Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brandon Johnson, a prisoner at HMP Wandsworth, on 12 September 2019

A report by the Prisons and Probation Ombudsman

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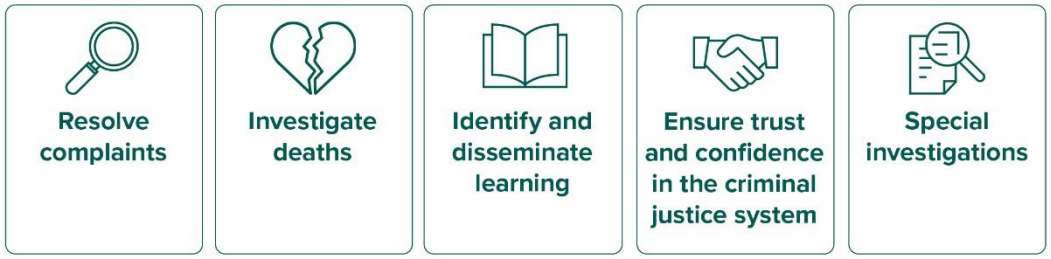
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

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

Mr Brandon Johnson died on 12 September 2019, of respiratory failure due to opiate poisoning, at HMP Wandsworth. He was 40 years old. I offer my condolences to Mr Johnson's family and friends.

Mr Johnson was receiving treatment for drug and alcohol dependence. His dosage of methadone was twice increased within six days. I agree with the findings of the clinical review that there should have been a more gradual approach to increasing Mr Johnson's methadone; and that it might have been wise to recheck a previous heart abnormality and review his risks.

Wing staff seemed unaware that Mr Johnson had not received his methadone on the day of his death and were not, therefore, concerned that he appeared to be asleep. I consider that the process for checking whether prisoners have collected their medication needs to be more robust to ensure that no one is overlooked in the future.

While staff clearly thought they were acting in Mr Johnson's best interests, it was inappropriate to attempt resuscitation when there were clear signs of rigor mortis.

It is disappointing that neither the Governor, nor a senior manager at Wandsworth, wrote to Mr Johnson's next of kin to offer condolences and formally acknowledge Mr Johnson's death while in their care.

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

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

Contents

Summary

Events

1. Mr Brandon Johnson was recalled to prison on 30 August 2019 and taken to HMP Wandsworth. He had a long history of substance misuse and had spent previous periods in Wandsworth.

2. Following clinical and substance misuse assessments, a prison GP prescribed alcohol detoxification and a daily dose of 30mg of methadone. Mr Johnson was closely monitored over the next five days.

3. On 2 September, another prison GP increased the dosage of methadone to 35mg, at the request of a nurse, as Mr Johnson felt the dose was insufficient and had complained of withdrawal symptoms. He was aware that Mr Johnson had received higher dosages in the past. The same GP and a substance misuse worker reviewed Mr Johnson on 5 September. Mr Johnson reported several withdrawal symptoms and the GP observed signs of this. The GP again increased the dose of methadone to 45mg.

4. On 12 September, several wing staff saw Mr Johnson in his cell during the day. Each time, he was lying in bed and they thought he was asleep. At around 4.00pm, a healthcare assistant realised that Mr Johnson had not attended to receive his methadone and went to get him. At 4.10pm, he went into Mr Johnson's cell with an officer and they found him unresponsive. Healthcare and operational staff performed cardiopulmonary resuscitation. Paramedics attended and, after examining Mr Johnson, confirmed his death at 4.29pm.

5. The prison had no contact details for Mr Johnson's next of kin. The police informed them of his death on 16 September.

Findings

6. The clinical reviewers concluded that, on balance, Mr Johnson's care was equivalent to that he could have expected to receive in the community. However, they found some shortcomings.

7. In 2018, a test had revealed that Mr Johnson had a prolonged QT interval, a heart abnormality which can increase the risk of erratic heart rhythms and sudden cardiac death. Mr Johnson had been prescribed methadone and olanzapine (an antipsychotic) and both medications can make this condition worse. Healthcare staff should therefore have reassessed Mr Johnson's risks.

