Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Simon Ludlow, a prisoner at HMP The Mount, on 25 November 2023

A report by the Prisons and Probation Ombudsman

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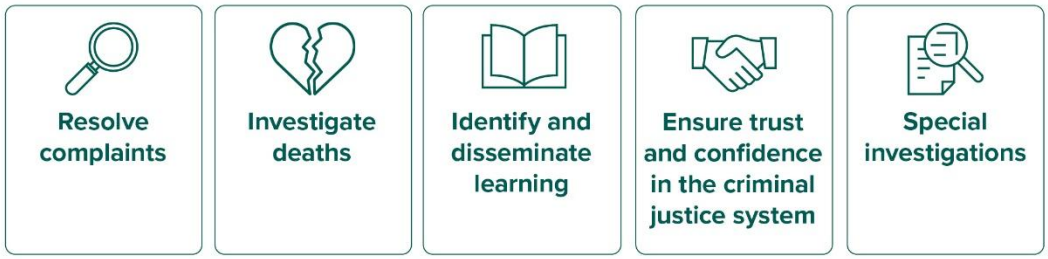
OUR VISION

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

WHAT WE DO



WHAT WE VALUE

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

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

Mr Simon Ludlow died from protonitazene toxicity, in his cell at HMP The Mount, on 25 November 2023. He was 51 years old. I offer my condolences to Mr Ludlow's family and friends.

The clinical reviewer concluded that Mr Ludlow's physical and mental healthcare was only partly equivalent to that which he could have expected to receive in the community.

Regrettably, I am reporting on yet another death caused by nitazene, a highly potent synthetic opioid. The investigation found that after Mr Ludlow's cardiac arrest due to an opioid overdose the week before he died, there was no review of his clinical needs; and the protocol for seeking additional substance misuse support was not followed. We do not know whether such support, within a relatively short period, would have influenced Mr Ludlow's judgement and decisions about using illicit substances, but it was undoubtedly a missed opportunity for guided reflection.

I am pleased to note that in response to one of my recent recommendations, The Mount and Forward Trust acted quickly and positively to raise the awareness of both staff and prisoners of the risks associated with synthetic opioids and continue to do so routinely during substance misuse triage. There was also valuable and productive engagement with prisoners on Mr Ludlow's wing after his initial overdose.

This version of my report, published on my website, has been changed to remove the names of staff and prisoners.

Adrian Usher
Prisons and Probation Ombudsman **November 2024**

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Summary

Events

1. Mr Simon Ludlow was remanded to prison on 3 December 2021 and was later sentenced to 12 years imprisonment for aggravated burglary. He transferred to The Mount on 13 December 2022.

2. Mr Ludlow had history of substance misuse, mainly cannabis, crack cocaine and heroin. At an induction screen on 16 December, he said that he had stopped using drugs and no longer took methadone. He declined a full assessment.

3. Following a self-referral to the substance misuse service in April 2023, a triage assessment concluded that Mr Ludlow did not need further help at that time, as he had previously completed relevant drug awareness courses and workbooks.

4. On 18 November, while a resident on The Annexe, a largely unstaffed wing for trusted prisoners, Mr Ludlow had a cardiac arrest. Drug paraphernalia was found in his cell and hospital doctors suspected an opiate overdose. Mr Ludlow was discharged on 20 November. On 23 November, he attended a support meeting with the Samaritans and the prisoners who had found and helped to resuscitate him.

5. Mr Ludlow was deemed no longer suitable to live on The Annexe, and moved to a standard residential wing (Nash Wing).

6. At around 7.25am on 25 November, wing officers conducting routine checks found Mr Ludlow slumped over his toilet, unresponsive. Drug equipment and substances were found close by. Staff attempted cardiopulmonary resuscitation (CPR) but were unable to revive Mr Ludlow. Paramedics found evidence of rigor mortis and confirmed that he had died.

Findings

7. The Mount has a protocol for managing prisoners who are found under the influence of illicit substances. This includes a requirement to notify the substance misuse service who, in turn, will offer support. There was no evidence of any input by Forward Trust (the substance misuse provider) after Mr Ludlow's suspected overdose the week before he died.

