Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Edmund Carley, a prisoner at HMP Hindley, on 1 May 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Edmund Carley died of heart failure at HMP Hindley, on 1 May 2018. Heart and lung disease, as well as methadone and psychoactive substances toxicity, contributed to his death. He was 39 years old. I offer my condolences to Mr Carley's family and friends.

I am satisfied that Mr Carley received a good standard of clinical care and substance misuse support, at least equivalent to that he could have expected to receive in the community. However, despite a dynamic substance misuse strategy, Mr Carley was reportedly able to frequently obtain psychoactive substances. The prison will therefore need to strengthen their approach to reduce the availability of illicit drugs, in line with the Prison Service's *Prison Drugs Strategy*.

I am concerned about the seemingly relaxed approach to attending to Mr Carley when he reported breathing difficulties and the failure to fully comply with the procedures for handling medical emergencies. This led to an unacceptable delay in starting resuscitation, calling an ambulance and escorting the paramedics to Mr Carley's cell. Staff must be reminded of their responsibilities and the need for urgency when dealing with potentially life-threatening incidents.

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

Sue McAllister CB
Prisons and Probation Ombudsman **December 2020**

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Summary

Events

1. Mr Edmund Carley was remanded to HMP Liverpool on 5 February 2018. He was subsequently convicted of burglary and sentenced to 83 weeks in prison. Mr Carley transferred to HMP Hindley on 28 March.

2. Mr Carley had a history of substance misuse in the community and in prison and was on a methadone maintenance programme. He also had mental health problems and was awaiting a forensic psychology appointment at the time of his death. Within a week of his arrival at Hindley, Mr Carley had mental health and substance misuse assessments and was assigned a named officer.

3. At 10.26pm on 1 May, Mr Carley activated his cell call bell. The wing's night officer answered it five minutes later and Mr Carley reported breathing difficulties. The officer telephoned the communications room and, when Mr Carley's condition appeared to worsen, he radioed the night manager.

4. The communications room contacted a nurse and the night manager at 10.36pm. The nurse reviewed Mr Carley's medical notes, collected equipment and went to meet the night manager.

5. At 10.49pm, the night manager, an officer and the nurse went into the cell. Mr Carley was unresponsive. The nurse began cardiopulmonary resuscitation (CPR) and asked the night manager to request an ambulance.

6. Paramedics arrived at 11.09pm and took over CPR. At 11.50pm, they confirmed that Mr Carly had died.

Findings

7. A dedicated mental health nurse provided coordinated mental health care and substance misuse support to Mr Carley. He received a good standard of mental and physical health care, equivalent to that which he could have expected to receive in the community.

8. Security intelligence reports indicated that Mr Carley took illicit drugs while serving previous prison sentences. No instances of illicit drug use were recorded during the relatively short period at Hindley in 2018, but after his death several prisoners said that he had frequently smoked psychoactive substances (PS).

9. The prison has implemented a new strategy and action plan to reduce the availability of illicit drugs, with an increased focus on treatment rather than punishment. However, the ready access that Mr Carley had to illicit drugs suggests that the strategy and processes for reducing substance misuse need to be strengthened.

10. At the time of Mr Carley's death, the night officer was unaware that in a life-threatening emergency and subject to a personal risk assessment, staff were permitted to enter a cell at night with the emergency key.

11. Staff did not follow the expected procedures for medical emergencies. Notably, an emergency code was not used when Mr Carley reported breathing difficulties. This resulted in an inordinate delay of 23 minutes between Mr Carley summoning help and staff attending the cell and beginning resuscitation. There was a further delay in requesting an ambulance and no advance provision was made to unlock prison gates to allow the ambulance crew to enter the prison and get to the cell quickly.

12. Although the prison liaison was efficient and responsive, there were difficulties in obtaining information from the healthcare department and getting access to relevant staff for interview. This impacted on the timeliness of the clinical review and investigation report.

