The death in custody of
a male prisoner
at HM Prison Lewes in May 2004

Report by the Prisons and Probation Ombudsman

for England and Wales

November 2004

This is the report of an investigation into the circumstances surrounding the death of a male prisoner at Lewes Prison in May 2004.

A post-mortem report concluded that the cause of death was an overdose of amitryptiline.

The man's death was one of a succession of tragedies for his family. I offer them my sympathy and condolences.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. Sussex Downs and Weald Primary Care Trust, have reviewed the man's medical history in prison and provided a number of learning points for future service development. I am grateful to them and to the Governor and staff of HMP Lewes for their invaluable assistance.

I make a total of 14 recommendations, including those from the clinical review.

STEPHEN SHAW CBE
PRISONS AND PROBATION OMBUDSMAN
2 NOVEMBER 2004

KEY EVENTS

The man was 59 years old. On admission to prison he gave his occupation as decorator. The man died at HM Prison Lewes on Wednesday 19 May 2004. The post mortem report says his death was caused by an overdose of amitryptiline, a tricyclic antidepressant. At the time of his death, the man was on trial at Lewes Crown Court charged with the murder of his wife, Susan. The man died during the night after his first day giving evidence.

The man was remanded to Lewes prison on 25 August 2003. He had not been in prison before. At first the man was considered to be at risk of suicide and self-harm, but he was not identified as being vulnerable in the period leading up to his death. When a prisoner is believed to be at risk, staff open a special file, F2052SH. A care plan is drawn up and regular reviews undertaken. All the staff in contact with the prisoner have access to the file and are required to make entries in accordance with the care plan and about any other significant events so that information can be shared and the prisoner's welfare carefully monitored.

F2052SH files were maintained for the man from 25 August until 12 September and again from 24 September to 10 October. When the man was admitted to prison he had a head wound, allegedly administered by his son, at the man's own request after the death of his wife. The man also said that he had recently attempted to kill himself on two occasions and he was found to be depressed and tearful. He was prescribed a night sedative, Zopiclone 7.5 mg once a day.

After induction, because of his age and the nature of his charge, staff considered that the man would find it easier to settle on a wing for convicted prisoners than on the more volatile remand wing. This meant he would have to wear prison clothes and go to work but the man was content with this. He seems to have been eager to keep occupied. The records indicate that the man appeared to settle well on C wing. Comments from staff and his cellmate bear this out. By 12 September he was apparently enjoying working in the kitchens and the F2052SH was closed.

Information received on 22 September gave rise to suspicions that the man might still have intentions of ending his life. It was said that he had arranged to make a will, wanted relatives to visit before 28 September, but not after, and that he might have paid someone to kill him in prison. The Safer Custody Manager realised that the man's deceased wife's birthday was imminent and was aware that such anniversaries can prompt suicide attempts. He re-opened the F2052SH file, noting the immediate concerns and that the man's wedding anniversary was on 2 December. He also made sure that an appropriate new cellmate was identified to move in straightaway when the man's previous cellmate was released on 29 September. This was good practice and I commend the member of staff for this. Entries on the file indicate that, on the face of it, the man seemed in good spirits and there was no evidence of any immediate suicidal intent. However, he acknowledged that he would be vulnerable on his wife's birthday and was willing to receive support. An entry by a doctor on 26 September comments that *"owing to nature of offence and recent suicide attempts [The man is] still at medium/high risk of suicide. Has no intent at present."*

The man saw a Community Psychiatric Nurse (CPN) on 30 September. The man was distressed and tearful and a doctor authorised an exceptional statutory dose of 15-mg Zopiclone. A doctor's entry on 1 October, recommends admission to the healthcare centre and that the man be seen by a psychiatrist. He prescribed Fluoxetine 20 mg once a day for 28 days and Zopiclone 7.5 mg for seven days at night. (Fluoxetine, commonly known as Prozac, is an anti-depressant. It is one of the groups of anti-depressants called selective serotonin re-uptake inhibitors (SSRIs). It causes less sedation than tricyclic antidepressants and is less dangerous in overdose.)

