Psychological Approaches

FINAL REPORT
OF AN INDEPENDENT INVESTIGATION
INTO THE CASE OF MR MIDLAND

Commissioned by HM Prison and Probation Service on behalf of the Secretary of State for Justice in accordance with Article 2 of the European Convention on Human Rights

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16 July 2021

Investigators

The lead investigator for the independent Article 2 Investigation into the events leading up to Mr Midland being found unresponsive on 28 April 2016 in HMP Featherstone is **Dr Deborah Brooke, Consultant Psychiatrist**. Dr Brooke has worked for 40 years in the National Health Service, including 20 years as a consultant forensic psychiatrist; she currently works with sick doctors.

She has extensive experience in ensuring quality in postgraduate medical education and appraisal and has had a regulatory role for over ten years with the General Medical Council's fitness to practice procedures – first as medical examiner and supervisor, then as panellist for the Medical Practitioners' Tribunal Service.

Dr Brooke was assisted by **Ms Louise Taylor**, who worked for HM Prison Service / the National Offender Management Service (NOMS) between 1981 and 2011. Ms Taylor was Governor of HMP Stafford between 2000 and 2006 and Governor of HMP Ranby between 2006 and 2011. (NOMS was succeeded by HM Prison and Probation Service on 1 April 2017.)

ACKNOWLEDGEMENTS

The investigators greatly appreciated the involvement of the family in this investigation and would like to extend their most sincere sympathy at the degree of disability suffered by Mr Midland and the impact this has had on his family and friends.

The investigators would also like to thank staff at HMP Featherstone, including the current and former health care staff, for their help with this investigation. Many people remembered this as a particularly sad event during a time of tremendous challenge as they tried to maintain a culture of rehabilitation in the face of the threat to that culture posed by the use of novel psychoactive substances (NPS).

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EXECUTIVE SUMMARY

1. This investigation was commissioned on 22 June 2018 by Her Majesty's Prison and Probation Service on behalf of the Secretary of State for Justice under the State's obligation under Article 2 of the European Convention on Human Rights (ECHR) to investigate the circumstances surrounding the events leading up to Mr Midland being found in an unresponsive condition in his cell on 28 April 2016.

2. The lead investigator was Dr Deborah Brooke, assisted by Ms Louise Taylor.

3. The period covered by this investigation is from 1 January 2016 to 28 April 2016.

4. At this time, the staff and management at HMP Featherstone were experiencing difficulty in reducing the entry into the prison of mood-altering substances, primarily novel psychoactive substances (NPS, 'mamba', 'spice', see Appendix 2). Levels of use of these substances had escalated over the preceding years in many UK prisons, with physical and mental consequences including physical collapse necessitating hospital care.

5. Mr Midland was serving a sentence of imprisonment in HMP Featherstone. He was known to have schizophrenia, complicated by polysubstance misuse, extending to alcohol dependency syndrome. Mr Midland continued to use illicit mood-altering substances in prison. This contributed to a deterioration in his mental state in the autumn of 2015. This may have been exacerbated by poor compliance with his antipsychotic medication.

6. His schizophrenia was managed robustly with a detailed assessment and an increase in his antipsychotic medication to be given under observation (rather than in his own possession). His mental state was slow to improve due to his use of novel psychoactive substances and non-prescribed

Subutex (buprenorphine, an opiate) but when he stopped these substances he quickly improved and in early 2016 was able to reflect on their adverse impact on his mental state. He declined offers of help with his substance misuse disorder.

7. He had a collapse, compatible with NPS use, on 17 April 2016.

8. On 28 April 2016 he was found in an unresponsive state in his cell in HMP Featherstone. He was transferred to hospital where he was diagnosed to have sustained brain damage due to lack of oxygen. The medical team in hospital arrived at a diagnosis of respiratory arrest, believed to be due to NPS use.

9. Mr Midland sustained severe and lasting brain damage. He did not have capacity to take part in this investigation.

FINDINGS

FINDING 1

The prison had put in place a number of multidisciplinary initiatives to reduce the supply of, and demand for, illicit drugs.

FINDING 2

The minutes of the prison's Substance Misuse Meetings between January 2016 and April 2016 showed that the Security representative did not always attend, so opportunities for shared working with Health Care on issues relating to drugs were lost.

FINDING 3

The minutes of the Substance Misuse Meeting of 4 March 2016 contains an action to issue a notice to staff to remind them that they have an obligation to make a referral to DARS (Drug and Alcohol Recovery Service) and Health Care when a prisoner is taken back to the wing and

placed on report[1] for being under the influence. The Article 2 Investigation could not find a record that these referrals were being made consistently. However, the investigators did not conclude that Findings 2 and 3 would have affected the outcome for Mr Midland.

FINDING 4

HMP Featherstone informed Mr Midland's family of his admission to hospital after a delay of six days, which the Article 2 Investigation found was unacceptable.

FINDING 5

HMP Featherstone did produce a Fact Finding Report after the event of 28 April 2016, but it was not a formal investigation. In view of the severity of the consequences suffered by Mr Midland, the Article 2 Investigation found that a more formal investigation should have been conducted by HMP Featherstone following the Fact Finding Report. This would have enabled the prison to reflect on any lessons to be learnt from the management of Mr Midland's case.

FINDING 6

Mr Midland's enduring mental illness was managed well. He was aware of the help available to users of illicit drugs.

FINDING 7

Areas of good practice included the involvement of prisoners to support other prisoners. Additionally, staff who had worked with Mr Midland were interviewed for this investigation, and they impressed the interviewers with their professionalism and commitment.

[1] To place on report means to make [a prisoner] liable for an adjudication and disciplinary sanctions. For adjudication, see Glossary.

FINDING 8

This report of the Article 2 Investigation concludes that nothing further could have been done to reduce the risks posed by novel psychoactive substances (NPS) to Mr Midland and therefore that this tragic incident could not have been prevented.

RECOMMENDATIONS

10. The Article 2 Investigation makes three recommendations:

Recommendation 1.

For HMP Featherstone, Midlands Partnership NHS Foundation Trust and Care UK

HMP Featherstone and the health care providers in the prison should explore how to maximize information-sharing between Health Care and Security so that both of these components of care can work together to reduce the ingress and use of illicit substances in the prison. This includes the completion of agreed actions in the Substance Misuse Meetings and the Security Committee Meetings.

Recommendation 2.

For HMP Featherstone

HMP Featherstone should review its procedures so that families are informed of a prisoner's illness with a minimum of delay.

Recommendation 3.

For HMP Featherstone

HMP Featherstone should comply with the mandatory action contained in Prison Service Order 1300 – 'Investigations' that a formal investigation is completed when there is serious harm to any person.

TERMS OF REFERENCE

11. The Terms of Reference for the investigation, set out in HM Prison and Probation Service's commission letter on 22 June 2018, are listed below. The time period covered by the investigation is from 1 January 2016 to 28 April 2016.

- To examine the management of Mr Midland by HMP Featherstone in the period before he was found unresponsive on 28 April 2016, and in light of the policies and procedures applicable at the relevant time;

- To examine relevant health issues, including mental health assessments and clinical care, in the period before Mr Midland was found unresponsive on 28 April 2016;

- To consider, within the operational context of HM Prison and Probation Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

- To provide a draft and final report of your findings including the relevant supporting documents as annexes;

- To provide your views, as part of your draft report, on what you consider to be an appropriate level of public scrutiny in all the circumstances of this case. The Secretary of State will take your views into account and consider any recommendation made on this point when deciding what steps will be necessary to satisfy this aspect of the investigative obligation under Article 2 of the ECHR.

THE CONCERNS OF MR MIDLAND'S FAMILY

12. Mr Midland's family expressed concerns that Mr Midland might have been assaulted prior to his collapses.

INTERESTED PARTIES

13. The Interested Parties in this investigation are as follows:

    HM Prison and Probation Service on behalf of the Secretary of State for Justice;

    Mr Midland's father on his behalf, legally represented;

    Care UK; and

    Midlands Partnership National Health Service Foundation Trust.

METHODOLOGY

14. As agreed with the commissioning body, this investigation was led by an investigator from health services, assisted by an investigator appointed by HM Prison and Probation Service. In line with Psychological Approaches' usual practice, the case and the draft report were quality-assured in confidence by Psychological Approaches prior to finalizing the report.

15. Information held on Mr Midland by HMP Featherstone was disclosed to the investigators after redaction (for example, the deletion of any third party information).

16. Medical notes were disclosed with the consent of Mr Midland's family. These included the notes from the prison and the notes from his admission to hospital on 28 April 2016.

17. All interviews were tape-recorded. Transcripts are included at Annexe C.

TIMELINE OF THE INVESTIGATION

13/11/18	The assistant investigator reviewed security information relating to Mr Midland at HMP Featherstone.
13/2/19	The investigators visited the prison and visited the sites of the incidents on 17 and 28 April 2016.
4/3/19	The investigators met with the father and step-mother of Mr Midland, with the solicitor of Mr Midland and his father in attendance.
5/3/19	The lead investigator visited Mr Midland in the company of his father.
5/6/19	The investigators visited the prison on to view the body-worn camera footage of the incident on 28 April 2016.
5/8/19	Interviews were conducted with nurse 1, Senior Officer 1 and Governor 2 by both investigators jointly in the prison.
28/8/19	Interviews were conducted with Prison Officer 1 and nurses 2 and 3 by both investigators jointly in the prison.

12/9/19	Governor 1 at the prison supplied information relating to the reduction and management of risk to prisoners and staff posed by NPS use during the period January to April 2016.
11/11/19	Nurse 4 was interviewed by both investigators jointly at her home.
6/2/20	The lead investigator viewed the hospital notes at the offices of the solicitor for the family.
21/2/20	The current provider of mental health in-reach at the prison (Midlands Partnership NHS Foundation Trust) provided copies of their policy relating to the management of inmates with 'dual diagnosis', that is, mental illness complicated by substance misuse.
15/7/21	At the conclusion of the investigation, the draft report was circulated to the Interested Parties, with a request for factual corrections. Midlands Partnership NHS Foundation Trust observed that the events covered in the Article 2 Investigation dated from 2016. The Trust has implemented revised procedures in the intervening years. These are summarised in a flow chart on the management of life-threatening illicit drug use, which was sent to the lead investigator on 15 July 2021. This flow chart is included in this report at page 71.