Recommendations

- The Governor should identify and address the key weaknesses in reducing the supply of drugs at Hindley and revise the Supply Reduction and Substance Misuse Strategy in light of the findings.
- The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.
- The Governor should ensure that within one month of receipt of this report, all operational staff are reminded of the requirements of Prison Service Instruction 03/2013 and the expected actions during medical emergencies, including using an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and alerting medical staff.
- The Governor should ensure that when an emergency ambulance arrives at the prison, paramedics are given swift and easy access to the relevant location.
- The Governor should arrange for a senior manager to share this report and discuss its findings with the staff involved in the emergency response.
- The Head of Healthcare should ensure that PPO requests for access to documents and healthcare staff are dealt with promptly, in line with PSI 58/2010.

The Investigation Process

13. The initial investigator issued notices to staff and prisoners at HMP Hindley, informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.

14. The investigator visited HMP Hindley on 10 May 2018. She obtained copies of relevant extracts from Mr Carley's prison and medical records.

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

16. The investigation was suspended three times between May 2018 and September 2019, while awaiting the cause of death and due to problems with the initial clinical reviewer. I am sorry that this report was delayed as a result.

17. In April 2019, the investigation team changed. A second investigator took over and a new clinical reviewer was appointed. The second investigator obtained copies of detailed statements from several staff and conducted telephone interviews with three members of staff on 11 and 14 June.

18. We informed HM Coroner for Greater Manchester West District of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. We wrote to Mr Carley's mother, his nominated next of kin, to explain the investigation and to ask if she had any matters for the investigation to consider. She had no specific questions, but asked for a copy of our report.

20. During the latter stages of the investigation, solicitors acting on behalf of Mr Carley's brother contacted the investigator to request a copy of our report.

21. Mr Carley's mother and his brother's solicitor received a copy of the initial report. They made no comments.

22. The initial report was shared with HM Prison and Probation Service (HMPPS). No factual inaccuracies were found. HMPPS accepted five of the six recommendations and their action plan is attached as an annex.

Background Information

HMP Hindley

23. HMP & YOI Hindley was formerly a young offender institution (YOI). In 2015, it became a category C prison for adult men sentenced to less than four years imprisonment, and young adults aged 18-21 serving sentences between 12 months and four years. It can hold up to 664 men.

24. Bridgewater Community Healthcare NHS Foundation Trust and Greater Manchester West Mental Health NHS Foundations Trust provide health services at the prison. Nurses staff the purpose-built healthcare centre 24 hours a day and GPs provide daily clinics, as well as weekend and out-of-hours support.

HM Inspectorate of Prisons

25. The most recent inspection of HMP Hindley was in December 2017. Inspectors found that there had been improvements since the previous inspection in July 2016. They reported that, overall, physical and mental healthcare was reasonable, with a range of appropriate services. However, provision had been affected by staff shortages. Inspectors considered that the clinical substance misuse and psychosocial teams provided a reasonably good service and had the capacity to meet significant future demand.

26. The inspection found that drugs were widely available. Over the previous six months, the number of positive mandatory drugs tests was 51%. In the inspection survey, 44% of prisoners said it was easy to get drugs and they linked the poor regime with the demand for drugs. Security intelligence was of good quality. The information received was not always followed up, but when acted on there were good outcomes. Staffing problems meant that only 22% of suspicion drug tests were carried out and inspectors were concerned that there was no formal supply reduction action plan.

Independent Monitoring Board

27. 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 December 2018, the IMB reported improvements, including more robust efforts to control the supply of PS. They found that security measures were “effective, proactive and timely.” The prison responded quickly to information in intelligence reports, including unannounced searches of staff; regular cell searches; and vigilance in monitoring contraband thrown over the wall.

28. The Board noted that although photocopying all incoming post had helped to control the supply of PS, the results of mandatory drug tests were around the same, which indicated that drugs were still getting into the prison. Due to the number of emergencies involving illicit substances, the psychosocial substance misuse team had worked hard to provide individual and group support. They were also leading the development of a recovery wing.

29. The Board stated that a third of survey respondents in August 2018, had reported that they did not feel safe and that the number of assaults on staff and prisoners had risen at the end of the year. The most frequent reasons given were bullying and 'issues with staff.' Unexplained injuries, as well as self-isolators continued to be a concern. They considered that prisoners had benefitted from effective use of and care given under the Challenge, Support and Intervention Plans (CSIP) and the prison's suicide and self-harm prevention measures.