A Charge Nurse visited the man on the wing at staff's request and gave support. The man did not want to leave C wing and it was agreed that he should stay on the wing but with the supervision of the Mental Health In-Reach Team. However, he was withdrawn from work in the kitchen on 7 October because of security concerns about his having access to kitchen utensils. At the man's request, healthcare staff made representations to the Security department that he should be permitted to work in the kitchen despite concerns about self-harm. The man was eager to be active.

The F2052SH file was closed on 10 October. There is no record of the review, except entries in the daily supervision and support record. An entry at 8.30am says the man was still asking about going on to the kitchen work party and that he was to have a review that day and was hoping to come off the F2052SH. An entry by a Senior Officer says that at 4.10pm, on returning to the wing from a visit, the man was seen for a review and the file was closed. The Senior Officer has signed the box closing the form. It is not evident from the F2052SH, that anyone else took part in the review. However, an entry in the Medical Record by a member of the Mental Health In-Reach team says: *"2052 closed at review. Maintains will not self-harm. Just had good visit by son. He has been seen by [a member of staff] who has advised him of clearance to return to kitchens".*

After the F2052SH was closed, nurses from the Mental Health In-Reach Team saw the man from time to time. On 24 October, he said he had taken tablets from another prisoner in order to calm himself down because of cellmate problems but he was to move cells that day. This would help and he did not want staff to feel they had to open a new F2052SH.

On 27 October, the man told a doctor that he had stopped taking the Fluoxetine because they were not helping him. He was still low in mood and experienced tearful episodes, thinking about his wife and having disturbing images and nightmares. He maintained he had no thoughts of self-harm. The doctor prescribed amitriptyline 75 mg, increasing to 100 mg after a week. This appears to have been dispensed in daily doses until March 2004 and then in weekly batches with a week's supply, 14 tablets, issued to the man at a time. The prescription charts are not entirely clear but it appears he was due to receive a fresh supply on 19 May. (Amitryptiline is a tricyclic antidepressant with sedating effects which is highly dangerous in overdose.)

On 2 December, his wedding anniversary, the man told Ms Clinton he had cried a lot but said he was okay. On 11 December he was tearful when speaking about his wife and was surprised by statements he had read from friends and family about

their relationship. He was also distressed that the police had charged his son over the assault. A Mental Health In-Reach entry records that a member of staff agreed to see the man at times, but he should alert the In-Reach Team if he needed to talk. On 7 January, the same member of staff noted that proceedings against the man's son were due in court on 9 February. If his son were to go to prison, the man would be very troubled. The entry says *"continue monitoring particularly around that date"* and that the man was aware that he should alert staff and the In-Reach Team if his mood deteriorated. On 16 January, the entry says that the man's son had been in court earlier than expected, but the outcome was not yet decided. The final entry by the In-Reach Team, on 23 January 2004, says *"on visits".*

There are two later entries in the medical record before the man's death. The man saw a doctor on 12 March when his blood pressure was checked and he was prescribed rampiril which is used to treat high blood pressure. On 19 April his blood pressure was checked again. The entry in the record is not easy to read but appears to say *"continue amitryptiline".*

The man's trial began on 4 May and he attended court every weekday. He began giving evidence on 18 May and died that night. The man's legal representative was aware that he had been tearful in court. This was in contrast to other days during the trial when he had seemed in good spirits. She said the judge had seen he was upset and adjourned for the day. She was not allowed to visit him in the cells because legal representatives are not allowed to see defendants during their evidence. However, the man sent a message via a security guard. He said his wife's dressing gown was lying on the floor in front of the witness box and it was upsetting him. He asked his legal representative to arrange for it to be moved. His legal representative had no special concerns about the man's welfare at the time.

When he returned to prison, the man confided to his cellmate that he had found giving evidence distressing, being especially affected by seeing photographs of his wife, and was feeling apprehensive about the likelihood of hostile questioning by the prosecution. His cellmate said he was tearful.