8. The clinical reviewer concluded that Mr Ludlow's clinical care was partly equivalent to that which he could have expected to receive in the community. She was concerned that there was no healthcare review on his discharge from hospital after his cardiac arrest, to determine whether he had any clinical or other support needs.

9. In response to a previous PPO recommendation about the risks associated with nitazenes, The Mount had circulated awareness literature and a video to staff and prisoners highlighting the dangers. The substance misuse service now routinely issues the information at triage assessments.

Good practice

10. Prison managers consulted residents on the Annexe for feedback on the handling of the medical emergency the week before Mr Ludlow died. They took on board several of the suggestions and made tangible improvements, such as first aid training for prisoners and written instructions on how to alert staff in an emergency.

Recommendations

- The Governor should ensure that prisoners found intoxicated are formally referred to Forward Trust and offered support for substance misuse.

- The Head of Healthcare should ensure that healthcare staff review all prisoners discharged from hospital after a significant medical event or treatment, to assess their health needs and offer appropriate support.

The Investigation Process

11. HMPPS notified us of Mr Ludlow's death on 25 November 2023.

12. The investigator issued notices to staff and prisoners at HMP The Mount informing them of the investigation and asking anyone with relevant information to contact her. No responses were received directly from prisoners. However, a member of the public, who wished to remain anonymous, raised concerns passed to him by a friend who was a serving prisoner. He alleged that Mr Ludlow had pressed his cell bell, shouting for help with chest pains and this had been ignored by staff. The investigator explored this issue and it transpired that the alleged events related to a different prisoner.

13. The investigator visited The Mount on 13 December and had discussions with the Governor, the Head of Safety and the Chair of the Independent Monitoring Board (IMB) about key regime and drug strategy issues. She also obtained copies of relevant extracts from Mr Ludlow's prison and medical records, staff statements, local policy documents and instructions, as well as CCTV and body worn camera footage. Evidence gathered from several other concurrent investigations at The Mount was also considered, including information the investigator had previously obtained during interviews with the Forward Trust Integrated Services Manager.

14. During her visit, the investigator also spoke informally to staff and prisoners, including one of Mr Ludlow's relatives. Mr Ludlow's family member questioned whether Nash Wing had been an appropriate location for Mr Ludlow, given the prevalence of drugs and whether he was adequately monitored after a cardiac arrest and hospital admission the previous week.

15. NHS England (NHSE) commissioned a clinical reviewer to review Mr Ludlow's clinical care at the prison. The investigator and clinical reviewer interviewed the Head of Healthcare and a Supervising Officer on 15 February 2024, using Microsoft Teams video conferencing.

16. We informed HM Coroner for Hertfordshire of the investigation. He gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

17. The Ombudsman's office contacted Mr Ludlow's daughter to explain the investigation. She had no specific matters for us to consider but asked for a copy of our report.

18. We sent a copy of our report to Mr Ludlow's daughter. She did not report any factual inaccuracies.

19. The initial report was shared with HMPPS. They found no factual inaccuracies but suggested recasting of some wording to remove ambiguity. HMPPS accepted the recommendations.

Background Information

HMP The Mount

20. HMP The Mount is a medium security prison. Practice Plus Group provides physical and mental healthcare. Forward Trust is contracted to provide psycho-social substance misuse services and mental health support under the Improving Access to Psychological Therapies programme (IAPT - solution focussed cognitive behavioural therapy (CBT) sessions). Counselling services are provided by the prison Chaplaincy.

HM Inspectorate of Prisons

21. The most recent inspection of HMP The Mount was in March 2022. Inspectors were concerned about the shortage of officers available to deliver a meaningful regime and ensure prisoner access to activities or appointments. Many prisoners were locked in their cells all day. Ofsted judged the provision of education, work and skills to be inadequate.

22. Steps to disrupt the supply of drugs were having a positive impact and far fewer men said they were easy to get hold of (29% compared to 50% at the previous inspection), but intelligence-led drug testing was yet to restart and less than half the requested cell searches were completed. Additional steps had been taken, including improved information sharing with the local police and greater use of CCTV around the perimeter wall. The prison photocopied all incoming mail and drug detection dogs were at the prison every day. Management of intelligence information was very good with prompt analysis.

23. An independent review of progress took place in February 2023. The inspectorate found that safety was reasonably good and the drug strategy and action plan were comprehensive. However, there was still a shortage of officers, so there had been insufficient progress on key priorities.