HM PRISON FEATHERSTONE

18. The prison was opened in 1976. It has an operational capacity of 703. It holds only convicted prisoners.

19. The Annual Report of the Independent Monitoring Board (IMB) at HMP Featherstone for the period 1 November 2015 – 31 October 2016, dated November 2016, was published on 16 December 2016.

20. At the time covered by this Independent Monitoring Board report, the Ministry of Justice performance rating for HMP Featherstone was 3, on a scale from 1 (serious concerns) to 4 (exceptional). This rating takes into account 34 criteria such as overcrowding and purposeful activity. The IMB report noted areas of good practice, particularly the work done by the Gym staff and the Chaplaincy. However, concern was expressed by the IMB at the extent of the ingress of illicit substances, with attendant concerns about health, debt and bullying;[2] there was concern at the amount of cancellation of appointments at hospitals[3], and at the levels of violence and bad behaviour from some prisoners and the damage being caused to persons and property.[4]

21. With regard to the ingress of drugs, and the use of drugs by prisoners, the IMB was satisfied that the senior management was aware of the situation and appeared to be taking appropriate action. This report commented that "This situation is however common throughout the prison estate".[5]

22. The IMB commented that a deterioration in engagement with the development opportunities at the prison may have been due to the prison

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2 'The Annual Report of The Independent Monitoring Board. HMP Featherstone. 1st November 2015 – 31st October 2016', November 2016. Page 5, paragraph 3.8. Website address at Appendix 1.

3 As above. Page 5, paragraph 3.4.

4 As above. Page 5, paragraph 3.10.

5 As above. Page 5, paragraph 3.8.

changing its role from a training establishment to a resettlement prison during the period before this report.[6]

23. HM Chief Inspector of Prisons reported on 27 March 2014 on an unannounced inspection of HMP Featherstone conducted between 14 and 25 October 2013 (see Appendix 1). This was the last report by HM Chief Inspector of Prisons before the period covered by this investigation (1 January 2016 to 28 April 2016). In 2013, the prison was a training prison, and the report commented favourably on the quality and quantity of work and education.[7] The report concluded that the prison was "a very positive establishment", with a good culture and relationships. However, the prison needed to develop its policies and systems to ensure the safety of more vulnerable prisoners, or prisoners who posed a higher risk.[8]

Structure of the Health Services in the Prison

24. During the period covered by this investigation, the contract for providing health care in HMP Featherstone was awarded to different organizations.

25. From January until 31 March 2016, the providers were:

- Primary Care: South Staffordshire and Stoke on Trent NHS Partnership Trust
- In-Reach (Mental Health): South Staffordshire and Shropshire NHS Foundation Trust
- Substance misuse services: Lifeline Project.

26. Care UK was awarded the contract from 1 April 2016. The primary care and clinical component of substance misuse services is now provided by

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6 As above. Page 14, paragraph 11.3.

7 Report on an unannounced inspection of HMP Featherstone by HM Chief Inspector of Prisons. 14-25 October 2013, dated 27 March 2014. Page 5. Website address at Appendix 1.

8 Report on an unannounced inspection of HMP Featherstone by HM Chief Inspector of Prisons. 14-25 October 2013. Dated 27 March 2014. Page 6. Website address at Appendix 1.

Care UK. Mental health in-reach and the psychosocial elements of substance misuse care are provided by Midlands Partnership NHS Foundation Trust.

MR MIDLAND

27. Mr Midland was 30 years of age at the time of his collapse on 28 April 2016. From the records, he had grown up in the Midlands, attending mainstream education and completing a Painting and Decorating course. He had worked as a landscaper, a labourer and as a DJ. He had had a psychiatric admission in 2011 for about a week. He had a diagnosis of schizophrenia (see Glossary), complicated by substance misuse. He was not in a relationship at the time of his reception into HMP Dovegate in 2014. He is described as likable and friendly. He did engage with staff with whom he was familiar, but sometimes it was difficult for him to keep appointments.

CHRONOLOGY TAKEN FROM THE RECORDS

28. Information extracted from the P-NOMIS (Prison National Offender Management Information System) records held on Mr Midland by HMP Featherstone (at Annexe A2.2):

22/11/14	**Received into HMP Dovegate. Unconvicted remand from Youth Court**
28/11/14	Criminal Justice Act 2003 (CJA03) Standard Determinate Sentence for affray, breach of personal licence conditions, burglary (stealing or attempting to steal in a dwelling), false imprisonment, wounding with intent to do grievous bodily harm
14/12/14	Relocated to Close Supervision Unit after suspected pass in Visits, (i.e., a suspicion that a visitor had given him an unauthorised item)

17/12/14	CJA03 Standard Determinate Sentence given on 17/12/2014 for offence of theft (from shop or staff), attempted theft of motor vehicle
24/12/14	Transferred to HMP Oakwood
6/2/15	Sentence-planning meeting. Plan to refer to Thinking Skills Programme and Chrysalis (a personal change programme supporting essential life skills and employability). "Will need to liaise with the substance misuse to address drugs issue – future targets will be RESOLVE" (an enhanced thinking skills programme which helps to improve problem-solving skills).
1/5/15	CJA03 Standard Determinate Sentence for theft from another person, racially / religiously aggravated alarm / distress by words / writing. Transferred to HMP Dovegate
2/5/15	On an ACCT (see Glossary)[9], presumably opened on reception. Initial ACCT review - does have occasional thoughts of suicide/self harm. Discussed drug use and links to voices in his head. Requested 2 observations an hour to continue, as 'he would not do anything if he knows someone is going to be checking on him'

[9] The Assessment, Care in Custody, Teamwork (ACCT) Plan is the prisoner-centred care-planning process used to help to identify and care for prisoners at risk of suicide and/or self-harm. The ACCT process requires that certain actions are taken to ensure that the risk of suicide and self-harm is reduced. Additional details are available in PSI 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody). Website address at Appendix 1

22/6/15	Target review. Has been sentenced to an additional 8 months. No one from ISMT [Integrated Substance Misuse Team, see Glossary] had been to see him. Offender Supervisor would send email. Only pleaded guilty to racial aspect because 'his solicitor told him to to avoid extra time.' 'No problem with ethnic minorities'.
14/8/15	**Transferred to HMP Featherstone from HMP Dovegate**
17/8/15	Drug and Alcohol Recovery Service Induction completed with Harm Reduction Information given
20/8/15	Alert Risk and Serious Harm – High made active
26/8/15	Sentence plan and objective plan meeting. Objectives include abstinence from drugs and apply to Drug and Alcohol Recovery Service and TSP / RESOLVE [enhanced thinking skills programmes, see Glossary]. Substance misuse issues include alcohol from teens. Mental health issues and being diagnosed with Drug Induced Psychosis. Mental health issues: being seen by a psychiatrist at Dovegate. Currently taking medication. Admitted under Mental Health Act for one week in October 2011. Last ACCT closed 13/7/15

1/9/15	"Appears to wander around in his own world for much of the time. He has informed me he is on Psycho Reactive drugs which may be the reason for his manner".
17/9/15	Green IEP for persistent incorrect use of cell bell [IEP, Incentives and Earned Privileges, see Glossary. In this context, this was a reprimand.]
28/9/15	Multi-Agency Safety and Health update – Diagnosed with schizophrenia in 2012 but a few discrepancies around diagnosis. Able to work but steer away from crowds and wing cleaning.
19/10/15	Fight with cellmate. When staff opened door, more prisoners entered cell in what appeared to be an attempt to assault Mr Midland
22/10/15	Violence Reduction Intervention. Issues with one prisoner. Does not anticipate further problems.
28/10/15	Fight with another prisoner. Placed on report, [i.e, a preliminary to an adjudication (See Glossary)].
29/10/15	Violence Reduction Intervention. Stated assaulted by prisoners that he had issues with previously. Said he did not retaliate.
2/11/15	Told member of staff to 'F*** off'.

3/11/15	Violence Reduction Intervention. Stated that he saw a couple of prisoners that he has issues with but did not throw any punches.
9/11/15	Violence Reduction review
12/12/15	IEP for misuse of cell bell. Downgraded to basic regime, resulting in the loss of some privileges until 27/12/15. [See 'IEP' in Glossary]
27/12/15	Returned to standard regime. On amber warning for 3 months (that is, a period of time during which a further breach of the rules might cause a change to his IEP level).
1/1/16	**Start of the period covered by this investigation, as specified in Terms of Reference**
15/2/16	Involved in an altercation in his cell with four other prisoners after being accused of being a cell thief. He sustained minor injuries and was seen by health care staff.
16/2/16	Placed on support plan log no 39/16 following yesterday's incident. Mr Midland requested move to another Houseblock.
22/2/16	

	Interim Violence Reduction support review. Mr Midland happy to associate and issues from previous week have been resolved.
26/2/16	Mr Midland fearful and wants to move off wing.
28/2/16	Palmed his medication [i.e. attempted to conceal his medication without taking it as prescribed].
29/2/16	IEP warning for concealing medication and when asked to return, failed to do so.
15/3/16	Violence Reduction Intervention – Mr Midland threated by another prisoner but claims he will sort it out himself.
30/3/16	Placed on report [i.e. a preliminary to an adjudication] for being under the influence of an illicit substance.
6/4/16	Placed on closed visits due to visitor being found in possession of a small bag of cannabis prior to visit.
12/4/16	Violence Reduction Intervention – stated has issues with drugs but claimed that he was recently spiked [i.e, given drugs without his awareness]. Received loss of Association at recent adjudications. Stated feels safe on unit. [Association is prisoners' recreation and association period when they are outside their cells.]
17/4/16	

	Discovered collapsed at the bottom of the stairs appearing to be having a fit whilst vomiting and struggling to breathe. Health care staff and paramedics attended. Mr Midland stabilised but had high heartbeat. Declined hospital and said he wanted to return to his cell. Placed on hourly observations. Placed on report for use of NPS.
22/4/16	Violence Reduction Intervention Mr Midland stated he does not remember much as he blacked out. Claimed it was a psychotic episode.
28/4/16	Found in an unresponsive state in his cell and admitted to hospital.