A prison officer, who was from another landing and did not know the man well, had called at his cell at about 7.45pm while his cellmate was out having a shower. This was about a canteen query that turned out to be about another man with the same surname. The officer spoke to the man only briefly but observed nothing untoward about his manner.

When one of the usual landing officers was on duty, he made a point of speaking to the man each day after he came back from court. This officer had been off duty for a few days, but returned on 18 May, and spent about 15 minutes with the man that evening, shortly before the cells were locked for the night. The man's cellmate said that by this time the man had *"put on a bit of face"* and the officer described his manner as *"chirpy"*. The officer recalled that the man explained about being upset by seeing his wife's clothes but said firmly that he was looking forward to the next day and then changed the subject.

The man’s cellmate raised the alarm at approximately 6:40am, on Thursday 19 May, when he could not rouse the man and believed him to be dead. The Night Orderly Officer was called and entered the cell with two nurses. The nurses checked for signs of life and in view of the man’s condition did not attempt resuscitation. An ambulance arrived, according to the log, at 7:08am. At 7:21am a paramedic pronounced life extinct.

Empty medication packaging was found in the man’s cell. This included one empty blister pack which had contained 7 amitryptiline 50-mg tablets and three empty polythene bags which had contained amitryptiline packs. The bags were dated 24 November 2003, and 4 and 10 May 2004. The man’s cell had been routinely searched on 31 March and 12 April 2004. There is no record that any excess medication was found during those searches.

ISSUES

Staff support for the man

The investigation discloses numerous instances of staff care for the man. He was clearly treated as an individual and with empathy and compassion. This was not management by rote. By agreement, the man was placed on a wing with sentenced prisoners where he felt more comfortable and was able to keep occupied. Staff went out of their way to secure his job in the kitchen because he enjoyed it and staff felt he was best served by keeping busy. Staff recognised that he might be particularly vulnerable at the time of his wife's birthday and his wedding anniversary and spent time talking with him. An officer made a point of talking with him when he returned from court on what proved to be the eve of his death. I note that in August 2003, following a suicide attempt, by another prisoner, the Governor of Lewes Prison issued Instruction 138/2003 making it a requirement for prisoners returning from court to be spoken to by residential officers to ascertain their well-being, for those interactions to be recorded and for any concerns to be relayed immediately to the wing manager

The Prison Service Safer Custody Group should consider advising other Governors to introduce Instructions similar to local instruction 138/2003.

The Governor and staff of HMP Lewes should be commended on the Reception and Induction process at Lewes as recorded for The man and in particular the individual consideration of prisoners' circumstances which led to The man being exceptionally located on C wing where his needs could be met most appropriately.

The Senior Officer should be commended for his conduct and action in the crisis period for the man in late September/early October and for his recognition of the significance of the impending anniversary dates.

The landing officer should be commended for his concern for the man and his professional approach throughout.

F2052SH procedures

There are some deficiencies in the recording of F2052SH procedures, for example apparent closure by a single manager and in constructing care plans providing for specific trackable measures rather than generalised safeguards which may be the responsibility of everyone and no one. The picture emerging is of some instances of excellent and thoughtful care by individual staff but possible weaknesses in the underpinning structures and processes. I understand that action is being taken to address this following a previous death of a prisoner at Lewes.

The establishment should re-audit its Suicide and Self-harm Policy to ensure that recent improvements are embedded and acted upon consistently.

Could the man's vulnerability immediately before his death have been anticipated?

On 1 October, a doctor had recorded that the man should be seen by a psychiatrist. There is no indication this was pursued. For a period, the man received considerable support from the Mental Health In-Reach Team. From January, the Team left it to the man to approach them if he needed help.

The man lulled staff into thinking he was coping. His legal representative, his cellmate and the officer who knew him best were aware he was upset by his experience in court. It would have been surprising if he had not been. But all were convinced that the man intended to be in court next day. The records of the man's meetings with the Mental Health In-reach Team indicate that on occasion he was prepared to articulate his feelings and was willing to ask for help when he felt he needed it.