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 February 2024, the IMB reported that trafficking illicit items was a big problem, with drugs and mobile phones widely available.

25. The IMB highlighted some of the prison's vulnerabilities, such as its location near 'County Lines' drug dealers' routes, as well as being surrounded by an airfield and housing estate. This enabled frequent drone deliveries and drugs thrown over the walls and most of the prison had no netting. Substantial amounts of contraband were found periodically.

26. The IMB also reported some of the actions taken to reduce the demand for drugs, including providing an incentivised substance free living (ISFL) wing for prisoners who want to be drug-free. However, the strategy had been impaired by funding and

the difficulty in recruiting and retaining staff. The prison had also trialled providing single use vapes, as the reusable/rechargeable vapes could be tampered with to use psychoactive substances.

27. In a discussion with the PPO investigator, the IMB Chair thought that in the four or five months before Mr Ludlow's death, there had been a decrease in the prevalence of illicit drugs on Nash Wing.

HMPPS Substance Misuse Group's Drug Diagnostic Report

28. After two deaths from PS in the summer of 2022, the HMPPS regional drug lead requested a full diagnostic review of The Mount's drug strategy. In September 2022, the drug diagnostic team concluded that the prison could do much more to reduce supply and demand, especially PS, and made 20 recommendations to improve the prison's drug strategy. Significantly they found that:

- There was evidence of an extensive supply of PS in the prison.
- The drug strategy was not fully developed and was not a 'live' document.
- There was no specific PS strategy.
- The approach to debt was not dynamic or linked to the drug strategy or intelligence reports.
- Intelligence analysis was good.
- The prison's significant staffing issues undermined their efforts to reduce supply and demand and made a 'whole prison approach' extremely difficult. In particular, the lack of prison regime fuelled the demand for drugs.
- Mandatory drug testing (MDT) was suspended due to lack of staff. This has since resumed.
- Wing Intelligence Liaison Officers (WILOs) who might plug the intelligence gap caused by the lack of MDT were not operating due to staff shortages.
- Conveyance of drugs by staff was a considerable risk due to their inexperience and vulnerability to organised crime (over 70% of staff had less than two years' experience).

29. In October 2023, the team conducted a follow-up visit. While they were content with the actions taken since their initial visit and suggested further improvements, they considered that the Forward Trust's inability to deliver the peer support programme was a significant risk to the prison.

Measures in place before Mr Ludlow's death to reduce trafficking and demand for drugs

30. Enhanced gate procedures were introduced in May 2021. All staff and visitors are searched, have their bags searched and walk through an airport style X-ray portal.

31. All prisoner mail is photocopied, checked by drug dogs and suspicious mail is put through narcotics trace detection equipment (Rapiscan machine). The prison holds a database of contaminated Rule 39 mail (confidential legal mail). All cards and photographs sent to prisoners must be sent via online delivery and printing services. Staff mail is logged and recorded.

32. Drug dogs, a regional resource, are based in the prison. Cell searches are requested for prisoners with supporting intelligence of drug involvement. All prisoners found under the influence should be added to the daily briefing sheet, given MDTs and receive a Code Blue Pack from the Forward Trust substance misuse team. This contains information on the substance involved, harm minimisation advice and a self-referral form.

33. A dedicated local police officer attends a quarterly police and prison tasking meeting. All drug-related information reports are disseminated to the police.

Previous deaths at HMP The Mount

34. Mr Ludlow was the 15th prisoner to die at The Mount since November 2020. Five of the previous deaths were due to natural causes, five were self-inflicted and four were drug-related. At least one other death at the prison has been caused by nitazenes.

Psychoactive substances

35. The term psychoactive substances is a broad term that refers to a drug or other substance that affects mental processes. Synthetic cannabinoids and synthetic opioids (including nitazene) are substances that mimic the effects of traditional controlled drugs such as cannabis, cocaine, heroin and amphetamines. Synthetic cannabinoids and synthetic opioids can be difficult to detect as the compounds used in their manufacture can vary and use of these substances presents a serious problem across the prison estate.

36. PS can affect people in a number of ways, including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of these substances can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, the use of PS is associated with the deterioration of mental health, suicide and self-harm. Testing for PS is in place in prisons as part of existing mandatory drug testing arrangements.