MENTAL HEALTH CARE

29. This information was extracted from Mr Midland's prison medical records in SystmOne (see Glossary), ('Patient Record', at Annexe A1.1).

30. On reception into HMP Dovegate on 22 November 2014, Mr Midland was on olanzapine (an antipsychotic), a benzodiazepine tranquillizer and a sleeping medication. He disclosed a history of drinking 280 units of alcohol per week (the recommended upper weekly limit for men at that time was 21 units). He was referred to the doctor for his substance misuse issues. The doctor instituted a reducing regime for all except the olanzapine.

31. Follow-up appointments were scheduled on 3 December with the Integrated Drug Treatment Service (IDTS); 12 December for blood tests; and 16 December with the smoking cessation service. Mr Midland did not attend any of these.

32. On 24 December, Mr Midland was transferred to HMP Oakwood. He was assessed by a substance misuse support worker. He declined help with substance misuse, saying that he was abstaining successfully, and he was confident that he would stay off substances. He was advised how to self-refer if he wanted help in the future.

33. On 29 December, Mr Midland was interviewed by a health worker who took a detailed history of his drug use. He was due to be allocated for follow-up and it is recorded that the help available for substance misuse was explained to him. The record states that Mr Midland had worked with substance misuse services in HMP Dovegate two years ago; that he had completed individual work there, and that Mr Midland was happy to be referred to community drug services on release.

34. On 9 January 2015, Mr Midland attended for a drug monitoring review. He said that he had not used illicit substances in HMP Oakwood, and he was confident that he would not use. It was agreed that he would not have routine follow-up about drug use, and he was advised that he could make an application if he changed his mind.

35. Mr Midland was transferred back to HMP Dovegate on 2 May. At Reception, when seen with an Integrated Substance Misuse Team (ISMT) worker, he disclosed that he had been using Subutex (buprenorphine, an opiate substitute) daily for three months and 'mamba', one or two spliffs daily. He was advised to meet with the ISMT (Integrated Substance Misuse Team) and an appointment was made for him. He disclosed a risk of self-harm, which was managed on an ACCT (a care plan in which the prisoner and the staff work together to ensure that the risk of suicide and/or self-harm is reduced) (See Glossary).

36. There is no record of Mr Midland's attendance at the appointment with the ISMT. On 11 May, he disclosed that he was having "muffled" auditory hallucinations (i.e. the false perception that he was hearing things, usually voices). After some unsuccessful attempts to meet him, Mr Midland was

assessed by a mental health in-reach community psychiatric nurse on 26 June and 7 August. At the 7 August interview, Mr Midland denied current use of illicit substances. The nurse requested a psychiatric assessment with a view to increasing the olanzapine (antipsychotic) medication; this was carried out, and the olanzapine increased to 15mg per day, on 10 August.

37. On 14 August 2015, Mr Midland was transferred to HMP Featherstone. Nurse 1 completed a full mental health assessment on 1 September. She noted his history of a previous psychiatric admission, and his current prescription of olanzapine. Mr Midland disclosed that he had experienced auditory hallucinations and paranoid feelings in the past.

38. Nurse 1 saw him again on 7 September, when she discussed with him whether he should be in possession of his medications, or whether they should be dispensed to him.

39. She discussed his case in the Multi-Agency Safety and Health meeting on the 28th September. Mr Midland was requesting work. There were no reported problems with his mental health.

40. On 30 September, Mr Midland did not attend a follow-up appointment with nurse 1. She noted that Mr Midland's general practice notes recorded that he had a diagnosis of schizophrenia. She made an appointment for him to see the psychiatrist.

41. On 20 October, Mr Midland refused to be seen by the psychiatrist, who reviewed his notes and concluded that he needed the services of the mental health in-reach team in view of his psychiatric history, and his limited engagement with services.

42. On 19 October, he was assaulted and was assessed by health care staff. On 28 October, there was an alleged assault by two peers.

43. During October and November, Mr Midland disclosed that he was experiencing psychotic symptoms on a background of smoking ‘mamba’. On 19 November, he reported hearing voices; he believed that microscopic speakers had been placed in his head, and his mood was incongruous as he described feeling “On top of the world”.

44. He stopped holding his own medication ‘in possession’ and it was given to him under observation. A review of his hospital notes confirmed that he had been diagnosed to have schizophrenia, probably since 2011, although it had been difficult to engage him in follow-up.

45. A full assessment was carried out by the psychiatrist and nurse 1 on 3 December. Mr Midland’s dose of olanzapine was increased to 20mg per day, still to be dispensed to him.

46. He was reviewed weekly, either by nurse 1 or the psychiatrist, during December. On 23 December, he appeared intoxicated, but denied using substances. He was still experiencing psychotic symptoms, and the possibility of a psychiatric hospital referral was discussed. However, on 4 January 2016, Mr Midland was seen by nurse 1 and he confirmed that he had been using Subutex on 23 December. He said that the increased dose of olanzapine had treated his psychotic symptoms. Nurse 1 recorded that she had “explored the negative effects of taking non-prescribed medication on both his mental and physical health”.

47. On the same date (4 January) Mr Midland was seen by the psychiatrist. He disclosed that he has been using ‘black mamba’ and Subutex up until the last two weeks, and since stopping, he had experienced a big reduction in his psychotic symptoms.

48. Nurse 1 saw Mr Midland again on 12 January and once again “explored the negative effects of taking non-prescribed medication on both his mental and physical health”. He said that olanzapine had treated his psychotic symptoms so there was no need for a referral to hospital.

49. On 15 February, Mr Midland was assaulted by another prisoner in his cell. He had identified him as a "Pad thief" (a prisoner that steals from other prisoners' cells), something he disputed. He sustained grazes to his head and he was seen by health care staff. An Anti-Social Behaviour and Support Management Plan was opened the same day[10] and reviews took place on 22 February and 29 February. The level of support offered was disappointing as the plan documented Mr Midland's regime rather than any meaningful engagement. It also treated him as a perpetrator rather than a victim, including comments such as "[Mr Midland] hasn't displayed any further incidents of violent or anti-social behaviour over the past 7 days. Complying with the regime" and "Excellent day, Stayed out of the way".[11] He was moved to a different Houseblock on 24 February.[12]

49. On 7 March he was seen by nurse 1. He was mentally well. She recorded:

> …"denied any recent mamba misuse and identified that this was the cause of his recent psychotic episode. We explored the need for him to remain illicit substnace [sic] free to maintain mental well-being, Mr Midland did not wish to engage with the substance misuse team as he did not feel he had a "problem" and was able to remain abstinent unaided." He "clearly identified that at the time of [the] recent relapse he was smoking mamba, explored negative effects on both physical and mental well-being".

They agreed that he could have his medication in his possession.

50. On 17 April, Mr Midland was found at the bottom of the stairs in his Houseblock. He appeared to be fitting. His heart rate was high (150 beats per minute), his pupils were dilated and unreactive to light. His

[10] Anti-Social Behaviour & Support Management Plan, opened 15 February 2016. At Annexe A2.3.2
[11] Anti Social Behaviour & Support Management Plan, opened 15.2.16. At Annexe A2.3.2
[12] Anti Social Behaviour & Support Management Plan, opened 15.2.16. At Annexe A2.3.2

oxygen level without additional oxygen was reduced (89%) but this improved when he was given oxygen. Paramedics attended but Mr Midland refused to go to hospital. He did not make any allegations of assault. He attributed this incident to a psychotic episode.

51. Nurse 1 made an entry on 5 May that she was made aware by primary health care colleagues on 25 April that Mr Midland had used substances and had required medical intervention. Nurse 1 made an appointment to meet with him on 4 May to assess the impact of this use on his mental state.

52. The prison medical record contains a description of the emergency involving Mr Midland on 28 April. Prison Officer 1 and nurse 4 were first on the scene, followed moments later by nurses 2 and 3.

ADJUDICATION RECORD

53. During this period of imprisonment, Mr Midland acquired four proven adjudications from incidents on the following dates:

    3/2/15 – disobeyed any lawful order;
    26/2/15 – possession of an unauthorized article;
    19/10/15 – fighting; and
    31/3/16 – endangering the health and/or safety of others by taking an illicit substance.[13]

DESCRIPTION OF THE INCIDENT ON 28 APRIL 2016

54. The investigators visited the cell occupied by Mr Midland at the time of the incident. It is very close to the Houseblock office.

[13] Adjudications For An Individual Prisoner. At Annexe A2.1.2

55. A contemporaneous description is available from the duty senior officer (Oscar One) in the Fact Finding Report into a Serious Incident on 28 April 2016:

> "At approximately 17.40 several unnamed prisoners went to the centre office and asked Officer 1 to check on Mr Midland as they thought he didn't look very well. Officer 1 went to Mr Midland's cell and immediately called a CODE BLUE [an alarm referring to physical health, see Glossary] as he found Mr Midland lying on the floor and he couldn't get a response from him. As Oscar One I attended the scene along with Governor 3 and nurses 2 and 3, Mr Midland was found to have no pulse and not breathing so the defribilator [sic] was used and oxygen was administered, emergency ambulance arrived at 17.56 and paramedics continued to administer treatment. Two officers were detailed to escort Mr Midland to hospital, ambulance left establishment at 18.45 to Hospital 1. The incident was recorded on my bodyworn camera".[14]

56. The body-worn camera footage has a total duration of 15 minutes and 10 seconds (15m.10s). It shows that nurse 4 and Officer 1 were at the scene when the person wearing the camera arrived. The audio quality is not good because of the background noise of the Houseblock, and the TV was on in Mr Midland's cell. The nursing staff are clearly visible, administering cardio-pulmonary resuscitation (CPR) throughout the duration of the recording.

57. The defibrillator analysed the rhythm of Mr Midland's heart on five occasions and on each occasion advised that CPR should continue – in other words, Mr Midland's heart was still producing electrical activity. The nurses concluded that his condition was a respiratory arrest, rather than a

[14] HMP Featherstone – Fact Finding Report into s serious Self-Harm and/or Assault Incident, undated, unsigned, page 1. At Annexe A2.5

cardiac arrest. They continued cardio-pulmonary resuscitation until the paramedics arrived to take Mr Midland to hospital.