8. Mr Johnson received a significant increase in his daily methadone dose between 31 August and 6 September. As the level of his illicit drug use in the community could not be verified and there was no requirement for close monitoring after the increase, greater caution should have been exercised in prescribing a higher dose within a relatively short timescale.

9. We are concerned that although wing staff had received a list of prisoners due to receive methadone on 12 September, they did not know that Mr Johnson had failed

to attend. Action therefore needs to be taken to prevent overlooking prisoners in the future.

10. We commend a healthcare assistant for checking on Mr Johnson when he did not collect his methadone.

11. Staff inappropriately attempted resuscitation despite clear signs of rigor mortis.

12. The prison did not comply with the mandatory requirement for the Governor or a senior manager to send a letter of condolence to Mr Johnson's next of kin.

Recommendations

- The Head of Healthcare should review the treatment policy and management of methadone, including assessing the need for ECG tests when starting methadone and additional monitoring when dosage is significantly increased.
- The Governor and Head of Healthcare should ensure that a copy of this report is shared with a healthcare assistant so that he is aware of the Ombudsman's comments.
- The Governor and Head of Healthcare should ensure there is a systematic process to identify prisoners who need to receive methadone.
- The Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis; and fully understand the circumstances in which they should not start, or continue resuscitation, in line with European Resuscitation Council Guidelines.
- The Governor should ensure that when a prisoner dies, a letter of condolence is sent to his family or next of kin, in line with national policy.

The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Wandsworth informing them of the investigation and asking anyone with relevant information to contact her.

14. The investigator visited Wandsworth on 20 September 2019. She spoke to members of the safer custody team; watched CCTV footage; and obtained relevant documents, including copies of relevant extracts from Mr Johnson's prison and medical records and staff statements.

15. NHS England commissioned independent clinical reviewers to review Mr Johnson's clinical care at the prison. Two clinical reviewers carried out the clinical review on their behalf. The investigator and a clinical reviewer jointly interviewed seven members of staff at Wandsworth, on 19 November 2019 and 7 January 2020.

16. Our investigation was suspended between 16 January 2020 and 10 February 2020, while awaiting the cause of death and the clinical review report.

17. We informed HM Coroner for Inner West London of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Johnson's aunt, who acted on behalf of Mr Johnson's next of kin, to explain the investigation. Mr Johnson's family asked for the investigation to consider the following questions and concerns:

    - The reasons for Mr Johnson's arrest and detention.
    - Had Mr Johnson been involved in any physical incidents with other prisoners?
    - Why was Mr Johnson asleep during the afternoon of 12 September?
    - The reasons for the delay in contacting Mr Johnson's family and the steps taken to trace them.
    - They did not have the opportunity to see Mr Johnson before his cremation.
    - They did not receive a letter of condolence, or any correspondence from a senior prison manager acknowledging Mr Johnson's death.
    - They did not receive Mr Johnson's property.

19. We have addressed the issues raised by Mr Johnson's family that fall within our remit.

20. Mr Johnson's family received a copy of our initial report. They raised several issues and concerns that did not impact on the factual accuracy of this report. However, a comment has been clarified in the report and the remaining issues have been addressed in separate correspondence.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations.

Background Information

HMP Wandsworth

22. HMP Wandsworth is a local prison in London and holds up to 1,452 men in eight residential wings. At the time of Mr Johnson's death, St George's University Hospital NHS Foundation Trust provided physical healthcare services at the prison. Oxleas NHS Foundation Trust has delivered these services since October 2019. Mental health services are provided by South London and Maudsley NHS Foundation Trust. There is an inpatient unit for up to six prisoners (the Jones Unit) which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Wandsworth was in March 2018. Inspectors noted that around nine per cent of prisoners were receiving methadone or buprenorphine for opiate dependence and prescribing was flexible and tailored to individuals. A third of prisoners were receiving psychosocial help for substance misuse problems. Inspectors found that the psychosocial and clinical services were well integrated and the staff worked effectively with wider healthcare and prison staff. Most prisoners were satisfied with the health provision.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to 31 May 2019, the IMB reported that they were very encouraged by the increase in the number of staff and the healthcare department had been allocated a dedicated team of officers. Healthcare peer support workers spoke to prisoners about the importance of health assessments and attending booked appointments.