Postvention

37. Postvention is a joint HMPPS and Samaritans initiative that aims to ensure a consistent approach to providing staff and prisoners support following all deaths in custody. Postvention procedures should be initiated immediately after every self-inflicted death and on a case by case basis after all other types of death. Key elements of postvention care include a hot debrief for staff involved in the emergency response and engaging Listeners (prisoners trained by the Samaritans to provide confidential peer-support) to identify prisoners most affected by the death.

Key Events

38. Mr Simon Ludlow was remanded to HMP Wandsworth on 3 December 2021. He was later convicted of aggravated burglary. On 18 November 2022, Mr Ludlow was sentenced to 12 years imprisonment. He transferred to HMP The Mount on 13 December.

39. A nurse conducted an initial health screen and noted that Mr Ludlow had been diagnosed with sciatica and depression but was otherwise fit and well. On 14 December, a nurse completed a second-stage health screen, which identified no significant health concerns.

40. Mr Ludlow told the nurses that he had not previously used drugs. However, previous prison and healthcare records showed that he had a longstanding history of substance misuse, including use of cannabis, crack cocaine and heroin, as well as instances of possible illicit activity at previous prisons.

41. On 16 December, a member of the Forward Trust substance misuse team conducted an induction screen. Mr Ludlow said that he was not actively using drugs and had stopped taking methadone ten months before. He declined assessments for substance misuse support and talking therapies.

42. On 30 March 2023, Mr Ludlow made a self-referral to Forward Trust. He said that his sentence plan required him to undertake a drug awareness course, which he had already attended at Wandsworth. On 12 April, a Forward Trust practitioner conducted a triage assessment and noted that relevant courses, as well as in-cell workbooks had been completed and that Mr Ludlow needed no further help. Advice on harm minimisation and the risk of overdose was given and Mr Ludlow was informed that he could self-refer again at any time in the future.

43. Mr Ludlow initially worked in the ‘Farms and Gardens’ workshop but transferred to a catering role in June. He had regular contact with his Prison Offender Manager to discuss his sentence plan and categorisation and she noted that he engaged well. Mr Ludlow was also allocated a prison key worker. Their sessions were initially sporadic, but from September 2023, meetings were more frequent. He said that he had no problems other than the difficulty in arranging an inter-prison telephone call with another relative.

44. On 14 August, Mr Ludlow moved to a cell in The Annexe - a discrete wing for highly trusted prisoners and those close to their release date - in which cells remain unlocked 24 hours a day and there are no staff patrols. An MDT on 22 August was negative.

45. On 18 November, two prisoners found Mr Ludlow in his cell, unconscious and not breathing. They pressed the general alarm and began CPR until wing staff arrived and took over. A code blue medical emergency was called (which indicates that a prisoner is unresponsive or has difficulty breathing) and paramedics attended.

46. The paramedics confirmed that Mr Ludlow had suffered a cardiac arrest. He regained consciousness after further rounds of CPR and was taken to hospital. Doctors suspected that his cardiac arrest was due an opiate overdose and prescribed antibiotics for aspiration pneumonia. Mr Ludlow denied that he had used

illicit drugs, but a tampered vape and tampered capsules were found in his cell (there is no evidence that these items were subsequently sent for tests).

47. Mr Ludlow was discharged from hospital mid-afternoon on 20 November. Due to the incident, he was deemed no longer suitable to live on The Annexe and was initially relocated to Brister Wing, the induction unit. On 21 November, a healthcare assistant took clinical observations, which were within normal range. An intelligence report submitted that day indicated Mr Ludlow had said that he missed 'weed' and wished he could smoke a joint. Although Mr Ludlow's security file noted that Forward Trust had been informed of his potential drug use, there is no evidence that he was seen by the service.

48. On 23 November, representatives from the Samaritans held a meeting with Mr Ludlow, the prisoners who helped to resuscitate him and a Listener from the wing, to provide emotional support and help them with closure. The Samaritans also spoke informally to other prisoners on The Annexe. On the same day, Mr Ludlow moved to a single cell on Nash Wing, a standard residential wing (where he had previously lived from 23 December 2022 to 14 August 2023).

