Investigation into the circumstances surrounding the death of a man at HMP Lewes in November 2008

Report by the Prisons and Probation Ombudsman for England and Wales

June 2009

This is a report into the circumstances surrounding the death of a man, a prisoner at HMP Lewes, in November 2008.

The man was found unconscious when his cell was opened that morning. The officer who discovered him called for healthcare assistance, and staff and paramedics attempted resuscitation. The man was then taken to hospital where he was stabilised but assessed as brain dead. He had suffered multi-organ failure.

The man's life support machine was turned off that evening with his family at his side. He was 38 years old. I offer my sincere sympathy and condolences to the man's family and friends for their loss.

The investigation was carried out on my behalf by my colleagues. A clinical review of the man's healthcare at Lewes was undertaken by a clinical reviewer on behalf of the local Primary Care Trust. I am grateful for his timely review. I would also like to thank the Governor of Lewes and his staff for their co-operation and assistance. Particular thanks go to the Governor's secretaries for their help throughout the investigation process.

The man had been in prison several times and was a heavy drug user. He had served seven years of a life sentence and had only recently been transferred to HMP Lewes. I understand he was frustrated by his sentence and on several occasions had harmed himself. However, while the man reported various minor ailments, there were no serious concerns about his well-being. He had begun re-using heroin in custody but, to his credit, had sought help and had started a methadone treatment programme shortly before his death.

I believe the man was well looked after while he was at Lewes. Like many prisoners, he had harmed himself and had used drugs whilst in custody. However, it is clear that neither played a direct part in his death which was due to natural causes. He died from a rare condition, thrombotic microangiopathy (TM), that did not present any symptoms indicating that he could collapse at short notice.

I have made two recommendations.

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

Stephen Shaw CBE
Prisons and Probation Ombudsman **June 2009**

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SUMMARY

The man was born in August 1970. He was arrested in January 2001 and sentenced to life imprisonment on 3 September that year.

After moving between a number of prisons, the man arrived at HMP Lewes in June 2008. He had apparently coped poorly in his previous prisons and was transferred to Lewes because of the healthcare services that they could offer.

At the end of October 2008, the man told staff that he had been using heroin on the wing for the previous five weeks. He was put on a methadone prescription. Beyond that, the man did not appear unwell to the prison staff who knew him.

At some point between the evening of 2 November and 8.00am on 3 November when he was found, the man collapsed in his cell. The officer who opened his cell realised that the man was unconscious and called for healthcare assistance. Cardio pulmonary resuscitation (CPR) was started quickly and continued until the paramedics arrived and took over. The man was taken to the local hospital in Brighton where he was declared brain dead. Prison staff contacted the man's family and alerted them to the seriousness of his condition. The family attended his bedside and made the decision to end his life support that evening.

The initial information given to my investigator suggested that the man's death might have been caused by suicide or a drugs overdose. He had collapsed unexpectedly and his substance misuse was, at the time, thought to have played a role in his death. However, the post-mortem report stated unambiguously that the man died of natural causes. Methadone was identified as a contributory factor, although what role it may have played is not explained.

I make two recommendations in this report.

THE INVESTIGATION PROCESS

1. The man died on 3 November 2008, following which my standard notices were sent to staff and prisoners alerting them to my investigation. Several prisoners wrote to my investigator. However, once it was established that the man's death was due to natural causes, their letters were no longer of relevance to the investigation.

2. My investigator contacted the prison and asked for the man's prison records. My investigator and a colleague went to Lewes on 7 December to open the investigation and meet senior staff, and to collect the relevant documentation.

3. The police and Coroner's office were contacted to ensure that any relevant information was shared, and to confirm that my investigation could continue.

4. My investigator wrote to the local Primary Care Trust to ask for the appointment of a clinical reviewer to examine the healthcare the man received while in prison. The clinical reviewer was unable to undertake joint interviews with my investigator, but used the transcripts of the interviews to inform his own report. My investigator and colleague travelled to Lewes in early December to interview wing and healthcare staff. Further interviews were carried out in January 2009.

5. One of my Family Liaison Officers contacted the man's family and arranged a visit. His mother, father and sister were present at the visit, which took place in November 2008. Several issues were raised concerning the man's clinical care at Lewes, and his sister wanted to know why he had been receiving methadone at the time of his death. The family wanted clarity about the reason for his death and information about why he was at Lewes. The man's mother also raised concerns relating to contact they had had with prison staff. This included a confirmation of a prison visit emailed to her on the day of her son's death, the return of the man's property, and staff behaviour at the hospital. A copy of my report will be sent to the man's family and I hope that it answers all their concerns.

6. The family raised a number of separate issues regarding the booking of prison visits at Lewes. My investigator has looked into these matters and, as they are not directly relevant to the circumstances of his death, has addressed them in a letter to the man's family. The man's family also raised a number of further issues at the draft report stage. My investigator considered these carefully and, with regard to one of them, went back to the clinical reviewer to request a further opinion.

HMP LEWES

11. HMP Lewes is a category B local prison serving the courts of East and West Sussex. It accepts both adult men and young adults, and has an operational capacity of 723.