Previous deaths at HMP Hindley

30. Mr Carley was the fifth prisoner to die at Hindley since May 2016. Two of the previous deaths were due to natural causes, one was self-inflicted and one inconclusive. We have made previous recommendations about the failure to use a code during emergency response procedures and the need to reduce the availability of and demand for drugs.

Psychoactive Substances (PS)

31. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of 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, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

32. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

33. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

Remand to HMP Liverpool

34. Mr Edmund Carley was remanded to HMP Liverpool on 5 February 2018, charged with burglary. It was not his first time in prison. He was well known to staff at Liverpool and he had been previously released from Hindley in September 2017. (Mr Carley was convicted on 5 March 2018 and sentenced to 83 weeks in prison.)

35. Mr Carley had an initial health screen with a nurse. He had a history of drug and alcohol misuse and tested positive for opiates, cocaine and benzodiazepines (sedatives). He said he spent around £100 per day on drugs and had been under the care of the community drug team. Mr Carley also had mental health problems and said he had had been diagnosed with post-traumatic stress disorder (PTSD). He reported five bereavements of close family members, within weeks of each other in December 2017. (There was later doubt as to the accuracy of this statement.)

36. A prison GP then assessed Mr Carley and noted that he regularly had withdrawal seizures if he did not drink and that he had fitted the previous day. Mr Carley suffered from depression and anxiety, with thoughts of suicide and he had attempted to hang himself in 2014 and 2017. His medication included mirtazapine (an antidepressant) and propranolol (a beta-blocker used to treat heart problems and anxiety). The GP prescribed methadone stabilisation and a diazepam detoxification. Mr Carley was referred to the substance misuse team and received methadone, daily.

37. Mr Carley arrived at Liverpool with a suicide/self-harm warning form, noting that he had threatened to kill himself if he was remanded into custody. Between 5 and 19 February, he was managed under the Assessment, Care in Custody and Teamwork (ACCT) procedures - the Prison Service care-planning system to support prisoners at risk of suicide and self-harm. Mr Carley told staff that he felt under threat across the prison and he named gangs and individuals with whom he had issues. He said that his face had been slashed during a previous sentence, due to stealing from drug dealers.

38. On 6 February, a nurse carried out a second reception screen and well man monitoring check. Mr Carley reported a family history of epilepsy and mini strokes, as well as multiple suicides in his immediate family. He mentioned PTSD and bipolar disorder. The nurse advised him how to access mental health services if he needed this in the future.

39. Mr Carley did not attend the drug and alcohol recovery service induction that day, so a referral pack and information on PS was posted in his cell.

40. In the evening, Mr Carley told a GP that the methadone was not relieving his symptoms. He became aggressive and insisted he wanted to be prescribed diazepam. The GP told him it was inappropriate to prescribe chlordiazepoxide and diazepam together, so the latter would be stopped. He agreed to increase the dose of methadone and prescribed a high dose of Librium to help Mr Carley's alcohol and benzodiazepine withdrawal.

41. On 8 February, a drug and alcohol recovery worker assessed Mr Carley. They discussed how to reduce harm and the risks of overdose, including mixing substances and low tolerance levels. The recovery worker opened a recovery plan and Mr Carley agreed to one to one counselling to explore the reasons for his drug use, triggers and understanding cravings. He also agreed to attend Narcotics Anonymous and Alcoholics Anonymous meetings to access peer support and help prevent relapse.

42. A nurse was assigned as Mr Carley's named nurse. On 4 March, he conducted a mental health review and noted ongoing issues with anxiety, compounded by a lack of medication. The nurse listed Mr Carley for a routine psychiatry appointment and agreed to see the GP about his propranolol, which had been stopped.

43. On 11 March, Mr Carley was found with a list of debts owed to another prisoner suspected of dealing drugs.

44. On 12 March, a counsellor held a bereavement counselling session on Mr Carley's wing. He noted that Mr Carley said he could not walk through the wing, as his face and throat had been slashed in another prison a few years before. This had left him extremely anxious and prone to panic attacks if he left his cell, or went anywhere in the prison. Mr Carley felt he needed to deal with this trauma before having bereavement counselling. The counsellor therefore discharged Mr Carley and referred him to a cognitive behavioural therapist, to work on these issues.