Events of 24/25 November

49. Mr Ludlow had a 20-minute telephone conversation with his daughter at 10.00pm on 24 November. At 12.50am on 25 November, he called her again for a few seconds and appeared to be slurring his words.

50. At 5.30am, an Operational Support Grade completed a routine roll check and noted no problems.

51. While conducting the next roll check, two officers found Mr Ludlow slumped over his toilet, unresponsive. A code blue was called at 7.25am and staff conducted cardiopulmonary resuscitation until paramedics arrived at 7.50am. The paramedics found rigor mortis in Mr Ludlow's jaw and arms, as well as other signs that he had died and confirmed his death at 7.53am. Drug paraphernalia and substances were found in the cell.

Contact with Mr Ludlow's family

52. Mr Ludlow's next of kin contact details were not up to date so the prison quickly decided to designate his daughter as his next of kin. The prison's family liaison officer and a colleague went to the address listed for Mr Ludlow's daughter, but she had moved home. He telephoned to get her new address and informed her of Mr Ludlow's death during their conversation as she wanted to know why he had asked to visit. He then met her to give additional information. He also notified a relative in another prison. The family liaison officer visited the family home on 30 November and held a meeting with several of Mr Ludlow's relatives.

53. In line with national policy, the prison contributed to the costs of Mr Ludlow's funeral.

Support for prisoners and staff

54. After Mr Ludlow's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

55. The prison posted notices informing other staff and prisoners of Mr Ludlow's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ludlow's death. They also provided Listeners on The Annexe and Nash Wing and requested postvention support.

Post-mortem report

56. The report of the post-mortem examination concluded that, on the balance of probability, the cause of Mr Ludlow's death was protonitazene toxicity. (This is a highly potent synthetic opioid, whose potency is three times that of fentanyl and 100 times that of heroin.)

Findings

Drug strategy at HMP The Mount

57. The Mount's drug strategy noted that PS was a popular drug and in high demand. A monthly meeting is held jointly with the drug strategy, safety and security leads and there is a daily triage meeting with security staff and data analysts. An additional security forum is chaired by the deputy governor.

58. After a full diagnostic review of the prison's drug strategy in Summer 2022, the prison accepted all 20 recommendations by the drug diagnostic team and produced a 'live' action plan. Additional measures included monthly counter-corruption training; production of a protocol for prisoners found under the influence of illicit substances; and six-monthly reviews of all prisoners in high-risk roles.

59. Previous PPO investigations have highlighted some of the barriers to improvement, including chronic staff shortages, which had hindered key actions such as drug testing programmes; the demographics of the prison, which enables distribution networks to be maintained; and the rural and physical environment, making it prone to drones and drugs being thrown over the wall.

60. The Mount's Head of Safety told the investigator that while illicit drugs, mainly PS and cannabis, were still prevalent on all wings across the prison, more action had been taken. Extra netting has been secured to restrict access by drones; discussions had been held with users and dealers, who had offered advice on handling; the process for families ordering newspapers from a local newsagent had changed, due to suspected illegal activity; and there had been increased emphasis on the analysis of intelligence and checking the validity of legal mail. Staffing levels had increased and the prison now operates the full regime.

61. The Head of Safety added that the prison's Safety and Drug Strategy Lead had set up a drug recovery support forum, attended by Forward Trust. It focuses primarily on those with chaotic use. The prison had resumed frequent MDT testing, as well as searching and had consistently met the quota since May 2024. This has led to increased finds of contraband. Staff are encouraged to report prisoners found under the influence of drugs and they are as proactive as possible. The lessons from early learning reviews and PPO reports are discussed at full staff briefings. Forward Trust had reinstated health and wellbeing champions, who are trained and supported.

Nitazenes

62. After recent investigations at The Mount and elsewhere, the Ombudsman expressed concern about the increasing number of deaths in prisons from PS mixed with nitazenes and made a public plea for prisoners to dispose of any PS in their possession.

63. In May 2024, the Ombudsman made a specific recommendation to The Mount, about the need to raise prisoners' awareness of the emergence of nitazenes, their extreme toxicity and the potential consequences of using substances laced with this opioid. In response, the prison has taken several steps, including the circulation of

information notices to staff and prisoners. Staff are mindful of the need to update the information as new risks emerge.

