Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Aaron Harte, a prisoner at HMP Peterborough, on 3 November 2022

A report by the Prisons and Probation Ombudsman

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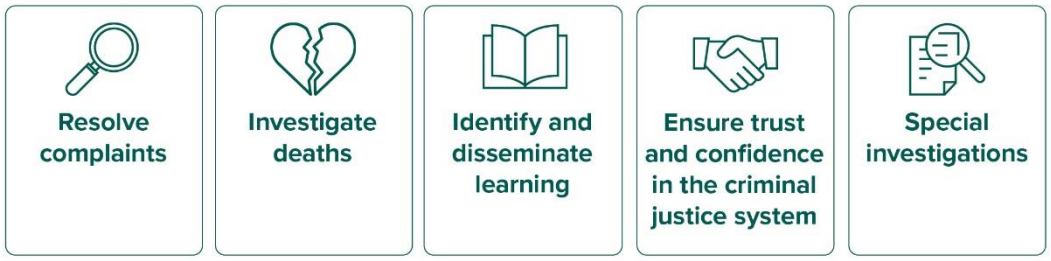
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Aaron Harte died from synthetic cannabinoid toxicity on 3 November 2022 at HMP Peterborough. He was 35 years old. I offer my condolences to Mr Harte's family and friends.

Peterborough has some robust measures in place to deter and detect illicit drugs entering the prison, but Mr Harte was still able to obtain psychoactive substances, which proved fatal. The most recent reports from His Majesty's Chief Inspector of Prisons and from the Independent Monitoring Board indicated that there had been some successes in reducing the entry of drugs into the prison. Peterborough should continue to prioritise and develop their drug strategy.

The clinical reviewer concluded that the healthcare Mr Harte received at Peterborough was of a good standard and equivalent to that which he could have expected to receive in the community.

While we make no formal recommendations, we bring a number of issues to the Director's attention.

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

Adrian Usher
Prisons and Probation Ombudsman **October 2023**

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Summary

Events

1. On 16 February 2022, Mr Harte was remanded to HMP Peterborough charged with stalking.

2. On his arrival at Peterborough, healthcare staff completed an initial health screen. They identified that Mr Harte needed alcohol detoxification. He also said that he had used cannabis and crack cocaine, although urine test results were negative. Mr Harte said that he had no thoughts of suicide or self-harm.

3. On 5 July, Mr Harte was released from court and was required to comply with the terms of a conditional licence. On 7 September, he was recalled to prison after breaching his licence conditions. He was sent back to HMP Peterborough.

4. When he arrived, Mr Harte started an alcohol detoxification programme, which lasted until 15 September. Staff from the substance misuse team at Peterborough offered him additional support but he declined. Prison and healthcare staff did not raise any concerns about Mr Harte's custodial behaviour or that he was using or involved with illicit drugs.

5. At around 4.30am on 3 November, two prison officers began to complete the morning routine check. When one of the officers checked on Mr Harte, he was concerned that Mr Harte was lying in an unusual position. The officer stood at the door and waited to see if Mr Harte would move, but he did not. The officer asked the duty manager to attend the cell.

6. When the staff entered the cell, Mr Harte was unresponsive and cold, and it was clear he was dead. Nevertheless, prison and nursing staff started cardiopulmonary resuscitation (CPR). The paramedics confirmed that Mr Harte had died.

Findings

7. Mr Harte was able to source and use illicit drugs, which caused his death.

8. Peterborough has taken some steps to address its drug supply issues, but Mr Harte's death is a reminder that there is always more to be done to reduce the availability and detection of drugs. The availability of illicit substances remains a problem across the whole prison estate and should remain a priority for Peterborough.

9. The clinical reviewer concluded that the healthcare Mr Harte received was of a good standard and equivalent to that which he could have expected to receive in the community.

10. The night staff did not enter his cell or radio a code blue emergency when they found Mr Harte unresponsive.

The Investigation Process

11. HM Prison and Probation Service notified us of Mr Harte's death on 3 November 2022.The investigator issued notices to staff and prisoners at HMP Peterborough informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

12. The investigator obtained copies of relevant extracts from Mr Harte's prison and medical records.

13. The investigator interviewed seven members of staff at HMP Peterborough on 22 December.

14. NHS England commissioned a clinical reviewer to review Mr Harte's clinical care at the prison.

15. We informed HM Coroner for Cambridgeshire of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer contacted Mr Harte's mother, to explain the investigation and to ask if she had any matters, she wanted us to consider. Mr Harte's mother said that she had no questions at that time. The family were sent a copy of our initial report, but no response to our findings was received.