Of course, self-reporting is not an adequate guide to suicidal intent. Someone who has formed a settled intention to end their own life is likely to disguise that fact. Risk assessment and the identification of appropriate support need to be guided by situational factors as well as what a person says of their own feelings.

The man's known attempts to end his life, and the times when he had been recognised to be vulnerable, were associated with his alleged offence and his feelings about his wife. It may not have been sufficiently appreciated that the trial was likely to render him vulnerable, just as the anniversaries had before.

Medication management at Lewes

It is likely that the man took his own life by overdose of his prescribed medication.

From 27 October 2003, until the time of his death the man was receiving amitryptiline. This was apparently issued to him daily until March 2004 then in weekly batches. Empty pill packaging was found in his cell.

Members of the Independent Monitoring Board expressed some concerns to my Assistant Ombudsman about the practice of issuing of medication to prisoners to hold in their possession in quantities which might prove lethal, or invite trading or extortion.

A number of factors bear on this issue. *A Pharmacy Service for Prisoners (Department of Health),* recommends a presumption that prisoners should hold medication in possession, *"subject to policy and risk criteria … for determining on an individual basis" when* this is not appropriate. As I understand it, the underlying principle is that prisoners should as far as possible be treated in the same way as patients in the community, and should exercise responsibility for managing their own medication. The clinical reviewer comments, in the covering letter to his review:

> *"Clearly the key issue would be around the dispensing of supplies of Amitryptiline in weekly doses but this is something we do regularly in primary care sometimes on a monthly basis when we are reassured of the lack of suicidal risk.*

Presumably prison routines rely upon the day-to-day monitoring of prison warders to detect mental health problems and pass these on to the appropriate teams.

I assume that at some stage the issue of his behaviour on the wing between January 24th and his death would be a matter of general inquiry amongst the prison staff and that the medical officer who saw him to check his blood pressure could be asked to confirm the apparent stability of his mental state during the two contacts in March and April."

I quote the clinical reviewer in full to indicate the assumptions that a doctor in the community brings to the prison environment. I do not think that it is necessarily the case that there would be any systematic review by wing staff of the behaviour of a prisoner taking prescribed anti-depressants, unless the prisoner was subject to F2052SH procedures or his behaviour was disruptive.

When a tragedy like the death of the man occurs, it naturally raises questions as to the validity of the principle of issuing in possession batches of medication that is dangerous in overdose. Those who are in prison may be subject to particular pressures from others or from their environment or from the absence of familiar support which do not apply within the community. Moreover, the Prison Service owes them a duty of care.

Issuing small quantities of medication at a time does not prevent purposeful accumulation. The only certain safeguard against that is supervised ingestion of every dose and even that can be evaded unless the medication is in liquid form. In my view, it would not be desirable, sensible or practicable to subject all prisoners to that indignity, nor for the Prison Service to divert the immense resources this would require. I have no doubt that a selective system based on risk assessment is preferable. But issuing small quantities day by day must afford protection against impulsive overdose.

My own view is that in-possession medication is entirely to be endorsed where it concerns medicines that are freely available in the community and not dangerous in overdose. However, different considerations apply to drugs that are not freely available and are dangerous. Prisoners are a vulnerable population. There is also the danger of bullying, trading and theft. I believe prisons need to be very careful if they are allowing prisoners to have in possession dangerous drugs over which the prison has little control. There is a danger that, under resource pressures, the element of active risk assessment on an individual basis may be lost.

The history of the in-possession policy at Lewes up to June 2003: At first, it was decided to issue one day's supply of all medications at a time. It proved impracticable for a single pharmacist to dispense medications in daily quantities. The policy was modified so that only selected medications were issued daily, but it was still found to divert healthcare staff from other clinical tasks to an unacceptable degree.