Previous deaths at HMP Wandsworth

25. Mr Johnson was the tenth prisoner to die at Wandsworth since September 2017. Six of the previous deaths were due to natural causes, one was self-inflicted, one was drug-related and the cause of the other has yet to be determined. There has been one further self-inflicted death and one due to natural causes.

Recall to prison

26. When prisoners are released on licence, they are required to comply with certain conditions while serving the remainder of their sentence in the community. They are given a copy of their licence with all the conditions they must follow and are supervised by the Probation Service. If they do not keep to the conditions of their licence, are charged with another crime, or behave in a way that causes their probation officer concern, the licence can be revoked, which results in a recall to prison. The recall can be for 28 days (known as a fixed-term recall) or to serve the

remainder of the original sentence (known as a standard recall). Prisoners are given the reasons for their recall and can make written appeals to the Parole Board.

Key Events

Background

27. On 21 August 2018, Mr Brandon Johnson was sentenced to 18 months imprisonment, for burglary and theft. He had a history of substance misuse and used heroin, crack cocaine, alcohol and cannabis. It was not his first time in prison. Mr Johnson was released on licence from HMP Thameside on 5 July 2019.

28. Mr Johnson breached his licence conditions by failing to attend his initial appointment with his offender manager and he was recalled to prison on a 28-day fixed-term recall on 12 July. After his arrest that day, he was admitted to hospital, where he had surgery for a hand infection sustained in a fight. On 16 July, Mr Johnson was taken to HMP Wandsworth and he was released on 8 August.

29. Although Mr Johnson attended his initial offender management appointment, he did not go to the subsequent meeting, or communicate with his offender manager. He also committed further offences of burglary and theft. He was again recalled.

Recall to Wandsworth on 30 August

30. Mr Johnson returned to Wandsworth on 30 August. During the reception procedures, it was noted that he was homeless (on both occasions, he had been released from prison without accommodation). He answered ‘yes’ when asked if his family and friends knew he was in prison but declined to name a next of kin. Mr Johnson was issued with a code to enable him to make external telephone calls on the prisoner telephone system. A cell sharing risk assessment concluded he was a standard risk and able to share a cell.

31. A Person Escort Record (PER) accompanies prisoners on all journeys between police stations, courts and prisons, to communicate risk factors. Mr Johnson’s PER noted that he was known to conceal drugs and there was a possibility that he had taken or concealed amphetamines.

32. A healthcare assistant conducted a urine test, which was positive for benzodiazepines, cannabinoids and cocaine. An Audit-C alcohol screen indicated that Mr Johnson might have problematic alcohol use.

33. The drug and alcohol screens were followed by an initial health screen. A nurse noted that Mr Johnson had been diagnosed with paranoid schizophrenia, for which he took daily medication. Mr Johnson reported that he smoked around £80 of heroin and crack cocaine daily and drank ten strong cans of lager. The nurse referred him to the substance misuse service.

34. A prison GP then assessed Mr Johnson, who gave slightly different information about his substance misuse in the community - £80 of heroin, £100 of crack cocaine per day and six to eight cans of strong lager. On examination, Mr Johnson had a tremor, stomach cramps and body aches and he was anxious, sweating and sneezing, with a runny nose. The prison GP prescribed alcohol detoxification and methadone maintenance therapy, at a dose of 30mg of methadone per day. (Healthcare staff carried out the clinical observations required during the first five days of taking methadone.)

35. A nurse conducted a secondary health screen on 2 September. She noted that Mr Johnson had presented with a crackling cough and was suffering continued withdrawal symptoms from opiates. She requested a GP review to adjust his medication, as he said his dose of methadone was not sufficient to prevent withdrawal symptoms. Mr Johnson did not attend a health assessment GP clinic appointment that day. However, a prison GP increased the dose of methadone to 35mg daily and booked a review for 5 September.

36. On 3 September, a clinical support assistant took clinical observations and noted that Mr Johnson was having hot flushes. Mr Johnson told her that his medication was not 'holding him' as well as before, he was not sleeping well and had muscle pains. She explained to him that they were symptoms of withdrawal. She repeated his observations in the afternoon and he said he was starting to feel a bit better and was happier because his medication had been increased.