58. Mr Midland's oxygen saturation ('sats', see Glossary) was extremely low throughout the duration of the recording. The nurses made the following observations of Mr Midland's oxygen saturation: at 4 minutes 10 seconds, 51%; at 7m.35s, 44%; at 8m.29s, 51%; at 11m.27s, 67%, and at 12m.58s, 58%. (Blood oxygen levels below 80% may damage the brain and the heart, so urgent treatment is needed.)

59. Mr Midland's heart rate was initially high (pulse 126 at 4m.10s) but this fell to a more normal rate (7m.35s, pulse 84; 12m.58s, pulse 97).

60. The Communications Log for the prison records that the Code Blue emergency call was made at 17.44; the ambulance arrived at 17.57 and the ambulance left with Mr Midland at 18.45.[15]

61. The investigators concluded that these were satisfactory response times.

INTERVIEWS WITH WITNESSES

62. All the witnesses stated that this period was an extremely difficult time in the prison, with multiple Code Blue emergency calls due to the adverse effects of NPS use. For example, Prison Officer 1 said that it was not uncommon to have 10 or 15 Code Blues in a day.[16]

63. All interview transcripts are in Annexe C. Four of the seven witnesses approved their respective interview transcript. The witnesses were each invited to return a signed copy; all except three signed transcripts were returned. None of those three witnesses, Prison Officer 1, nurse 1 and nurse 4, raised an objection to the contents of their transcript.

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[15] HMP Featherstone. Communications Room Occurrence Log. 28.4.16, page 2. At Annexe A2.4

[16] Transcript of interview with Prison Officer 1, page 2. At Annexe C

Nurse 1

64. Nurse 1 was a Community Psychiatric Nurse working with the in-reach team for the prison and the care co-ordinator for Mr Midland's mental health care. She remembered him clearly and explained that he had formed a trusting relationship with her. She described that the use of NPS caused serious problems for the prison during the autumn of 2015 and the first three months of 2016, and she explained the measures that the psychiatric in-reach team took to manage the effects of NPS (using three cells for special observations; maintaining excellent liaison between the prison staff, the substance misuse service and the psychiatric in-reach team; holding weekly multi-disciplinary meetings to discuss cases of concern). She thought that Mr Midland was probably suffering from auditory hallucinations (due to his schizophrenia) when he was involved in fights in October 2015. She described the management of his illness, his difficulty in acknowledging his substance misuse and his discussion about this with her in March 2016.

Senior Officer 1

65. Senior Officer 1 was Mr Midland's Offender Supervisor so his contact was largely about sentence-planning, including raising awareness of rehabilitation interventions and liaising with Mr Midland's Offender Manager outside the prison. He was the senior officer on the wing during Mr Midland's first collapse on 17 April 2016. He did not have many memories of Mr Midland due to the intervening three years, but he had been able to check the records before our interview.

Governor 2

66. Governor 2 talked from a management perspective about the problems faced by the prison in reducing the ingress of NPS, and the strategies used to reduce this, including enhancing the security of the windows.

Prison staff also used body-worn camera footage to show prisoners, after the event, how they had presented when under the influence of NPS.

Prison Officer 1

67. Prison Officer 1 was the first officer to attend Mr Midland's cell. Mr Midland was lying on the floor and was unresponsive. There was nothing to suggest a fight – the cell was unremarkable. Mr Midland's condition was similar to the frequent cases of NPS use that the prison officers were attending to. Prison Officer 1 had attended to Mr Midland on many occasions when his condition suggested intoxication with NPS; it was usual practice to give people time to recover in their cell (if they were not incapacitated). On this occasion, he recognized that Mr Midland would need urgent help from health care staff. He put Mr Midland in the recovery position and activated the emergency call (Code Blue), and then stayed with him until health care staff arrived, which he thought took three or four minutes.

Nurse 2

68. Nurse 2 describes that she responded to the Code Blue emergency call. She saw immediately that Mr Midland was in need of resuscitation. There was no evidence of disturbance or disarray in his cell, and no signs of trauma on his body. She asked nurse 3 to bring the defibrillator and she remained focused on administering CPR. She knew that he was seriously ill.

Nurse 3

69. Nurse 3 attended the incident with nurse 2. He also did not notice anything unusual about the cell – specifically, there were no signs of any disturbance. He did not see any marks to suggest that Mr Midland had sustained any traumatic injuries. He went to collect the defibrillator and worked with his colleagues to administer CPR.

70. Nurse 3 had also attended the incident on 17 April, when Mr Midland was found in a stairwell, and appeared to be having an epileptic fit. Nurse 3 did not see any evidence of bruising or trauma on that occasion.

Nurse 4

71. Nurse 4 describes that she attended immediately as she was close to the cell. She was the first nurse to arrive. The cell was tidy, with no signs of disarray which might have suggested a fight. There were no contusions on Mr Midland's body. He was clearly lacking in oxygen and she knew that his condition was very serious. She stated that there were enough trained staff and they did everything that they could for Mr Midland. She expressed her sympathy for Mr Midland and his family.

INFORMATION FROM THE HOSPITAL NOTES[17]

72. On arrival in the Accident and Emergency Department, it was noted that the administration of naloxone (a drug which reverses the effects of opiates) had had no effect. This is strong evidence that Mr Midland's collapse was not due to opiate use. There was no evidence at all of injury. Subsequent investigations for a cause of his respiratory arrest were negative (for example, a brain infection).

73. Urine toxicology was reported on 6 May as follows[18]:

> "Please note trace of adamantyl-type NOID marker detected below 5ng/mL positive cut off used by LC-MS/MS. Adamantyl-NOID marker includes AKB-48, 5f-AKB48 and STS-F35, which mimic cannabis and can be found in many herbal legal highs."

74. This sample was taken on 3 May, so this result has been influenced by the body's metabolism of substances during the period since 28 April. However, traces of a marker for substances found in synthetic cannabis were detectable, albeit below the cut-off point for a positive result.

75. Radiological investigations showed changes consistent with brain damage due to lack of oxygen. This was the diagnosis on discharge, when Mr Midland was transferred from the acute hospital for ongoing care on 24 August 2016.

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[17] Extracts from the Hospital 1 records for Mr Midland. At Annexe A1.4.
Toxicology reports (6 May 2016) and Clinical Biochemistry reports (9 May 2016), by NHS Trust 2. At Annexe A1.4

[18] Toxicology reports (6 May 2016) and Clinical Biochemistry reports (9 May 2016), by NHS Trust 2. Page 2. At Annexe A1.4

CONCLUSIONS ABOUT THE CAUSE OF MR MIDLAND'S COLLAPSE

76. Investigations after his admission to hospital confirmed that Mr Midland had evidence on MRI scan (magnetic resonance imaging, see Glossary) of brain injury due to a lack of oxygen, sustained during his respiratory arrest.

77. The body-worn camera footage showing that it was not necessary to give Mr Midland's heart an electric shock is consistent with the condition described as electromechanical disassociation, in which there is electrical activity generated by the heart, but there is no cardiac output. The most common cause for this is hypoxia, that is, a lack of oxygen to the tissues.

78. Having taken into account the previous assaults on Mr Midland, on this occasion, the evidence is persuasive that he had used a substance which caused him to stop breathing. This is because his cell was tidy, with no evidence of a fight; there were no external injuries and no injuries detected in hospital; his collapse of 11 days previously suggests that he had relapsed into NPS use and traces of a marker for NPS were present in his urine five days after his admission to hospital.

THE PRISON'S RESPONSE TO NPS USE IN 2016

79. In the period 2014 – 2015, NPS use was new to the UK's prisons. It was causing profound risks to the health of many prisoners, often necessitating emergency treatment in hospital. Although classified as 'legal highs' at that time, NPS-type drugs were not allowed within prisons. At that period, these substances were not detectable on urine screening.

80. Nationally, prison staff had become increasingly concerned about the unpredictably severe consequences of NPS use during the years

preceding the period covered by this investigation, i.e. before January 2016. For example, the Prison and Probation Ombudsman had issued a 'Learning Lessons Bulletin' in July 2015, examining the deaths of prisoners where the use of NPS-type drugs was suspected (see Appendix 1).

81. HMP Featherstone completed its eighth Strategic Assessment in March 2016. At that time, the prison's security objectives included to prevent escapes, the entry of drugs, the misuse of authorized drugs and the entry of prohibited and illicit items such as firearms and mobile phones.[19]

82. The Strategic Assessment listed six control strategy priorities, the first of which was listed as 'prohibited items'.[20] Other strategic priorities such as organized crime groups and debt explicitly included the topic of drugs. The lead for the prohibited items strategic priority was Governor 2, Head of Residential and Services. The prison had identified that the vulnerable areas for the ingress of prohibited items were mail, visits, misuse of prescribed medication, items thrown over the wall and staff corruption. It was also recognized that there was an increase in the use of drones. The drugs of choice were new psychoactive substances (NPS), also known as spice.