Transfer to HMP Hindley

45. Mr Carley transferred to HMP Hindley on 28 March. A nurse carried out a full initial health screen. She recorded Mr Carley's medical history and referred him to the GP and the mental health team. Mr Carley continued to receive methadone.

46. On 2 April, a mental health nurse assessed Mr Carley. They had a detailed discussion about his substance misuse history and he was given advice on harm minimisation. Mr Carley also saw another nurse to start the smoking cessation programme, using nicotine replacement therapy.

47. On 3 April, Mr Carley asked to be seen in the substance misuse clinic, as he felt his mental health was deteriorating and a mental health nurse spoke to him. She referred him for counselling and noted that he would be offered regular ongoing support.

48. Shortly afterwards, the nurse who had been assigned as Mr Carley's named nurse, created a methadone maintenance programme care plan and scheduled a 13-week review for 2 May, with the drug treatment team and prescriber.

49. On 4 April, a nurse conducted a mental health assessment. Mr Carley felt that none of the substance misuse and mental health services had helped him and he declined the offer of the services at the prison, such as the anxiety management group and Cognitive Behavioural Therapy (CBT), as this had not helped him in the past. The nurse noted that he was already on the waiting list for counselling. She planned to discuss Mr Carley at the weekly mental health meeting and to explore a referral to the psychology team. She also referred him to the chaplaincy.

50. On 5 April, Mr Carley and a substance misuse nurse discussed the aims of Mr Carley's treatment in depth. The nurse maintained Mr Carley's existing dose of methadone.

51. Mr Carley then asked to see a nurse in the substance misuse clinic. He told her that other prisoners had shouted at him, threatening to cut him and "send a hit up" when he attended for his methadone and he was afraid to leave the wing. The nurse completed Mr Carley's five-day review. She then spoke to prison senior managers and it was agreed that in view of his anxieties about other prisoners, he could receive his methadone on his wing. A pharmacy technician also arranged for his nicotine replacement patches to be sent to the wing. (This was withdrawn on 17 April, as Mr Carley failed a medicine compliance check.)

52. Mr Carley refused to attend initial induction sessions, stating that he had issues off the wing and would not leave. Wing staff contacted the safer custody team, but they had no information on any problems between Mr Carley and other prisoners. On 12 April, his induction was conducted on the wing.

53. On 16 April, Mr Carley was allocated to work on the servery and his work and attitude were noted as good.

54. On 25 April, Mr Carley offered staff details of a mobile phone in return for two vapes.

Events on the night of 1 May

55. CCTV footage shows that at 10.26pm on 1 May, Mr Carley's cell call light lit up. An Operational Support Grade (OSG) went to the cell at 10.31pm. He told the investigator that Mr Carley was standing by the cell door and said he could not breathe, but he did not mention any pain. The OSG said he could tell Mr Carley was in distress and genuinely unwell. He went to the wing office and telephoned the OSG in the communications centre to report this.

56. The OSG returned to the cell around three and a half minutes later and saw Mr Carley sitting on his bed. He then went to a stairwell a few yards away, which was more private and spoke to the night manager, who said he was on his way and that he did not need to call him again. When the OSG went back to the cell, Mr Carley was on his knees, collapsed on the cell floor. There was no response when he called out to him. The OSG telephoned the communications room again to say that Mr Carley was in distress.

57. At 10.36pm, the OSG in the communications room telephoned a nurse and radioed the night manager. At 10.38pm, the OSG with Mr Carley radioed the communications room to repeat that Mr Carley was struggling.

58. The nurse checked Mr Carley's medical records, collected the ECG machine from the healthcare centre and went to the communications centre to meet the night manager. They then went to the wing with an officer. On the way, the nurse collected the emergency bag from the treatment room.

59. At 10.49pm, the night manager and the officer went into the cell. They found Mr Carley lying face down on the floor, with his knees drawn up under him. The night manager felt Mr Carley's shoulder and he was cold to the touch. He said his first

thought was there were stereotypical signs of PS use, as he noticed a vape pen with paper wrapped around it and Mr Carley had vomit around his mouth.