17. An inquest into Mr Harte's death was opened on 16 November 2022 and concluded on 16 September 2025. A jury concluded that Mr Harte died as a result on synthetic cannabinoid toxicity.

Background Information

HMP Peterborough

18. HMP/YOI Peterborough is operated by Sodexo Justice Services. It holds men and women in separate sides of the prison. There is 24-hour healthcare provision. All healthcare is provided by Sodexo under the provisions of their contract with the Ministry of Justice.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP/YOI Peterborough men's prison was a scrutiny visit in November 2020. Inspectors concluded that, despite some staffing difficulties, the integrated substance misuse service had been providing good clinical and psychosocial support, with regular face-to-face assessments and joint reviews. There had been a good flow of local intelligence which was being analysed effectively, and the prison was addressing emerging risks, such as the entry of drugs.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report for the year to March 2022, the IMB reported that it was encouraged by the impact that security measures had had in reducing the flow of illicit substances into the prison. The IMB reported that all incoming personal mail for prisoners was photocopied to prevent any impregnated with drugs from reaching the wings. Parcels that were sent to the prison were checked by dogs and if necessary screened for drugs. Airport-style security was introduced in May 2021 for all staff and visitors, including X-ray scanning, and the prison used transparent bags for staff possessions and searches.

Previous deaths at HMP Peterborough

21. Mr Harte was the fourteenth prisoner to die at Peterborough since May 2019. Of the previous deaths, two were self-inflicted, ten were from natural causes and one was drug related. In a previous investigation into the drug related death of a prisoner in 2021, we noted that the prison must continue to develop strategies to reduce the supply and demand of illicit drugs in Peterborough.

Psychoactive Substances (PS)

22. PS (formerly known as 'legal highs') continue to be a serious problem across the prison estate. They can be difficult to detect and can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health,

suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Key Events

23. On 16 February 2022, Mr Harte was remanded to HMP Peterborough charged with stalking.

24. When Mr Harte arrived at Peterborough, healthcare staff completed an initial health screen. Mr Harte told nursing staff that he used illicit drugs including cannabis and crack cocaine, but urine test results were negative for any substances. Nursing staff identified that Mr Harte needed alcohol detoxification. He said that he suffered with anxiety, depression, and paranoia. Healthcare staff referred him to the mental health team. He was later assessed and prescribed appropriate medication and was monitored regularly. Mr Harte said that he had no thoughts of suicide or self-harm.

25. On 5 July, Mr Harte appeared in court and was served with a restraining order. Due to time he had already served in prison on remand, he was released from court on a conditional licence.

26. On 7 September, Mr Harte was recalled to prison after he had breached the conditions of his licence. He was sent back to HMP Peterborough.

27. When Mr Harte arrived at Peterborough, healthcare staff completed another initial health screen and a drug test, and the results showed that Mr Harte had used diazepam. Mr Harte said that he was prescribed this medication for alcohol detoxification while he was in police custody. He said that he had not used any other illicit drugs. Nursing staff referred him to the alcohol intervention service and the mental health team.

28. Mr Harte started an alcohol detoxification programme, which he completed on 15 September. Nursing staff saw him daily and staff from the substance misuse team monitored him during the night.

29. On 12 September, a nurse reviewed Mr Harte's mental health referral and offered him an assessment at the clinic.

30. On 20 September, a worker from the substance misuse team saw Mr Harte and offered him additional support, but he declined the offer.

31. A Prison Custody Officer (PCO) completed keyworker sessions with Mr Harte between September and October. During these sessions, Mr Harte said that he had settled on the wing and was coping well. He felt safe and raised no other issues.

32. Mr Harte asked another PCO about his release date, and the PCO confirmed that he was due for release on 21 November. Mr Harte told the PCO that he would like to work while in prison, but he started to feel stressed when he struggled to secure a job on the wing. Mr Harte told the PCO that he felt that having a job would help him resolve some of his mental health issues.

33. Mr Harte later secured a job in the prison kitchen, which meant that he was out of his cell for most of the day and this made him happy. He said that he was making preparations for his release and was in contact with his family.