83. The strategy for prohibited items listed the key findings from 2015.[21] The Core Objectives were listed as:

- *"Raise awareness of all staff on how to prevent prohibited items entering the Establishment.*
- *Establish co-ordinated, collaborative ways of working to reduce ingress*

this includes continuing to work with HMP Oakwood, HMYOI Brinsford [adjacent prisons] *and the local Police Force*

[19] HMP Featherstone Strategic Assessment Jan 2016 2017, p.2. At Annexe A3.4
[20] HMP Featherstone Strategic Assessment Jan 2016 2017, p.3. At Annexe A3.4
[21] HMP Featherstone Strategic Assessment 2016 2017, p.6. At Annexe A3.4

- *Improve communication to the staffing group and provide further information relating to Drones.*
- *Identify all possible data sources to be exploited by the security office to*

inform Threat

- *Increase the use of alternative intelligence sources...*
- *Improve staff awareness of the intelligence requirement with regard to corruption prevention.*
- *Use Intel to target searching.*
- *Partnership working with the Police to identify the with* [sic] *regard to NPS.*
- *Investigate the use of Drone blocking equipment with NOMS."*

84. The number of prohibited items found per month was measured as part of the strategy. For the first four months of 2015 to 2016, there had been an increase in prohibited items found, followed by a decrease for the next three months before the amount of prohibited items found increased significantly in December 2015 and January 2016. In interview, nurse 1 commented on the increase in incidents where prisoners were found under the influence of spice around this time.[22]

85. We were given copies of documentation to demonstrate delivery of the strategy. On 15 February 2016, the Governing Governor issued a Notice to Prisoners advising them that all mail would be screened by the drug dog and any item screening positive for contamination would be withheld, may be sent to a laboratory for further testing, forwarded to the police or disposed of.[23] This policy was reviewed in a subsequent Notice to Prisoners issued on 30 March 2016 with the addition that following the introduction of NPS legislation before parliament, all positively indicated mail would be referred to the police for further criminal investigation.[24]

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[22] Transcript of interview with nurse 1, dated 5 August 2019, p. 2. At Annexe C
[23] NTP 015-2016 Incoming Mail, 15 February 2016, from Governor 1. At Annexe A3.3
[24] NTP 028-2016 Incoming Mail. 30 March 2016, from Governor 1. At Annexe A3.3

86. The Governor also issued a Notice to Prisoners on 23 March 2016, highlighting the dangers of NPS use. This notice listed a number of adverse effects of use, including specific mention of respiratory arrest and lack of oxygen causing a "high risk of death".[25]

87. Following the hospitalization of Mr Midland, the Governor also advised prisoners that Mr Midland was seriously ill as a result of possibly taking NPS. He took the opportunity to advise prisoners where they could receive support and also advised them to avoid illegal drug use and to use the DARS (Drug and Alcohol Recovery Service) and peer support workers.[26] In a Notice to Staff, staff were advised of the risk of drones and the action to be taken if a drone was heard or seen.[27]

88. A comprehensive Substance Misuse Policy and Strategy (Drugs and Alcohol) was implemented by the prison in 2016 (at Annexe A3.4). The policy refers to national standards, which prioritised reducing availability of substances, and demand for their use, within prisons. It aimed to reduce supply and demand for drugs by multi-disciplinary working, a seamless care pathway, mandatory drug testing, staff awareness and collaboration with other agencies. The strategy identified areas of the prison that were the main routes of entry for contraband and included the measures in place to reduce the risk of drugs and other contraband entering the prison. The different types of searching, mandatory drug testing and swab testing with their use and frequency were identified.

89. The strategy also included measures to reduce the harm caused by drugs by use of the Drug and Alcohol Recovery Service (DARS), Featherstone Recovery Champions (i.e. peer support), Integrated Substance Misuse Service (ISMS), Alcoholics Anonymous, the Health Care department, the PE Department and the Health Trainer Service. The extensive use of prisoners as trainers and support workers is an example of good practice.

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[25] NTP 026-2016 The Dangers of NPS, 23 March 2016, from Governor 1. At Annexe A3.3
[26] NTP 041-2016 Mr Midland, 6 May 2016], from Governor 1. At Annexe A3.3
[27] NTS 035-2016 Drone Sightings, 8 March 2016, from Governor 1. At Annexe A3.3

90. The strategy included the terms of reference for the monthly Substance Misuse meetings, chaired by the Head of Reducing Reoffending and required membership included representatives from the Offender Management Unit, Residential and Services, Residential and Safety, Health Care, DARS, Integrated Substance Misuse Service, Security, Industries, Gym and Mandatory Drug Test Representative. The representation and terms of reference were appropriate.

91. We were given the minutes of the four Substance Misuse Meetings, which took place between January 2016 and April 2016. These meetings monitored and reported on the execution of the substance misuse strategy. There were some notable successes such as the recovery of in excess of £36,000 of illicit items, of which £30,000 was related to drugs/NPS.[28] The January Substance Abuse meeting reported that there had been a local NPS strategy meeting on 7 January[29], but we were not given a copy of the minutes of this meeting. It was subsequently decided that the NPS strategy would be incorporated into the Substance Misuse Meeting.[30] Detailed reports were submitted by DARS and Health Care, but it was disappointing to see that there was frequent lack of attendance by other departments in the prison. For example, representatives from the Security department and mandatory drug testing failed to attend any of the four meetings, for which we were given minutes and for three of the meetings, also failed to submit a report.[31] Action points identified at the meeting were also not followed up by the next meeting. In fact, the April 2016 meeting contained action points from the January 2016 meeting.[32]

[28] Minutes of Substance Misuse Meeting on 8 January 2016, p. 4. At Annexe A3.2
[29] Minutes of Substance Misuse Meeting on 8 January 2016, p. 6. At Annexe A3.2
[30] Minutes of Substance Misuse Meeting on 4 March 2016, p.3. At Annexe A3.2
[31] Minutes of Substance Misuse Meetings on 8 January 2016, 5 February 2016, 4 March 2016 and 8 April 2016. At Annexe A3.2
[32] Minutes of Substance Misuse Meeting on 8 April 2016, p.5. At Annexe A3.2

92. These observations formed the basis of our **Finding 2**:

> **"The minutes of the prison's Substance Misuse Meetings between January 2016 and April 2016 showed that the Security representative did not always attend, so opportunities for shared working with health on issues relating to drugs were lost."**

93. The minutes of the Substance Misuse Meeting of 4 March 2016 contains an action to issue a notice to staff to remind them that they have an obligation to make a referral to DARS (Drug and Alcohol Recovery Service) and Health Care when a prisoner is taken back to the wing and placed on report[33] for being under the influence. The Article 2 Investigation could not find a record that these referrals were being made consistently. However, the investigators did not conclude that Findings 2 and 3 would have affected the outcome for Mr Midland.

94. This forms the basis of **Finding 3**:

> "**The minutes of the Substance Misuse Meeting of 4 March 2016 contains an action to issue a notice to staff to remind them that they have an obligation to make a referral to DARS (Drug and Alcohol Recovery Service) and Health Care when a prisoner is taken back to the wing and placed on report[34] for being under the influence. The Article 2 Investigation could not find a record that these referrals were being made consistently. However, the investigators did not conclude that Findings 2 and 3 would have affected the outcome for Mr Midland."**

[33] To place on report means to make [a prisoner] liable for an adjudication and disciplinary sanctions. For adjudication, see Glossary.
[34] As above.

95. We were given copies of minutes of the four Security Committee Meetings that took place between January 2016 and April 2016. The representation was appropriate and the meetings were well attended, although the focus of the meeting appeared from the minutes to be reporting of statistics rather than driving actions from them. The minutes of the Security Meeting held on 20 January 2016 recorded that the following actions had been completed after the last meeting (held on 17 December 2015):

> "DARS [Drug and Alcohol Recovery Service] completed posters for the dangers of hooch and NPS along with a leaflet drop to all prisoners' cells. Posters remain around the site reference NPS".[35]

However, actions that were identified were frequently carried forward from one meeting to another. For example, an identified action to include the relationship between a prisoner and their visitor on closed/banned visitor paperwork was carried forward from January 2016 to April 2016.[36] Actions needed to address the intelligence gaps identified in the Strategic Assessment were not discussed in the meetings.

96. We were given a copy of HMP Featherstone's Searching Policy (at Annexe A3.4), which included the level of searching for prisoners in different circumstances, staff, visitors and grounds. The Security Committee demonstrated that target searching, staff searching and Mandatory Drug Testing (MDT) was taking place.[37]

97. The prison had also been proactive in measures to improve and maintain physical security. For example, there are references in the minutes[38] to a "violence reduction CCTV bid" being "in progress" and "PIDS [Perimeter Intrusion Detection System remedial work" being "agreed". It was identified that not all house units were fitted with non-opening ventilation

[35] Minutes of Security Committee Meeting held on 20 January 2016, p.1. At Annexe A3.1
[36] Minutes of Security Committee Meetings held on 20 January 2016, 22 February 2016, 16 March 2016 and 20 April 2016. At Annexe A3.1
[37] As above. At Annexe A3.1
[38] Minutes of Security Committee Meeting on 20 January 2016, page 3. At Annexe A3.1

windows and that these allowed items to be retrieved from drones. Windows were being replaced on Houseblock 5 and netting was put in place. It was agreed that the Deputy Governor and two others would review weak spots and the window replacement schedule.[39]

98. Governor 1 wrote to us on 12th September 2019 setting out the additional measures taken to prevent ingress of illicit items into the prison as follows:

> "It is difficult to safeguard our perimeter from throw-overs as our authority and ability to counter such act is limited to inside the prison. The most important thing for us is when throw-overs do occur we get the parcel[s] before prisoners do by carrying out Perimeter/Fence [checks], and restricting prisoner movement away from areas around the perimeter fence. When we have prisoners working within the grounds such as horticulture and Recycling they are searched at the end of their activity.
>
> As part of dealing with the risk of throw-overs, around the time noted, we increased our fence patrol from 3 times a day to a full-time role which guaranteed more patrol cover around the fence and prison throughout the day. In addition we erected high posts with nets between House-block 5 and the perimeter fence where most of the throw-overs were taking place." (At Annexe A3.3.)

99. As described by Governor 2 in his interview, the prison was using body-worn camera footage to show prisoners how they were presenting when under the influence of NPS.[40]

100. The minutes of Substance Misuse Meetings (at Annexe A3.2) demonstrate that prisoners were involved with both the gymnasium and the Drug and Alcohol Recovery Service to provide information to other

[39] Minutes of Security Committee Meeting on 20 April 2016, section 8, page 3. At Annexe A3.1
[40] Transcript of interview with Governor 2, page 2. At Annexe C

prisoners and to provide administrative support, although vacancies were in place, reducing the amount of support that could be provided.