64. Forward Trust has also created leaflets and posters about fentanyl and nitazene. This information and a nitazene risk minimisation video have been added to the Content Hub, which prisoners can access. Forward Trust will give the leaflets to prisoners at every triage assessment and continue to discuss the risks with them at every opportunity.

Disposable single use vapes

65. We acknowledge that The Mount has made many improvements to try and reduce both the demand for and the trafficking of drugs. The Governor and the PPO investigator discussed what more could be done and how the Ombudsman could influence this. The Governor said that a key priority was to stop supplying rechargeable vapes which prisoners modified to smoke illicit substances and introduce single use vapes that could not be tampered with. Centrally, there had been some resistance to this, due to the higher cost. Nevertheless, he planned to implement it and felt that advocacy from the Ombudsman might be beneficial for this and other prisons. The IMB Chair supported this initiative and noted in the most recent IMB report that it had been trialled.

66. Since the discussion, the Government has decided to introduce legislation to ban the sale and supply of single use vapes. In light of this, it would be inappropriate for the PPO to advocate the supply of such vapes at this time.

Substance misuse support

67. Mr Ludlow had engaged with the substance misuse service at his previous prison. However, at a triage assessment on 12 April 2023, he declined the opportunity of a full assessment or support from Forward Trust. The cardiac arrest a week before his death was thought to be due to an opiate overdose.

68. The Mount has a detailed protocol for managing prisoners found intoxicated, or those who test positive for an illicit substance. Actions include formally reporting an incident to Forward Trust, who check whether the individual is already working with them and, if so, the relevant practitioner would intervene. If not, an action plan is drawn up, with details such as whether the prisoner was a regular user and if the service had tried to engage with him before.

69. The Head of Safety said that there is now a greater focus on supporting prisoners taken to hospital after an adverse reaction to substances, so that the emphasis is not just on disciplinary action. We note that Mr Ludlow was provided with such support by way of a meeting with the Samaritans.

70. Although there are entries about this serious incident in Mr Ludlow's personal and security records (the latter indicating that Forward Trust had been informed), there is no evidence that he was offered substance misuse support. We consider that in these circumstances, the onus is on the prison to evidence that a referral was made and they were unable to do so. It is vital that the process is robust and this was a significant omission. We recommend:

The Governor should ensure that prisoners found intoxicated are formally referred to Forward Trust and offered support for substance misuse.

Clinical care

71. The clinical reviewer concluded that Mr Ludlow's care at The Mount was of a reasonable standard, but only partly equivalent to that which he could have expected to receive in the community. We share the clinical reviewer's concern that, given the gravity of the incident the week before his death, there was no healthcare review of Mr Ludlow's clinical or other needs when he returned to the prison. The Head of Safety said that operational staff had not been directed to monitor Mr Ludlow. We recommend:

    The Head of Healthcare should ensure that healthcare staff review all prisoners discharged from hospital after a significant medical event or treatment, to assess their health needs and offer appropriate support.

72. The clinical reviewer made an additional recommendation about the management of hypertension, which is not included in this report as it was unrelated to the cause of Mr Ludlow's death. However, the Head of Healthcare will wish to consider it.

Good practice

73. After Mr Ludlow's cardiac arrest on The Annexe, prison managers consulted prisoners and actively addressed some of the learning points raised. There were concerns that prisoners did not know how to raise the alarm to get the attention of staff. In response, the prison had issued instructions on how to notify an emergency when The Annexe is not staffed.

74. Additionally, the prison ran emergency first aid sessions for prisoners on The Annexe, including basic bandaging, dealing with burns, cardiopulmonary resuscitation and how to use the defibrillator.

Governor to note

Requesting an ambulance in an emergency

75. Prison records show that in response to the code blue call at 7.25am, when Mr Ludlow was found, the night orderly officer asked if an ambulance was required and this was requested at 7.27am. The Ambulance Service records show that the call was received at 7.30am. Given the apparent delay and the discrepancy in timings, the Governor will wish to check whether prison clocks are accurate and that staff know they are not expected to either seek or give approval before requesting an ambulance in response to a medical emergency code.

Inquest

76. At an inquest held on 9 February 2026, the coroner concluded that Mr Ludlow's death was due to a drug overdose and illicit substances in the prison, and the extent of any detailed cell searches possibly contributed to the death.

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