34. On the night of 2 November, two Operational Support Officers (OSO) were both on night duty. At around 10.30pm, they completed a routine check of all prisoners on the wing. OSO A had checked Mr Harte's cell and he was not concerned about him. He said that Mr Harte was sat on his bed.

Events of 3 November

35. At around 4.30am on 3 November, both OSOs began completing the first routine check of the morning. When OSO B reached Mr Harte cell, he looked through the observation panel and thought that Mr Harte was lying in a strange position. He said that he could not imagine himself lying like that and that he thought it would not be comfortable. Mr Harte was lying on his side, with his head towards the window (at the back of the cell) looking downwards. One of Mr Harte's hands and his legs were hanging off the bed, and his back was facing the door.

36. OSO B waited to see if Mr Harte moved, but he did not. He called OSO A across to ask what he thought, and they both stood at the door and tried to listen for any sounds of breathing. They knocked on the door and flashed their torches into the cell, but Mr Harte did not respond. OSO B said that he and OSO A felt that they needed to check on Mr Harte, so he radioed for the night manager to attend the wing.

37. A Senior Prison Custody Officer (SPCO) was the duty night manager. He telephoned the wing and spoke to OSO B, who said that they could not get a response from Mr Harte. The SPCO did not instruct them to go into the cell.

38. At approximately 4.35am, the SPCO arrived at the wing and saw other staff outside the cell including the deputy night manager. The staff entered the cell. Mr Harte's body was twisted, and he was lying face down on the duvet. The SPCO called to Mr Harte, but he did not respond. He then shook his arm. He said that Mr Harte felt very cold, and his body was rigid. When he turned Mr Harte over, his first thought was that he had died as there were clear signs of rigor mortis. Staff moved Mr Harte onto the floor and began CPR. The SPCO radioed a code blue at 4.36am.

39. At approximately 4.40am, nursing staff arrived at the cell and took over resuscitation attempts. Paramedics arrived, and at 4.48am, they confirmed that Mr Harte had died.

Events following Mr Harte's death

40. Prison managers informed the police of Mr Harte's death and they attended the prison. Prison staff told the police that Mr Harte had a history of illicit drug use. The police searched Mr Harte's cell and seized a number of items, including a vape pen and two orange tablets, to be tested for illicit drugs.

41. In a statement to the Coroner, the police said that that when they attended the prison on the day of Mr Harte's death, they were made aware that another prisoner on the same wing was suffering from what was believed to be an illicit drug-induced seizure caused by a suspected psychoactive substance. Prison staff conducted a search of the wing and found a herbal substance known as 'Pandora's Box' which is known to have strong effects. Prison staff notified the police.

42. The police did not confirm whether the items seized from Mr Harte's cell were tested. However, Mr Harte was prescribed medication which he was required to take under supervision by nursing staff, therefore it is likely that the two orange tablets found in his cell were illicitly obtained.

Contact with Mr Harte's family

43. A chaplain was appointed as the prison's family liaison officer (FLO). Mr Harte had a close relative also at Peterborough. The prison was concerned that Mr Harte's mother might learn of his death from another prisoner and concluded that they needed to act swiftly. The FLO called Mr Harte's mother on the morning of 3 November and broke the news of Mr Harte's death and offered his condolences. He remained in contact with Mr Harte's mother and updated her on the process that would follow.

44. The prison offered a contribution to funeral costs in line with Prison Service policy.

Support for prisoners and staff

45. Prison managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

46. The majority of those staff interviewed and that had been involved in the events on 3 November told the investigator that they felt that there was a lack of support offered on the day and that there was little or no follow up care provided for them.

47. The prison posted notices informing other prisoners of Mr Harte's death and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by the death.

Post-mortem report

48. The post-mortem report gave Mr Harte's cause of death as synthetic cannabinoid toxicity.

Findings

Drug strategy at HMP Peterborough

49. Mr Harte died of synthetic cannabinoid toxicity (the toxic effects of illicit PS use). Clearly, he was able to obtain illicit drugs at Peterborough, despite the prison's best efforts to reduce drug supply and demand. We have not identified any evidence to suggest that either the prison or the police established where or when Mr Harte obtained the PS.