101. SMART (a mutual aid meeting for people in recovery from substance misuse), Alcoholics Anonymous meetings and acupuncture were provided by the Drug and Alcohol Recovery Service weekly. Prisoners were also able to access ‘seeds in the ears', (i.e. acupuncture or acupressure focused on the ear to assist in abstinence), which was also made available in the workplace rather than in a group setting. The Drug and Alcohol Recovery Service was proactive in working with Inclusion (an outside provider of substance misuse treatment) to increase the groups available to prisoners and to ensure that staff were trained appropriately.[41]

[41] Minutes of Substance Misuse Meeting on 8 April 2016, p.2. At Annexe A3.2

KEY ISSUES FROM THE MANAGEMENT OF THE AFTERMATH OF THE EVENT

102. Prison Service Instruction 64/2011 – 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)', requires that "*All prisoners must be asked to nominate a next of kin who must be updated regularly*".[42] Mr Midland had been asked on 14 August 2015 and had identified a next of kin.[43]

103. The Prison Service Instruction also requires that where prisoners have suffered sudden life-threatening harm, the prisoner's wishes on whom they would like to be contacted must be ascertained where possible. In the event that the prisoner is unable to communicate their wishes, the prison must contact the nominated next of kin who must be given an accurate account of what has happened. As Mr Midland could not communicate his wishes, his family was contacted but the Fact Finding Report does not indicate when this was done or what information was passed on.[44] As early reports from hospital indicated that the prognosis was very poor, a Family Liaison Officer (FLO) was appointed on 4 May 2016. Engagement with next of kin is required for prisoners who have suffered a rapid deterioration in their physical health regardless of whether death is likely to occur as a result of injuries.

104. Prison Service Instruction 64/2011 states that *"Every contact with the family and their representatives should be recorded wherever possible."* This contact should be in an FLO log[45]. Prison Officer 2 was appointed as the FLO. A member of the prison staff made initial contact with Mr Midland's family on 4 May (the investigators have not been able to

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[42] PSI 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody), section 32, p. 9. Website address at Appendix 1.

[43] HMP Featherstone, Safer Custody. Current Next of Kin details, dated 14 August 2015. At Annexe A2.3.2

[44] 'HMP Featherstone. Fact Finding Report into a serious Self-Harm and/or Assault Incident' undated, unsigned. At Annexe A2.5

[45] PSI 64/2011 – Management of prisoners at risk of harm to self, to others and from others (Safer Custody), Chapter 13, pages 62 and 63. Website address at Appendix 1

ascertain the identity of this member of staff). A log was started and records that this member of staff made contact with Mr Midland's next of kin to advise that Prison Officer 2 would be the contact for the family. Mr Midland's relative asked a number of questions about the incident and, although the member of staff was not aware of the answers, they telephoned Mr Midland's next of kin 35 minutes later with information about the circumstances. In response to the family's question about why the family were not contacted immediately, the member of staff recorded that:

> "Family were not contacted immediately as he presented as if he would recover when he arrived at the hospital. However he deteriorated over the next couple of days and as soon as the hospital advised we contacted NOK we did so, which was Wednesday 04th May 2016".[46]

105. This observation is the basis of our **Finding 4:**

> **"HMP Featherstone informed Mr Midland's family of his admission to hospital after a delay of six days, which the Article 2 Investigation found was unacceptable."**

Mr Midland was not in a position to contact them himself and, given the severity of his condition in the hospital, his family should have been informed earlier.

106. During the long hospitalisation of Mr Midland, when the gravity of his condition had become clear, Governor 1 attempted to obtain early release on compassionate grounds for Mr Midland, but this was not possible.[47]

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[46] A log of the FLO's initial contact with Mr Midland's family, undated, unsigned. Page 1. At Annexe A2.5

[47] Letter dated 11 July 2016 to Member of Parliament 1, from Governor 1. At Annexe A3.5

INFORMATION FROM THE POLICE

107. A detective sergeant from Staffordshire Police sent an email to the then Head of Security and Intelligence at the prison, dated 12 December 2016 (at Annexe A2.5), in which he stated that the absence of injuries recorded at the hospital had led the police to conclude that there was no evidence to substantiate any claim that Mr Midland had been assaulted or forced to take drugs before his collapse on 28 April 2016. The Police had closed the case with regard to criminal investigation.

COMPLIANCE WITH STANDARDS

Mental Health Policies

108. During the period covered by this investigation, 1 January 2016 to 28 April 2016, the contract for providing health care in HMP Featherstone was awarded to different organizations.

109. From 1 April 2016, mental health in-reach to the prison was provided by Midlands Partnership NHS Foundation Trust, who supplied us with a copy of their Dual Diagnosis Policy, dated March 2016. This describes the management of patients with enduring mental illness and substance misuse in the light of the national policy. The Policy stipulates that the primary responsibility for the treatment of individuals with enduring mental illness and problematic substance use should lie with mental health services. (At Annexe A1.3.)

110. The care given to Mr Midland was compliant with this policy. Nurse 1 took the lead role in his mental health care. She documented in Mr Midland's prison medical records discussions with him on the impact of substance misuse on his mental state during the period covered by this investigation (on 4 and 12 January and 7 March 2016).[48]

Royal College of Psychiatrists Standards for Mental Health Care in Prisons

111. The website address for the Royal College of Psychiatrists' 'Standards for Prisons Mental Health Services', June 2015, is included at Appendix 1.

112. Standards 15 and 16 (on page 7) stipulate that there should be a written care plan for every patient receiving mental health in-reach, and this care

[48] HMP Featherstone. Mr Midland. Patient Record. Part 1. At Annexe A1.1

plan should be developed in collaboration with the patient. We did not see evidence of a written care plan by nurse 1 for Mr Midland. However, the record of her contacts with Mr Midland provide evidence of a collaborative approach, in that she has explored his drug use with him, and respected his decision to decline referral to the substance misuse team on 7 March 2016, because he said that he "was able to remain abstinent unaided".[49]

113. Standard 21 (on page 7) stipulates that there should be written policies for liaison and joint working with substance misuse services and primary care in cases of co-morbidity. The Dual Diagnosis Policy[50] provided by Midlands Partnership NHS Foundation Trust for this investigation is compliant with this.

114. In the opinion of the investigators, this Policy could benefit from the inclusion of more operational detail, in terms of the structures that support such liaison. However, the period covered by this investigation coincided with the handover of service between providers. Midlands Partnership NHS Foundation Trust, as the provider of both mental health in-reach and the psychosocial treatments for substance misuse, has been better placed to develop this liaison and joint working in the years since 2016.

Prison Service Policies

115. Prison Service Instruction 15/2014 – 'Investigations and learning following incidents of serious self-harm or serious assaults' required that

> "*Governors must ensure that all incidents of serious assaults" …*
> *"and serious self-harm were telephone reported to the National Operations Unit (NOU) in line with PSI 11/2012 Incident Reporting*

[49] HMP Featherstone. Mr Midland. Patient Record. Part 1. At Annexe A1.1
[50] Dual Diagnosis Policy. Version: v1.0. March 2016. Midlands Partnership NHS Foundation Trust. At Annexe A1.3

System; and investigated at an appropriate level; and that any lessons are learned from the incident".[51]

116. Governors were also required by PSI 15/2014 to:

"*ensure that when requested by Equality, Rights and Decency (ERD) Group the serious assaults questionnaire*" – (Annex B to PSI 15/2014) – was "*completed and returned to ERD Group within three working days of the incident being reported. When the ERD Group indicates that an independent investigation may be required, all documentation relating to the prisoner(s) involved in the incident (for example, core record, medical record, and Assessment, Care in Custody and Teamwork or Cell Sharing Risk Assessment forms) must be retained.*"[52]

117. After the incident on 28 April 2016 when Mr Midland was found unresponsive, the questionnaire was returned in full within three working days of being requested by ERD Group, but it is not known from our documentation whether or not it was completed within three working days of the date of the incident as the questionnaire does not include the date of completion.[53] We understand that information was requested by ERD Group on 10th May 2016, and the questionnaire and the Fact Finding Report were both returned on 12th May 2016.[54]

118. A senior caseworker on the Safer Custody Casework Team informed HMP Featherstone on 22 July 2016 that it was necessary for the prison to gather the papers referring to his collapses on 17 and 28 April and store

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[51] PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults. Paragraph 9, pages 2 and 3. Effective: 14 April 2014 to 2 April 2018. Website address at Appendix 1

[52] PSI 15/2014 (as above). Paragraph 10, page 3. Website address at Appendix 1
The Equality, Rights and Decency (ERD) Group was within the National Offender Management Service, which was replaced by HMPPS on 1 April 2017.

[53] Serious Self-harm Incident Questionnaire, undated. At Annexe A2.5

[54] Email trail 10 May 2016 – 18 Nov. 2020. Includes exchange 10 – 12 May 2016 between the Head of Safer Prisons at HMP Featherstone and ERD Group, NOMS. At Annexe A2.5

them securely in case an Article 2 Investigation would be commissioned.[55] We were satisfied that documentation relating to Mr Midland was retained.

119. Lastly, Prison Service Instruction 15/2014 required that:

> "*In all cases in which a questionnaire was completed and returned to ERD Group, Governors must ensure that a copy of the investigation report is submitted to ERD Group not later than one week after the investigation has been completed*."[56]

Whilst a Fact Finding Report was completed, it does not include the name of the author, a signature or date. The 'Enquiry' section in the report asks about contributory factors and it is recorded only that "There is a suspicion that Mr Midland had taken an illicit substance".[57]

120. Prison Service Order 1300 –'Investigations' distinguishes between simple investigations and formal investigations, with the emphasis being on undertaking simple investigations wherever possible. However, paragraph 1.6.1 requires that a "formal investigation will be necessary if, from the findings of a simple investigation or from the outset, it appears that … there was serious harm to any person".[58] The undated, unsigned report was identified in its title as a Fact Finding Report. It is apparent that the Fact Finding Report was almost entirely based on the contents of the questionnaire and failed to explore the issues in more depth. The investigators concluded that this was unlikely to have been a formal investigation. In view of the severity of the consequences suffered by Mr Midland, the Article 2 Investigation concludes that a more formal

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55 Email on 22 July 2016 at 08:25 from a Senior Caseworker in the Safer Custody Casework Team, National Offender Management Service, to the Head of Safer Custody, HMP Featherstone. The email is entitled: Serious incident at HMP Featherstone. At Annexe A2.5

56 PSI 15/2014 Investigations and learning following incidents of serious self-harm or serious assaults. Effective: 14 April 2014 to 2 April 2018. Paragraph 11, page 3. Website address at Appendix 1

57 HMP Featherstone – Fact Finding Report into a Serious Self-Harm and/or Assault Incident, undated, unsigned. Page 2. (At Annexe A2.5)

58 PSO 1300 – Investigations, Page 8, paragraph 1.6.1. Date of update: 25/07/05. Website address at Appendix 1

investigation should have been conducted by HMP Featherstone following the Fact Finding Report. This is the basis of our **Finding 5**:

> **"HMP Featherstone did produce a Fact Finding Report after the event of 28 April 2016, but it was not a formal investigation. In view of the severity of the consequences suffered by Mr Midland, the Article 2 Investigation found that a more formal investigation should have been conducted by HMP Featherstone following the Fact Finding Report. This would have enabled the prison to reflect on any lessons to be learnt from the management of Mr Midland's case."**

121. Prison Service and Health Care managers have a duty of care to support staff when they have been involved in dealing with a potentially distressing incident. Prison Officer 1 and nurses 2, 3 and 4, the staff who responded to the incident, all told us that they were satisfied that they were supported following the incident.[59]

CONCLUSIONS: TERMS OF REFERENCE

To examine the management of Mr Midland by HMP Featherstone in the period before he was found unresponsive on 28 April 2016, and in light of the policies and procedures applicable at the relevant time;

122. The management of Mr Midland by both the prison and by mental health in-reach services was appropriate and in line with the relevant policies and procedures.