60. The nurse then entered the cell. She could not find a pulse and asked one of the other staff present to get the defibrillator. She attempted to clear Mr Carley's throat with a suction device and began oxygen therapy and cardiopulmonary resuscitation (CPR), with breaths and chest compressions. The nurse told the night manager that they needed an ambulance. By then, two or three rounds of resuscitation had taken place.

61. At 10.52pm, the night manager asked the communications centre to call an ambulance. The nurse, the night manager and the officer continued cardiopulmonary resuscitation (CPR).

62. A rapid response paramedic and two ambulances arrived at 11.04pm. One of the paramedics said they had to wait for staff to open the main gates and as they went through the prison, several gates had to be unlocked and relocked, which took some time. They reached the cell at 11.09pm and took over the resuscitation attempt. At 11.50pm, a paramedic confirmed that Mr Carley had died.

63. Several prisoners subsequently gave information about Mr Carley. At a substance misuse group meeting on 3 May, prisoners said that Mr Carley had often smoked PS.

64. A prisoner said in a statement that he had looked through a gap at the top of his cell and saw that Mr Carley's cell call bell was lit. He heard him banging on his door shouting for help and there was a delay in staff attending. He said he had heard staff say, "make sure we get our story straight." Another prisoner said he heard Mr Carley say that he could not breathe.

65. A prisoner told an officer that Mr Carley had been smoking PS heavily. He had complained of chest pains and a lump on his side, but had not asked to see the prison GP.

66. A prisoner, who had been a friend of Mr Carley for over ten years, wrote to the investigator to give his account of events. He said that the day before Mr Carley died, he had heard him complain to nurses several times about chest pains. He added that on the night that he died, Mr Carley had banged his cell door for at least 20 to 30 minutes shouting for help, as he could not breathe. When the night officer (OSG) went to his door, Mr Carley asked him to get help, but the OSG had stood there for around 5 to 10 minutes. The prisoner said it then went quiet, the OSG said, "are you ok" and got no reply. The OSG then waited another 10 to 15 minutes before getting help. The prisoner felt that Mr Carley's death might have been avoided if staff had handled the incident quickly. He said that he had also heard staff saying they had to get their stories straight.

Contact with Mr Carley's family

67. A member of the prison's chaplaincy was assigned as the family liaison officer (FLO). The Governor and the FLO visited Mr Carley's mother, his next of kin, to break the news of his death. They arrived at 1.45am, offered condolences and provided information and their contact details. The FLO continued to support the family over the following weeks.

68. The prison paid the full costs of Mr Carley's funeral, which was held on 25 May 2018.

Support for prisoners and staff

69. After Mr Carley's death, the Governor and the night manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The prison posted notices informing other staff and prisoners of Mr Carley's death and offering support. A prison manager conducted a further debrief on 5 June 2018.

Post-mortem report

70. The post-mortem report indicated that Mr Carley's death was due to:

    1a acute myocardial insufficiency
    1b coronary artery atheroma
    2 emphysema, methadone toxicity and 5F-MDMB-PINACA (PS) toxicity.

    (Sudden heart failure and heart disease caused by a build-up of fatty deposits narrowing the arteries and restricting the flow of blood to the heart muscle. Contributory factors were chronic lung disease, which had affected breathing due to the narrowing of airways; methadone toxicity and PS toxicity.)

71. The toxicologist recorded that the blood analysis indicated a level of methadone higher than Mr Carley's prescribed dose.

Findings

Clinical care

Physical and mental healthcare

72. During previous sentences, Mr Carley had reported difficulty breathing and palpitations. On one occasion, it was recorded as a possible anxiety or panic attack. At Hindley, there was nothing in his medical record to indicate lung problems, or reports of symptoms requiring respiratory or chest investigations.

73. Mr Carley received a prompt and comprehensive mental health assessment on transfer to Hindley. He had a named mental health nurse, who provided coordinated mental health care and substance misuse support. He had been referred to the forensic psychology service and was on the waiting list at the time of his death. Mr Carley was appropriately prescribed medication for depression and anxiety.