50. At the last HMIP inspection in 2022, inspectors reported that there had been some success in reducing the entry of drugs to the prison, a good flow of local intelligence was being analysed effectively, and the prison was addressing emerging risks, such as the entry of drugs. This was a view shared by the IMB, who found that there were robust procedures in place, including that all incoming personal mail for prisoners was photocopied to prevent any impregnated with drugs from reaching the wings. Parcels sent in were checked by dogs and if necessary, screened for drugs. Airport-style security was introduced in May 2021 for all staff and visitors, including X-ray scanners and transparent bags for staff possessions and searches. The IMB indicated that good progress had been made.

51. We acknowledge the difficulty in preventing drugs entering the prison. PS is especially prevalent. Peterborough has a large perimeter and is situated in an open and accessible area vulnerable to 'throw-overs' and drones. The illicit drugs market in prison is usually controlled by organised crime gangs and the scale of the problem requires a co-ordinated approach. Although it is clear that some things are being done very well at Peterborough, including the analysis of intelligence and the system for checking the validity of legal mail, the threat from drugs is constantly evolving and more can always be done.

52. We were told that Peterborough has not yet requested a review of their drug strategy by HMPPS Substance Misuse Group. The Director should consider whether a full diagnostic review of the prison's drug strategy, including any potential areas of weakness in the prison's efforts to reduce supply, would be helpful.

Mr Harte's substance misuse support

53. When Mr Harte arrived in prison, he said that he had a history or illicit drug use but he only tested positive for diazepam, which he had been prescribed in police custody. Mr Harte completed an alcohol detoxification programme in September 2022. Staff from the prison's substance misuse team offered him additional support, but he declined the offer.

54. Staff raised no concerns about Mr Harte being involved in the use or supply of illicit drugs and had recorded no concerns about him being under the influence of illicit substances during his time at Peterborough.

Clinical care

55. The clinical reviewer concluded that the healthcare that Mr Harte received was of a good standard and was equivalent to that which he could have expected to receive in the community.

56. She found that healthcare staff completed appropriate medication reviews for his alcohol withdrawal. He was reviewed regularly and received on-going support for his mental health.

Emergency response

57. Prison Service Instruction (PSI) 24/2011 gives national guidance for entering cells at night. The PSI says that under normal circumstances, the night orderly officer must give authority to unlock a cell at night and a cell opened with a minimum number of staff (according to local risk guidelines) present. However, the PSI goes on to say, that the preservation of life must take precedence over this. Where there is or appears to be threat to life, staff may open and enter cells on their own if they feel safe to do so, having performed a dynamic risk assessment and informed the control room.

58. The investigator asked the SCO about the procedures for unlocking a cell during the night state. The SCO said that if a member of staff deemed it necessary to call a medical emergency code, or they thought that there was a serious risk to life, they could enter the cell without waiting for the duty manager or other staff to arrive.

59. The two OSOs on duty were not sure whether Mr Harte was okay and did not consider there was immediate cause for concern. OSO B said that, had he considered there was immediate risk to life, he would have gone into the cell. When the deputy night manager arrived, about one to two minutes before the SCO, Mr Harte was still unresponsive. We consider that, at this point, with three staff present (one of whom was the deputy night manager), the SCO should have unlocked and entered the cell.

60. The Director should consider how he can support his staff, particularly those in senior roles, to make swift, confident decisions in uncertain situations.

Director to note

Resuscitation

61. Resuscitation Council (UK) guidelines state that staff should consider whether CPR efforts would be successful and, in the patient's, best interests. The guidelines state that, "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. Rigor mortis normally sets in between two and six hours after death, indicating that Mr Harte had been dead for some time when he was found.

62. We understand the wish to continue resuscitation until death has been formally recognised but trying to resuscitate someone who is clearly dead is distressing for

staff and undignified for the deceased. The guidance highlights that resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile. The guidelines give examples of futility as including the presence of rigor mortis. Staff should be given clear guidance about the circumstances in which resuscitation is inappropriate in line with the Resuscitation Council Guidelines.

Staff support

63. During interviews with staff, most said that they did not feel that they had been offered adequate support following Mr Harte's death, and in some cases support was not provided at all, other than attending the de-brief. The impact on staff who are involved either directly or even indirectly with a death in custody can be traumatic, and for their well-being they should be supported, be given the opportunity to raise concerns and receive help where needed.

64. We bring these learning points to the Director and the Head of Healthcare's attention.

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