123. Management and staff at the prison were aware of the health risks posed by the ingress of novel psychoactive substances (NPS) and had implemented multiple strategies to reduce this.

[59] Transcripts of interviews with staff (At Annexe C)

124. The response from Health Care was to share information, to refer to drug services and to establish procedures for the management of acute intoxication.

125. Despite these initiatives, NPS were still being used by prisoners. At the time of Mr Midland's collapse on 28 April, the health care staff were experienced in resuscitating prisoners who were intoxicated from using NPS. The health care staff who responded to the emergency did all they could, but it is likely that the chemical effect of the substance used by Mr Midland led to a sustained failure to breathe which caused brain injury due to lack of oxygen. The investigators concluded that the event could not have been prevented.

To examine relevant health issues, including mental health assessments and clinical care, in the period before Mr Midland was found unresponsive on 28 April 2016;

126. Mr Midland had a diagnosis of multiple substance misuse, which extended to alcohol dependency. He had disclosed that he had used substances, including NPS, during the period of deterioration in his mental state (October to December 2015). Although he endorsed abstinence early in 2016, he was clearly at risk of relapsing and using again.

127. The risk of relapse was discussed with him by nurse 1 and he declined to access help from substance misuse services in March 2016. He had declined such referrals in the past.

128. The Investigation has considered whether further interventions should have been made with Mr Midland in the days after 17 April (when his collapse in the stairwell and his seizure strongly suggested that he had relapsed into substance misuse). Primary care staff did share this information with nurse 1 on 25 April, and she made an appointment for Mr Midland on 4 May. In view of Mr Midland's rejection of referrals to

substance misuse services in the past, the investigators concluded that this plan was appropriate.

129. Respiratory arrest (stopping breathing) is a known hazard of NPS use. In fact, staff from the prison stated that there were up to 10 or 15 "Code Blue" emergency calls per day due to NPS use at that time.[60] Mr Midland had collapsed and had a seizure (also a known hazard of NPS use) 11 days before his respiratory arrest. Therefore, Mr Midland was at risk because of NPS use.

130. A sustained respiratory arrest of the depth and duration of that suffered by Mr Midland is a rare outcome. In the current state of knowledge regarding NPS there are no evidence-based risk assessments and there is no structured guidance, as yet for predicting high-harm outcomes. Medical interventions relate to the general care of individuals who may have ingested NPS, and the care of Mr Midland was in line with this. The investigators concluded that this incident could not have been predicted.

To consider, within the operational context of HM Prison and Probation Service, what lessons in respect of current policies and procedures can usefully be learned and to make recommendations as to how such policies and procedures might be improved;

131. This Investigation has concluded that the Substance Misuse Meetings from January to April 2016 showed a lack of attendance by a representative from the Security staff. Further, opportunities to share information with the Drug and Alcohol Recovery Service when a prisoner had been placed on report by prison staff for being under the influence of an illicit substance were missed. HMP Featherstone should explore how to maximize information-sharing between Health Care and Security so that both of these components of care can work together to reduce the ingress and use of illicit substances in the prison.

[60] Transcript of interview with Prison Officer 1, page 1. At Annexe C

Recommendation 1.

For HMP Featherstone, Midlands Partnership NHS Foundation Trust and Care UK

It is recommended that HMP Featherstone and the health care providers in the prison should explore how to maximize information-sharing between Health care and Security so that both of these components of care can work together to reduce the ingress and use of illicit substances in the prison. This includes the completion of agreed actions in the Substance Misuse Meetings and the Security Committee Meetings.

Recommendation 2.

For HMP Featherstone

It is recommended that HMP Featherstone should review its procedures so that families are informed of a prisoner's illness with a minimum of delay.

Recommendation 3.

For HMP Featherstone

HMP Featherstone should comply with the mandatory action contained in Prison Service Order 1300 – 'Investigations' that a formal investigation is completed when there is serious harm to any person.

To provide a draft and final report of your findings including the relevant supporting documents as annexes;

To provide your views, as part of your draft report, on what you consider to be an appropriate level of public scrutiny in all the circumstances of this case.

132. Please see paragraphs 138 to 141.

Addressing the family's concern that Mr Midland was assaulted prior to his collapse on 28 April 2016

133. Recognizing that Mr Midland had been assaulted previously, the investigators could find no evidence to suggest that Mr Midland was assaulted before his collapse on 28 April 2016.

134. The evidence is strong that he became profoundly hypoxic because he stopped breathing. It is difficult to envisage that he might have been overpowered in his cell without evidence of damage to his surroundings or visible signs of injury.

Good Practice

135. The management of Mr Midland's schizophrenia was effective and caring. His illness had responded to an adequate dose of antipsychotic medication and he had a supportive relationship with his care co-ordinator (nurse 1). He was able to be honest with her about his substance misuse, and they discussed the adverse impact of this on him. The investigators were greatly helped by nurse 1's meticulous and thorough clinical records.

136. The involvement of prisoners to support other prisoners is an example of good practice. The prison should be encouraged to expand this initiative.

137. HMP Featherstone's drug strategy in effect at the time was comprehensive, detailed and complied with national standards [see para 88].

THE APPROPRIATE LEVEL OF PUBLIC SCRUTINY

138. The State's investigative obligation under Article 2 of the European Convention on Human Rights includes an element of public scrutiny. It is necessary to consider, firstly, whether there are serious conflicts in the evidence, which require the questioning of witnesses in a public setting to

test the credibility of their evidence. This Article 2 Investigation did not find serious conflicts in the evidence.

139. The second consideration is whether the investigation has uncovered convincing evidence of widespread or serious systemic failures, such that a public hearing might be warranted to maintain public confidence. The investigation has not found evidence to suggest widespread or systemic failures.

140. The lead investigator and the assistant investigator in this case have concluded that publication of their final report will be sufficient to satisfy the State's obligation for public scrutiny.

141. We very much hope that our Findings and Recommendations will make a significant contribution to the management of prisoners who have vulnerabilities and who use substances in the future. We do not think that further public scrutiny would add significantly to our conclusions.

GLOSSARY

ACCT	The Assessment, Care in Custody and Teamwork (ACCT) Plan is the prisoner-centred care-planning process used to help to identify and care for prisoners at risk of suicide and/or self-harm. The ACCT process requires that certain actions are taken to ensure that the risk of suicide and self-harm is reduced. Additional details about ACCT are available in PSI 64/20111 – 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)', Chapter 5, from page 26. Website address at Appendix 1.
Adjudication	Adjudications are the procedure whereby offences against the Prison Rules alleged to have been committed by prisoners are dealt with. The adjudication process awards punishments for specific incidents committed. Adjudications, along with the separate Incentives and Earned Privileges Scheme (IEP, contribute to maintaining order and control, and a safe environment, within an establishment.
Association	Association is prisoners' recreation and association period when they are outside their cells.
Chrysalis	Personal Change Programme supporting essential life skills and employability

Code Blue	An alarm within the prison referring to breathing and respiratory difficulties. The Control Room automatically calls an emergency ambulance.
DARS	Drug and Alcohol Recovery Service
Dual Diagnosis	The co-occurrence of a severe and/or enduring mental illness and problematic use of drugs and/or alcohol.
IEP	Incentives and Earned Privileges. The Incentives and Earned Privileges scheme is a series of incentives designed to encourage good behaviour and challenge misbehaviour. It is separate from the adjudications process, but along with adjudications, it contributes to maintaining order and control, and a safe environment, within an establishment. IEP schemes generally have three privilege levels; these are determined by commitment to rehabilitation, purposeful activity and good behaviour. Basic regime is the most austere. Standard is the entry point for prisoners into an establishment. Enhanced offers a range of access to privileges such as purchases and visits, depending on each individual prison.
IMB	Independent Monitoring Board. Volunteer members of the public who are independent of the prison, and who make an average of three – four visits per

	month to monitor day-to-day life in the prison and ensure that proper standards of care and decency are maintained.
ISMS (ISMT)	ISMT refers to the Integrated Substance Misuse Team, a drug treatment service which commenced at Featherstone on the 1 October 2007. ISMS (in HMP Featherstone's 2016 drug strategy) refers to the Integrated Substance Misuse Service. ISMS was provided by Lifeline, who also provided the Drug and Alcohol Recovery Service. It involved all staff working together to help those with drug-related problems. The service undertook the prescribing and dispensing of opiate substitution, such as methadone and Subutex. Individuals could access ISMS by referrals from Health Care and Drug and Alcohol Recovery Services. The key elements of ISMS were: • Improved clinical management with greater use of stabilisation and maintenance prescriptions • Intensive Drug and Alcohol Recovery Service support during the first 28 days of custody • Greater integration of substance misuse treatments with other clinical interventions • Better targeting of Interventions to match individual need, including ISMS specific group work packages and one to one sessions • Strengthened links to Community Services.