The present system allows a prisoner to be issued with daily or weekly quantities of medication, or possibly as much as 28 days supply of innocuous treatments. From

the prescription chart, the man was receiving daily doses of amitryptiline for some months and that in March 2004 this was increased to weekly quantities. The increased quantity issued in possession was because the man's demeanour on the wing had seemed stable for some time. That may well be so. By all accounts, the man had not displayed any signs of vulnerability for some months. However, there is no record in the medical record or elsewhere of the reason for the change in quantity issued. In my view, any change in risk assessment should be recorded, with the reason for it.

There is an inconsistency between current practice and the format of the prescription chart. The pre-printed standard chart in use throughout the Prison Service and apparently similar to those used in hospitals is divided into sections for 'in-possession medications' and 'not in possession medications'. It was common practice for doctors to use the 'not in-possession' section of the chart to record medications which would nonetheless be issued in possession. Generally the doctors were aware of this and would give an express instruction if they expected ingestion to be supervised.

In a matter as critical as the prescribing, dispensing and administration of medication, I find it worrying that a form should be in common use that apparently does not accurately represent what happens in practice.

The current review of the In-Possession Medication Policy should be completed within three months, in collaboration with the Primary Care Trust. It should take account of this report; it should provide for changes in risk assessment always to be recorded with reasons; and it should incorporate arrangements for individual risk assessment and for compliance monitoring.

Prison Health should examine the current pro forma and guidance for prescribing, dispensing and administration of medications and consider authorising Prison/PCT partnerships to revise the documents to promote safe practice.

The In-Possession policy should be linked to the establishment searching strategy. Discipline staff should be instructed to inform Healthcare staff when excess medication is found in cell searches and risk should then be reassessed.

The use of tricyclic antidepressants

There is extensive use of amitryptiline as a first prescription for depression and to patient demand for it, perhaps because of its sedating effect. In the man's case, an SSRI was prescribed initially and was changed to amitryptiline at his instigation.

I recognise that it is for individual clinicians to prescribe the most appropriate medication for the individual patient. However, any prisoner judged to be in need of anti-depressant drugs must by definition be vulnerable to some extent. I commend the work at Woodhill prison and elsewhere, in conjunction with the NHS, to minimise reliance on dangerous drugs. The toxicity of a drug in overdose must be one

important aspect of the risk assessment required as part of a policy on how medication is to be issued.

The appropriate bodies should review the use of tricyclic antidepressants at HM Prison Lewes taking cognisance of the Woodhill report.

Response to the discovery of the man

There must always be the strongest presumption in favour of attempting resuscitation when a prisoner is found in a state of collapse, no matter what the apparent cause. It is recommended that staff instructions are revised to make this clear. Staff made no attempt to resuscitate the man. However, the two staff in attendance were both experienced nurses, and one in particular had been accustomed to declaring life extinct in his previous work. I am satisfied that they were able to make a proper judgment that the man was beyond resuscitation.

The Governor should take advice from the Prison Service Safer Custody Group and issue to all staff an instruction for staff first on scene at an apparent death which does not involve hanging

The Death in Custody Contingency Plan (although not found lacking) is overdue for review and this should be rectified.

Supporting prisoners facing a life sentence

The man slipped through the net of the system for supporting prisoners facing a potential life sentence. It was found that the Lifer Manager was overstretched and his concern were noted that presenting potential lifers with information about the life sentence sometimes had an adverse impact on well-being, at what can be a difficult and emotional time for the prisoner. The evidence of this investigation indicates no link between the man's death and the failure to apply the systems for managing potential life prisoners. However, the investigation has identified a problem and I make some suggestions to rectify it.

The Governor reviews the resourcing of lifer management with a view to a significant increase including leadership from the Senior Management Team.

Lifer staff assigned to issuing the mandatory documents to potential lifers should be trained in appropriate interviewing skills reflecting the sensitivity of their task.

The existing audit action plan for PSS 31 Life Sentence Prisoners should be completed within the timescales set.

RECOMMENDATIONS

The Prison Service Safer Custody Group should consider advising other Governors to introduce Instructions similar to local instruction 138/2003.

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