37. On 5 September, a prison GP and a member of staff from CGL substance misuse service, held a review. The prison GP noted that Mr Johnson had been on 40mg methadone when he left Wandsworth on 8 August. Mr Johnson told them that, on his release, he had attended the housing and probation offices, before going to the CGL office and was told it was too late to get a prescription, so he had relapsed into illicit drug use. He said that he was suffering withdrawal symptoms, with watery eyes, restlessness, aches and pains, loss of appetite and his mood was 'up and down.' The prison GP noticed that Mr Johnson appeared agitated and his legs were restless. He increased the daily methadone dosage to 45mg, starting the next day. Mr Johnson agreed to engage with CGL and would be given a 'recall pack.'

38. Little was recorded over the next three days. The next significant entry was on 9 September. Mr Johnson had been referred to the mental health in-reach team and had been discussed in the team meeting. A nurse recorded that he was going to lose his single cell, but he could not go in a cell with another man as he was abused in care and it was hard for him. She noted that a community psychiatric nurse would review him.

39. On 10 September, a CGL drug worker went to Mr Johnson's cell to carry out a full assessment. Mr Johnson initially said he was happy to complete the assessment. However, after a short while it was clear that that he was feeling ill, so she only asked a few basic questions and planned to continue another time. Mr Johnson spoke about his abuse as a child and that he did not want to share a cell with another man. He said he sometimes felt paranoid and usually kept to himself. She told Mr Johnson that he could contact her using the prisoner kiosk and she would return when he felt better.

40. She told the investigator that Mr Johnson had presented in a similar way to other prisoners: weary and a bit tired of all the questions that had been asked several times before. However, he had been courteous and pleasant. He had mentioned having a sore throat and that he had had a seizure a year before, but there had been no outcome from the hospital. Other than an apparent cold and the demeanour typical of a prisoner dependent on opiates, she did not notice any other symptoms and certainly none of concern. She said that if he had seemed very ill, she would have sent a message to the GP.

41. On the same day, a consultant forensic psychiatrist noted that Mr Johnson's schizophrenia, alcohol and opiate misuse had been discussed at the in-reach

meeting. His mental state was stable, he was compliant in taking olanzapine (an antipsychotic medication to treat schizophrenia and bipolar disorder) and he would be followed up by the in-reach team.

42. At 4.10pm, Mr Johnson moved from E wing to cell A4-29 on A wing. An officer said that he was moved because he had refused to share a cell. Mr Johnson had told him that he had been abused as a child and felt uncomfortable sharing with another prisoner. Due to this refusal, Mr Johnson was also placed on 'basic' the lowest level of the former Incentives and Earned Privileges (IEP) scheme - which is intended to incentivise prisoners to comply with the rules and engage in the regime and rehabilitation.

43. During the evening, an offender supervisor gave Mr Johnson a licence recall pack. Mr Johnson told him, he did not need to explain the details of a standard licence recall, as he had been recalled before. He signed the acknowledgment form and said he did not need to be represented. As he started to walk away, Mr Johnson called him back and returned the pack, as he had noticed it was for someone else with a similar name. The offender supervisor went back to the cell a few minutes later, with the correct pack for Mr Johnson. He said that throughout their conversation, Mr Johnson was calm, polite, rational and coherent.

Events of 12 September

44. At approximately 10.40am, an officer and a servery worker delivered a cold lunch meal to Mr Johnson in his cell. In a statement, the officer said that Mr Johnson was lying on the bottom bunk, with his arm above his head. He said Mr Johnson had moved slightly when he told him that his lunch was being delivered, but he did not say anything to them. The servery worker had placed the items on the side table beside Mr Johnson's bed. The officer said he was not concerned about Mr Johnson at that time, as he appeared to be sleeping. (The investigator was unable to speak to the officer as he had left the Prison Service.)

45. At 1.45pm, prisoners were unlocked for association, but those on 'basic' remained in their cells (as they were only allowed out for the last 30 minutes). A supervising officer (SO) assisted the wing officers to unlock the cells. She looked through the observation panel and saw Mr Johnson, apparently asleep, lying on his left side. One of the officers shouted that he was on 'basic' so she carried on unlocking the other cells.