MASH	Multi-Agency Safety and Health, a multidisciplinary meeting within HMP Featherstone
MRI scan	Magnetic resonance imaging (MRI) is a medical imaging technique used in radiology to form pictures of the anatomy and the physiological processes of the body.
To place on report	To make [a prisoner] liable for an adjudication and disciplinary sanctions
P-NOMIS	Prison National Offender Management System. The Prison Service's electronic recording-keeping system
RESOLVE	An enhanced thinking skills programme which helps to improve problem-solving skills
Oxygen saturation, 'Sats'	Oxygen saturation ('sats') refers to the amount of oxygen that the blood is carrying. It is a percentage, obtained by a simple painless test using a sensor on the skin. Normal healthy levels are from 94 to 99%. Values under 90% indicate that the person is lacking oxygen. Blood oxygen levels below 80% may damage the brain and the heart, so urgent treatment is needed.
SCRAs	Synthetic cannabinoid receptor agonists (SCRAs) are a large group of drugs, which have a strong effect on the

	endocannabinoid system, a complex cell-signalling system identified in the early 1990s by researchers exploring THC, a well-known cannabinoid. Cannabinoids are compounds found in cannabis.
Schizophrenia	A mental disorder characterised by distortions of thinking and perception and by blunted or inappropriate affect (mood). Thoughts, feelings and acts are often believed to be known to, or shared by, others and explanatory delusions (false beliefs) may develop. Auditory hallucinations (false perceptions) are common. Schizophrenia is treated by antipsychotic medication. It is regarded as a severe and enduring mental illness.
Severe and/or enduring mental illness	A mental disorder that would necessitate referral to secondary mental health services from primary care in the absence of problematic substance misuse
SystmOne	SystmOne is a clinical software brand that provides clinicians and health professionals with a single, shared electronic Health Record (ECHR) available in real time at the point of care. It supports the 'one patient, one record' model of health care.
TSP	Thinking Skills Programme – a cognitive skills programme which addresses the way offenders think and their behaviour associated with offending

VR	Violence reduction. These interventions within the Prison Service are of different intensity, for example VR2 refers to more active monitoring of an individual.

APPENDIX 1. WEBSITES REFERENCED IN THIS REPORT

'Report on an unannounced inspection of HMP Featherstone by HM Chief Inspector of Prisons. 14-25 October 201', dated 27 March 2014, can be found at:

https://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/04/Featherstone-2013.pdf

'The Annual Report of The Independent Monitoring Board Report. HMP Featherstone. 1st November 2015 – 31st October 2016', November 2016, was published on 16 December 2016. It can be found at:

https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2016/12/Featherstone-2015-16.pdf

'Prison and Probation Ombudsman for England and Wales. Learning Lessons Bulletin. Fatal Incident Investigations Issue 9: New Psychoactive Substances, July 2015' can be found at:

http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/07/PPO-Learning-Lessons-bulletin-issue-9-New-Psychoactive-Substances.pdf

Prison Service Instruction 15/2014 – 'Investigations and learning following incidents of serious self-harm or serious assaults'. Effective Date: 14 April 2014. Re-issued on 13 July 2016. Expiry Date: 2 April 2018.

Please note that the version re-issued on 13 July 2016 states: "**Update July 2016** – Instruction has been updated to rectify typographical errors of acronyms. No change has been made to the policy content."

This PSI can be found at:

https://www.justice.gov.uk/downloads/offenders/psipso/psi-2014/PSI-15-2014-Investigation-and-Learning-following-Incidents-of-Serious-Self-harm-and-Serious-Assaults-Revision-July2016.pdf

Prison Service Instruction (PSI) 64/2011 – 'Management of prisoners at risk of harm to self, to others and from others (Safer Custody)'. Issue Date: 09 September 2013. Expiry Date: 31 January 2016. However, it remained extant with minor changes in wording which did not alter the substance of PSI 64/2011. Thus, it covers the period of this investigation.

It can be found at: https://www.justice.gov.uk at: 64-2011-safer-custody.doc

Prison Service Order 1300 – 'Investigations' can be found at:

https://view.officeapps.live.com/op/view.aspx?src=http%3A%2F%2Fwww.justice.gov.uk%2Fdownloads%2Foffenders%2Fpsipso%2Fpso%2FPSO_1300_investigations.doc

The Royal College of Psychiatrists: 'Standards for Prison Mental Health Services', 1st Edition, June 2015, can be found at:

https://www.rcpsych.ac.uk/docs/default-source/improving-care/ccqi/quality-networks/prison-quality-network-prison/prison-qn-standards/prisons-standards-first-edition.pdf?sfvrsn=9f8c7fad_2

APPENDIX 2. NOVEL PSYCHOACTIVE SUBSTANCES (NPS)

This text is taken from Abdulrahim D, Bowden-Jones O, on behalf of NEPTUNE group. *Harms of Synthetic Cannabinoid Receptor Agonists (SCRAs) and Their Management*. London: Novel Psychoactive Treatment UK Network (NEPTUNE), 2016. This can be found at:

http://neptune-clinical-guidance.co.uk/wp-content/uploads/2016/07/Synthetic-Cannabinoid-Receptor-Agonists.pdf

'NPS', 'spice' and 'mamba' all refer to a group of compounds which have effects on the receptors in humans called the endocannabinoid system. These compounds are called synthetic cannabinoid receptor agonists (SCRAs).

What particular brands contain is likely to vary. Brand names are not reliable indicators of what is consumed. Analytical tests have shown that the cannabinoid constituents and dosage can vary greatly both between products and between batches of the same brand. There may even be differences within the same package. There is also evidence that some products contain a combination of different SCRA compounds.

SCRA products in the UK are sometimes known generically as 'Spice', the name of a popular brand. However, not all products labelled 'Spice' are SCRAs. Stimulant drugs also branded 'Spice' have been sold.

Over 200 SCRAs have been detected on the global drug market, with an estimated 150 – 160 available to UK consumers. There are wide differences between the various SCRAs, including in metabolism, potency, toxicity and duration of effects.

The evidence base on the harms associated with the use of SCRAs and their management is still emerging and remains limited. Little is known about the metabolism and toxicology of SCRAs in humans. It cannot be assumed that the risks associated with their use will be comparable with those of cannabis

and there are concerns that they may have a greater potential to cause harm. SCRA products can also have unpredictable effects. There is emerging evidence that the risks of requiring emergency medical treatment as a consequence of using SCRAs are much greater than for natural cannabis.

Common physical effects of SCRAs include a tachycardia (a fast heart rate) and nausea. Reduced levels of consciousness and coma have been reported. The risk posed to prisoners' health by NPS has been recognized for some years and recommendations have been made for custody staff (for example, the Prison and Probation Ombudsman's Learning Lessons Bulletin 9, 2015). The need for training prison staff in harm reduction and the psychosocial management of substance misuse has been emphasized.

Education is the main preventative health intervention, especially in preventing the proportion of users who use NPS for the first time in prison. Topics include drug refusal skills, risks to physical and mental health, and the unpredictable effects of NPS compounds as they are composed of different types of substances with varying and unpredictable strengths. Education should be available to all prisoners without the need for them to identify as a user.

APPENDIX 3. PSYCHOLOGICAL APPROACHES CIC

Our Ethos and Our Team

Psychological Approaches CIC is a not-for-profit community interest company focused on work with individuals with complex mental health needs – often associated with a history of offending and social exclusion – for whom services may be difficult to access, and sometimes poorly-equipped to meet their needs.

Our ethos is one of collaboration and partnership with other organisations. Together, we can support the workforce with a focus on development in four areas:

- commitment to the task
- competence and confidence in the delivery of the service, and
- containment of emotional states to improve staff well-being.

We attend to the evidence base for best practice, and in so doing, we help organisations to review and evaluate services in order to achieve better outcomes. We understand how important it is to focus on improved quality of care, delivered in ways to maximize efficiency and impact.

Our independent serious incident investigation team comprises five senior practitioners from a multi-disciplinary background with many decades of experience in forensic mental health services and clinical governance. We adopt a whole-team approach to independent serious incident investigations, with an emphasis on peer review and ratification of findings.

LIST OF ANNEXES

ANNEXE A. DOCUMENTS READ AND DISCLOSED

Annexe A3.1. Minutes of Security Committee Meetings

Annexe A3.2. Minutes of Substance Misuse Meetings

Annexe A3.3. Documents relating to the response of HMP Featherstone to the ingress of drugs

Annexe A3.4. Policy and Strategy documents: HMP Featherstone

Annexe A3.5. Letters to Members of Parliament

ANNEXE B: DOCUMENTS REVIEWED BUT NOT DISCLOSED

Annexe B1: Body-worn camera footage of the incident on 28 April 2016

Annexe B2: Information from HMP Featherstone – reviewed but not relied upon

ANNEXE C: TRANSCRIPTS OF INTERVIEWS WITH WITNESSES

Nurse 1, 5 August 2019	:	Transcript as sent to witness for approval
Senior Officer 1, 5 August 2019	:	Approved
Governor 2, 5 August 2019	:	Approved
Prison Officer 1, 28 August 2019	:	Transcript as sent to witness for approval
Nurse 2, 28 August 2019	:	Approved
Nurse 3, 28 August 2019	:	Approved
Nurse 4, 11 November 2019	:	Transcript as sent to witness for approval

Flow chart following life threatening illicit drug use.

Identify code blues/illicit drug related incidents by the daily handover report

↓

Recovery champion to make contact with the prisoner to encourage engagement and offer support from the substance misuse team

↓

IF ACCEPTED SUPPORT:
An assessment appointment will be offered with recovery worker

↓

Psychosocial and clinical support offered including structured key work sessions and prescribing options

↓

Referred for group work activities and encourage to access mutual aid support

↓

Offered inclusion gym

↓

Exit treatment and/or referred to community support for release

↓

IF DECLINED SUPPORT:
Ongoing recovery champion contact following code blue/illicit drug related incidents

↓

Contact made to safer custody and OMU if continues with problematic behaviour

↓

Discussed at Safety Intervention Meeting (SIM)

↓

Continue recovery champion contact