Support for Mr Carley's substance misuse

74. Mr Carley had a history of substance misuse in the community and in prison. Numerous intelligence reports from previous sentences recorded drug-related behaviour - he had been found under the influence of PS; had links to drug dealing and bullying, as both as a perpetrator and a victim; had received cannabis from one of his visitors; drugs, drug paraphernalia, mobile phones and improvised weapons had been found in his cell; he had refused to cooperate with mandatory drug tests and had failed a test.

75. Mr Carley was on a methadone maintenance programme and his named nurse gave him advice on harm minimisation. There were no reports of drug taking during his last period in prison. However, after his death, other prisoners indicated that he had regularly used PS and had mentioned chest pains. There were conflicting statements among the prisoners as to whether Mr Carley had reported his chest pain to healthcare staff.

76. The clinical reviewer considered that the integrated substance misuse and mental health services were of good quality, with person-centred care during screenings and interventions, and effective sharing of information between services. We agree with the clinical reviewer that Mr Carley received a good standard of care at Hindley, at least equivalent to that he could have expected to receive in the community.

77. The clinical reviewer identified scope for improvements on issues that did not impact on Mr Carley's death, so we have not repeated them here.

Drug strategy at HMP Hindley

78. After an inspection at Hindley in December 2017, HM Chief Inspector of Prisons was concerned that illicit drugs were readily available and there was a high level of positive mandatory drug tests. The prison has a Supply Reduction and Substance Misuse Strategy, which sets out several measures to reduce the demand and

supply of illicit drugs. It gives the background of psychoactive substances and their use, with processes and instructions on handling prisoners suspected of such use.

79. The Head of Security and Intelligence at Hindley said that since the inspection and Mr Carley's death, a lot of work had taken place. The drug strategy had been disjointed, but a new strategy and an action plan have since been put in place. The prison had held a drug strategy summit with all staff, to discuss concerns and ideas. It would be run again to allow staff input to the action plan.

80. He explained that action on recurrent use of illicit substances used to be punishment based. However, they now adopt a different approach, based on treatment. TVs are no longer automatically removed from prisoners on the basic level of IEP and they do not automatically lose their job. The rationale is that if a prisoner's TV is removed, he has nothing else to lose, so there is no incentive to stop drug use. Users are automatically referred to the substance misuse service. The prison has also introduced a recovery wing and prisoners can self-refer to this. In response to the Chief Inspector's criticisms about conducting suspicion tests and cell searches, the Head of Security and Intelligence said that drug testing is a flexible task, which is sometimes reduced to accommodate other duties.

81. Drug taking and trading is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.

82. In relation to reducing the supply of drugs, we note that the new Prison Service strategy says:

"Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact."

83. It is a concern that despite improved security measures and substance misuse support, introduced after the prison's last inspection, Mr Carley was clearly able to obtain illicit drugs. This suggests that much more needs to be done to tackle the issue of drugs at Hindley. We make the following recommendation:

The Governor should identify and address the key weaknesses in reducing the supply of drugs at Hindley and revise the Supply Reduction and Substance Misuse Strategy in light of the findings.

Unlocking cells at night

84. HMPPS national policy and the prison's local policy provides for prison staff to open cells at night without the authority of the night manager, where there appears to be

danger to life, subject to a dynamic risk assessment to ensure their safety. The night OSG said that OSGs do not enter cells. In the event of an emergency at night, they are expected to open the pouch with the emergency cell key and wait for officers to arrive before opening the cell.

85. The OSG had little contact with prisoners and did not know Mr Carley. He was therefore unaware of his character and temperament, but was satisfied that he was genuinely and severely unwell. In the circumstances, it seems reasonable that the OSG did not attempt to enter the cell while Mr Carley was alert and aware. However, once he became unconscious, the OSG should have considered going into the cell.

86. Hindley issued a local instruction on 21 May 2018, after Mr Carley's death, setting out the correct procedures for opening cells at night. However, given staffs' incorrect and possibly entrenched understanding about entering cells, we cannot be certain that the policy has been properly embedded. We make the following recommendation:

The Governor should ensure that all staff understand the importance of entering a cell without delay in an emergency in order to help preserve the life of a prisoner.