46. Just after 3.00pm, while most prisoners on the wing were in the exercise yard, two officers out cell checks to ensure that prisoners did not have televisions to which they were not entitled. They went to Mr Johnson's cell. As they could not see a television through the observation panel, an officer remained at the door while the other officer went into the cell. The officer said he greeted Mr Johnson, explained what they were doing and quickly looked around. Mr Johnson did not respond. He was lying on his left side with his hands on his face and appeared to be sleeping. The officer said it was not unusual for prisoners to be asleep during the afternoon. He thought he saw slight breathing and heard him faintly snoring. The check was very brief, as Mr Johnson had few possessions and the cell was bare.

47. That afternoon, a healthcare assistant was helping to dispense methadone. He knew Mr Johnson well and noticed that he had not collected his medication with the

other prisoners on E wing. He then checked the records and saw that he had moved to A wing. After all the A wing prisoners had received their methadone, He realised that Mr Johnson had still not attended, so he went to get him. At around 4.10pm, he went to the landing and asked an officer to open the cell.

48. The officer opened the observation panel and called out to Mr Johnson. He then opened the door and they both called out again. There was no response, or movement, so the officer tapped Mr Johnson on the shoulder. The healthcare assistant realised something was wrong, as Mr Johnson's eyes were open and there was fluid leaking from his mouth. He asked the officer to call a code blue emergency (which indicates that a prisoner is unresponsive or has breathing difficulties). The officer left the cell and shouted to another officer to call a code blue and ask for the emergency response nurse. The code blue was called at 4.10pm and the control room requested an ambulance immediately.

49. The healthcare assistant could not find a pulse and saw no chest movement. Two nurses (formerly NAME) arrived with emergency bags, followed by additional nurses, wing officers, a SO and custodial manager. The healthcare assistant said that Mr Johnson was lying on his front, with his hands under his chin, and the SO said that he was lying in the same position as she had seen him in earlier.)

50. The nurses and operational staff began cardiopulmonary resuscitation, taking it in turns to perform chest compressions. After one or two rounds of chest compressions, they placed Mr Johnson on the floor and continued. They were unable to use an oral airway as Mr Johnson's jaw was stiff and locked, so they inserted a nasal airway. They attached a defibrillator (a portable machine that sends an electric shock through the heart to try and restore a normal heartbeat) but no shock was advised.

51. A rapid response paramedic arrived at the prison at 4.15pm (and reached the cell at 4.22pm). This was followed by two ambulances at 4.18pm and 4.23pm and a further rapid response paramedic at 4.24pm. The paramedics did not attempt resuscitation. At 4.29pm, they confirmed Mr Johnson's death.

52. Vials of blue/green coloured liquid were found in Mr Johnson's cell. The Coroner's office told us that, following testing, they were found to be washing up liquid. (Prisoners sometimes use shampoo or washing up liquid to enhance the effect of illicit drugs but it is not possible to say if Mr Johnson was doing this.)

Contact with Mr Johnson's family

53. Mr Johnson had told staff that he was not in contact with his parents or other relatives and had given no contact details for his next of kin. He had been in prison before, but had received no visits since 2013 and, during this period in custody, had made no telephone calls to family members listed on his existing telephone contact list. The prison's family liaison officer (FLO) contacted the Probation Service, the police and Mr Johnson's solicitor to try and trace his family.

54. On 13 September, a community substance misuse service gave the FLO contact details for Mr Johnson's next of kin that they had recorded a few years before. She went to the address given, but there was no reply. She therefore asked the police to try and contact his father to break the news.

55. On 16 September, the police informed Mr Johnson's next of kin of his death and gave him the FLO's telephone number. On 17 September, Mr Johnson's stepmother telephoned the prison. She declined the offer of a home visit and agreed to consult Mr Johnson's next of kin about visiting Mr Johnson's cell. The same day, Mr Johnson's next of kin, spoke to the FLO, on behalf of his next of kin. The FLO and the deputy family liaison officer visited them on 23 September to explain the expected processes and to offer support.

56. The next day, the FLO tried to arrange formal identification of Mr Johnson, at a time convenient for his family. However, the Coroner's office advised her that this was unnecessary, as they had identified Mr Johnson by his fingerprints and thought that it might be better for his family to see him at the funeral director's premises. The FLO informed them of this, but Mr Johnson's family was subsequently advised by the funeral director that his body was unsuitable for viewing. She kept in touch over the following weeks, including liaising with the Coroner's office and funeral director.

