prison would have added anything to the resuscitative effort – the paramedic equipment was only used after the prisoner's collapse when moving him was attempted long after the ambulance arrived. Nevertheless if the Head of Healthcare of the Clinical Director believes it would be a helpful item of equipment, the Care Trust should arrange to provide it in the near future."

I agree with these comments.

8. Recommendations

I make the following recommendations:

1. Roll-check procedures

The Governor of Castington should consider what benefits there might be in changing his policy for the conduct of morning roll checks so that the security and health requirements can both be met.

2. Retention of CCTV footage

The Governor should consider submitting a bid for funds to enable the CCTV equipment in the visits complex to be upgraded so that CCTV footage is preserved in the same manner as that installed in the wings, where video tapes are saved rather than being over-taped.

3. Detoxification

The Governor, in conjunction with the Area Drug Co-ordinator and Primary Care Trust , should review the local policy for chemical detoxification to bring it in line with the national guidelines as stated in the Orange Book: Drug Misuse and Dependence – Guidelines on Clinical Management, Department of Health, 1999).

Housekeeping points: suggested areas for improvement

1. Drug misuse strategy

More use should be made of the national Supply Reduction and Good Practice Guide and this document should be reflected in the establishment's drug strategy.

Consideration should be given to the use of clear plastic cups in the visits area in order to make the potential for passing drugs more difficult. (See recommendation 15:53 of the Good Practice Guide.)

PE and visits staff should be included in drug strategy meetings, as they, like the Chaplaincy staff who are already included, can be sources of useful information about potential drug misuse or attempts to supply illicit drugs.

2. Emergency first aid training and equipment

Consideration should be given to the provision of an appropriate number of defibrillators in the near future. If provided, appropriate staff should be trained in their use.

The Prison/Care Trust partnership should review the need for refresher training in CPR for officers.

Good Practice

1. Efforts to revive the prisoner

The staff who attempted to revive the prisoner should be commended.

2. Good Practice

The Psychological Assistant, although relatively junior, persuaded the prisoner of the benefits of CARATs support after he had initially rejected it. This is an example of good practice.