Emergency response

87. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, sets out the actions staff should take in a medical emergency. The instructions require use of a code system in emergencies, to ensure that an ambulance is called immediately in a life-threatening medical emergency and to enable staff to bring the relevant equipment. It is a requirement to call an emergency code in the event of a prisoner reporting chest pains, or breathing difficulties.

88. There is no electronic system to record the activation and deactivation of cell bells on Mr Carley's wing and the cell bell records cannot be printed. However, it appears from the CCTV that Mr Carley activated the bell at 10.26pm and it was answered at 10.31pm. The OSG told the investigator that he was aware of the emergency response codes. He went to the office to telephone the control room, rather than using his radio, as the cells are close together and if prisoners hear an emergency, they sometimes "act up" and escalate the situation, e.g. shouting comments, or encouraging the person to self-harm. After making the first call to the communications room, the OSG thought the night manager would take the necessary action.

89. At 10.36pm, the OSG in the communications room telephoned a nurse. As the nurse did not know it was an urgent incident, she took the time to briefly review Mr Carley's medical records and collect the ECG machine, before going to the communications centre to meet the night manager and getting the emergency bag. At 10.38pm, the night OSG radioed the OSG in the communications room to repeat that Mr Carley needed help. At 10.49pm, the night manager went into the cell with an officer, shortly followed by the nurse.

90. At 10.52pm, after two or three rounds of CPR, the night manager asked the control room to call an ambulance. He said he had reflected since Mr Carley's death, but could not explain why he did not think to call a code blue as soon he went into the

cell. He said he had been intensely focussed on resuscitating Mr Carley and using the defibrillator.

91. National and local guidance is clear that breathing difficulties are a medical emergency, which requires an immediate response. However, 23 minutes had elapsed between the activation of the cell bell and staff entering the cell, with a further three-minute delay before an ambulance was called. (The prison pointed out a discrepancy of three minutes between the CCTV and radio transmission timings, but this does not negate the considerable overall delay in attending to Mr Carley.)

92. We have serious concerns about the handling of the emergency response and the resulting delays. Use of the relevant code informs staff not only that there is an emergency, but also of its nature and enables better preparation. It is understandable that in stressful situations, mistakes can be made, but a quick response is vital in increasing the chances of successful resuscitation. In this case, the lack of an emergency code resulted in an excessive and unacceptable delay in going to Mr Carley's cell, starting CPR and calling an ambulance. In addition, no arrangements were made to facilitate quick access for the paramedics.

93. We note that the prison issued Governor's Order 16/2018 Emergency Response in Custody on 24 May 2018, reminding staff of the procedures. However, use of a code in emergencies is a matter we have raised with Hindley before and given the gravity of our findings, we need to be satisfied that staff are fully aware of the need to comply with these procedures. We make the following recommendations:

The Governor should ensure that within one month of receipt of this report, all operational staff are reminded of the requirements of Prison Service Instruction 03/2013 and the expected actions during medical emergencies, including using an emergency code immediately when there are serious concerns about the health of a prisoner, so that there is no delay in calling an ambulance and alerting medical staff.

The Governor should ensure that when an emergency ambulance arrives at the prison, paramedics are given swift and easy access to the relevant location.

The Governor should arrange for a senior manager to share this report and discuss its findings with the staff involved in the emergency response.

Access to healthcare information and staff

94. The designated prison liaison officer was prompt and responsive to requests for information throughout the investigation. However, the investigator and clinical reviewer experienced difficulties obtaining policies and documents requested directly from the healthcare department, as well as getting access to interview healthcare staff. This impacted on the delivery of the clinical review and the investigation report. We make the following recommendation:

The Head of Healthcare should ensure that PPO requests for access to documents and healthcare staff are dealt with promptly, in line with PSI 58/2010.

Inquest

95. The inquest, held on 24 October 2023, gave a narrative conclusion. It found that Mr Carley died from natural disease to which combined methadone and 5F-MDMB-PINACA Toxicity (Spice) were contributory.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100