57. Mr Johnson's funeral was held on 20 November. In line with national policy, the prison contributed to the funeral expenses.

58. During the PPO's investigation, the prison arranged for Mr Johnson's property to be returned to his family.

Support for prisoners and staff

59. After Mr Johnson's death, prison managers debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. They reminded staff of the Employee Assistance Programme and gave them the opportunity to go home if they wished. They also offered private conversations. A representative from the staff care team was present.

60. Staff checked the wellbeing of other prisoners on the wing and reviewed those assessed as being at risk of suicide or self-harm. They increased the observations for one prisoner who said that he had been affected by Mr Johnson's death. The prison posted notices informing other staff and prisoners of Mr Johnson's death and offering support.

Post-mortem report

61. The post-mortem report concluded that the cause of Mr Johnson's death was respiratory failure caused by opiate poisoning, with schizophrenia as an underlying factor.

62. The report noted that methadone was detected in Mr Johnson's stomach contents and urine. The level of methadone in his blood was above the potentially fatal concentration in individuals who have a tolerance to methadone.

Findings

Clinical care

63. Mr Johnson arrived at Wandsworth 13 days before his death. Staff carried out appropriate health assessments and re-prescribed medication. Many of them knew him well from previous periods in custody. He was described as a quiet, polite and compliant prisoner who tended to keep to himself, and the investigation found no evidence of any altercations with other prisoners. Entries in the security intelligence system in January and February 2019, indicated past suspicion that Mr Johnson had used psychoactive substances, but there were no records of him buying, selling, or being found with illicit drugs in prison.

64. The clinical reviewers considered all aspects of Mr Johnson's clinical care, including those unrelated to substance misuse. They noted:

> "The care provided followed the expected pathways and all the necessary assessments and monitoring indicated by the reception medicals and the fact that he was being prescribed methadone were carried out."

65. The clinical reviewers concluded that, on balance, the care Mr Johnson received was equivalent to that which he could have expected in the community. However, they identified some deficiencies and made recommendations. The issues directly linked to Mr Johnson's cause of death are outlined below.

Management of Mr Johnson's opiate dependence

Risk of abnormal heart rhythms

66. The clinical review noted that Mr Johnson did not have an electrocardiogram (ECG – to measure the heart's rhythm and activity to show whether it is working normally). A previous ECG, in 2018, had shown a prolonged QT interval (a measurement to assess some of the properties of the heart). Abnormal QT intervals can increase the risk of erratic heart rhythms and sudden cardiac death. The clinical reviewers considered that as Mr Johnson had been prescribed two drugs that prolong the QT interval (olanzapine and methadone), it might have been prudent to repeat the ECG and reassess Mr Johnson's risks.

Increase in dosage of methadone

67. Mr Johnson was initially prescribed 30mg of methadone per day. Although no explanation was given for this dose, the clinical reviewers considered it acceptable, taking account of Mr Johnson's long history of opiate dependency and that he had left Wandsworth three weeks earlier on a dose of 40mg.

68. On 2 September, a prison GP increased the methadone dose to 35mg without seeing Mr Johnson, who had failed to attend the appointment to review this. At interview, the prison GP said that he would normally see the prisoner before doing so, but he was content to accept a nurse's judgement and observations of withdrawal symptoms, and he expected to see Mr Johnson at a five-day review two days later.

69. Mr Johnson reported no problems or withdrawal symptoms over the next two days. However, during the review on 5 September, he asked for an increase in dose. The prison GP saw signs of opiate withdrawal and further increased the dose to 45mg. He said at interview that he had fully assessed Mr Johnson and pointed out that much higher doses of methadone had been previously prescribed.

70. The clinical reviewers noted that Mr Johnson's self-reported use of street drugs could not be verified and that going from 30mg to 45mg between 31 August and 6 September was a "fairly rapid increase". They considered that "a more cautious approach to increasing the dose of methadone should have been adopted". This was particularly relevant because after the increase there was no requirement for the kind of monitoring that takes place in the first five days of receiving methadone (such as twice daily clinical observations and hourly overnight monitoring).

71. However, the clinical reviewers noted that the same decisions about increasing the dose might have been made in the community and that there would have been no monitoring there.

72. In view of the clinical reviewers' findings, we make the following recommendation:

    The Head of Healthcare should review the treatment policy and management of methadone, including assessing the need for ECG tests when starting methadone and additional monitoring when dosage is significantly increased.

Dispensing methadone

73. On the day of his death, Mr Johnson was on the list of those due to receive methadone. At around 11.00am that morning, the list had been given to wing staff responsible for escorting prisoners to the treatment room and the prisoners were expected to attend at any time up to 4.00/4.30pm. Mr Johnson was discovered just after 4.00pm, through the assiduousness of a healthcare assistant, who knew him well and realised he had not attended for his medication. We commend him for his actions.

74. At interview, the healthcare assistant said that Mr Johnson never missed his methadone. He explained that prisoners are checked off the list, so even if he had not known him personally, healthcare staff would have realised that his medication was outstanding. In spite of having a list of prisoners, operational staff seemed unaware that Mr Johnson had not attended and we are concerned that there might be a gap in the process. We make the following recommendation:

    The Governor and Head of Healthcare should ensure there is a systematic process to identify prisoners who need to receive methadone.

    The Governor and Head of Healthcare should ensure that a copy of this report is shared with the healthcare assistant so that he is aware of the Ombudsman's comments.

Resuscitation

75. European Resuscitation Council (ERC) Guidelines for Resuscitation 2015, say that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including

the presence of rigor mortis. Every decision should be made on the basis of a careful assessment of an individual's situation.

76. Healthcare staff attempted resuscitation for around 15 minutes. Staff found that Mr Johnson's jaw was locked and some said that parts of his body were rigid. A nurse, who delivers life extinct training, said that she did not immediately identify rigor mortis, as she was aware that Mr Johnson was a substance misuse patient and drug overdoses can sometimes cause a locked jaw.

77. The clinical reviewers considered that staff should have been able to determine that Mr Johnson was dead. We acknowledge that they tried their best to give Mr Johnson the chance of recovery. However, they should understand that it is inappropriate to attempt resuscitation when there are clear and recognisable signs of death. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff are aware of the signs of rigor mortis; and fully understand the circumstances in which they should not start, or continue resuscitation, in line with European Resuscitation Council Guidelines.

78. Rigor mortis normally sets in within two to six hours of death. We note that this suggests that Mr Johnson was probably dead when an officer entered his cell at 3.00pm.

Contact with Mr Johnson's family

Delay in notifying Mr Johnson's family of his death

79. No next of kin details were recorded for Mr Johnson as he had denied the existence of any immediate family when these details were requested on reception. This was plausible, given that he had previously told probation staff that most of his childhood had been spent in care.

80. The investigation found that Mr Johnson had an approved list of around 30 telephone numbers on the prisoner telephone system, mostly of friends and a few relatives. He tried to make two telephone calls on 4 September, to the same number, but they were not connected, as the number had not been approved.

81. The FLO quickly attempted to get relevant information from several sources. It is unfortunate that when she went to the home of Mr Johnson's next of kin, the day after his death, he was not at home and he did not learn of Mr Johnson's death until three days later.

82. Mr Johnson chose not to disclose that he had close relatives. We are satisfied that the FLO made every effort and explored all reasonable avenues to trace his next of kin and that she provided a good standard of support once they were identified.

Letter of condolence

83. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, includes a mandatory requirement for the Governor to write a personal letter of condolence to the family of

a deceased prisoner. Mr Johnson's family said that they did not receive a letter from either the Governor, or a senior manager, formally acknowledging Mr Johnson's death. We are aware that there was a change of Governor around the time of Mr Johnson's death, but the prison was unable to provide evidence that any senior staff member had written to Mr Johnson's family. We make the following recommendation:

The Governor should ensure that when a prisoner dies, a letter of condolence is sent to his family or next of kin, in line with national policy.

Inquest

84. At the inquest, held on 24 June 2024, the jury concluded that Mr Johnson died from cardiorespiratory failure as a result of poor heart health. They concluded that chronic cocaine misuse more than minimally contributed to his poor heart health.

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Independent Investigations

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