12. The prison has a 19 bed healthcare unit under the responsibility of the local Primary Care Trust. Drug treatment began in 2001 and a new drug treatment wing (B Wing) was created in 2004 with room for 29 prisoners. Lewes operates the Integrated Drug Treatment System so maintenance prescriptions are available as well as detoxification.

13. In her most recent inspection report in August 2007, HM Chief Inspector of Prisons described Lewes as "reasonably safe", but with weaknesses in anti-bullying and suicide prevention measures. Drug and alcohol work was described as effective and as having good links with the local community. HM Chief Inspector's report particularly commended the extremely good relationships between staff and prisoners.

14. Each prison has an Independent Monitoring Board (IMB) made up of members of the community. The Board's role is to ensure that the prison is properly run and that prisoners are treated decently. The Board produces an annual report for the Secretary of State. The most recent report from the Lewes IMB commented on how population pressures across the prison estate had resulted in the retention of life sentenced prisoners due to the lack of capacity at lifer centres. The Board said that lifers were waiting a long time at Lewes before moving to an appropriate lifer unit. The Board praised the healthcare unit and detoxification regime.

15. The man's death was only death at Lewes in 2008. Lewes experienced three deaths in 2007, none of them due to natural causes.

KEY FINDINGS

Between 15 January 2001 and 9 June 2008

16. The man was arrested in January 2001 and remanded to HMP High Down. He was subsequently transferred to a number of prisons before his trial in September 2001. Following conviction for murder, he was sentenced to life imprisonment on 3 September 2001 and sent to HMP Whitemoor.

17. He stayed in Whitemoor for three years before being transferred to HMP Wakefield. The man then moved to a number of prisons before arriving at HMP Kingston in May 2008. The man complained about pain in his back on 5 May and requested pain relief medication (his back problems apparently started in 2006 following an incident in the gym). He was given Cocodamol and Ibuprofen (pain relief and anti-inflammatory medicines) over the next month, but was unhappy with this medication.

18. An Assessment, Care in Custody and Teamwork (ACCT) document was opened on 5 June 2008 due to the man's low mood and frustration over the treatment of his back pain. (An ACCT document is the form used by the Prison Service to monitor and support prisoners deemed at risk of suicide or self-harm.) He had also refused food and began a protest in the form of non-compliance with prison rules. The man was segregated for his own safety the following day after threatening to set fire to his cell. The decision to segregate was made in anticipation of his being transferred to Lewes. Staff at Lewes would be better able to manage his healthcare needs due to the greater healthcare provision.

19. Although they are not relevant to the circumstances of his death, I have looked into the man's ACCTs since they are important in telling the story of his life in prison.

Between 10 June and 2 November 2008

20. The man arrived at Lewes on 10 June. It was unusual for Lewes to accept someone as far into their life sentence as the man. The Lifer Manager at Lewes told my investigator that the man " … is quite unique to us at Lewes in that he was somebody that came out of the lifer system into a non-lifer local prison." (Prisoners serving life sentences would normally only be in local prisons from the time of their arrest to shortly after sentencing. Following an assessment they would be moved to a first stage lifer prison to undertake offending behaviour work.) Lewes had very few offending behaviour courses for the man to do.

21. On his arrival, the man was received into the healthcare centre. Following his reception meetings he was placed in a safer cell. (Safer cells have specially designed furniture and fittings to reduce the number of ligature points.) At 2.30am on 11 June, staff noticed that he had covered his door with his mattress and they could not see through the observation panel. When staff went inside, the man was standing at the back of the cell holding a razor to his

neck. He handed the razor to the staff and was escorted to the segregation unit. He returned to the healthcare unit the following morning.

22. An ACCT review meeting was held on 12 June at which the man said that he did not have suicidal feelings but that his self harm feelings fluctuated. He faced a disciplinary hearing for covering his door and was punished with seven days loss of canteen and association, suspended for three months. On 14 June, the man was returned to a standard prison wing. A further ACCT review meeting took place on 17 June and he was said to be settled, with low risk of self-harm. Further reviews were held on 25 and 28 June where the man was described as settling into wing life well, with no current concerns. The ACCT document was closed on 21 July. The post-closure review held on 28 July reported no problems and confirmed the closure of the ACCT.

23. On 7 July, the man was moved up to the fourth landing on his wing. His personal officer wrote in his documents:

> "Since his move to the 4's landing things have improved for the man he has really got his act together. His attitude and mental wellbeing has improved greatly so much so that he has been given a chance as a wing cleaner which he has taken with great enthusiasm."

24. The role of wing cleaner gave added responsibility and extra time out of his cell which noticeably improved the man's mood. However, on 15 September, the man failed a mandatory drugs test. This resulted in his immediate sacking from the position. The personal officer recalled that the man took the news well and accepted responsibility for the consequences of the failed drug test.

25. On 29 September, the man became distressed due to concerns about his sentence. He showed staff a noose he had made but said that he could not find anywhere to attach it. Another ACCT document was opened. Staff carried out a risk assessment and the man expressed suicidal ideas as he felt hopeless due to his sentence. He said that he felt as though he had limited prospects for release, and was frustrated since his failed drug test meant that he was unable to transfer to the therapeutic community at HMP Dovegate. It was decided to move the man to a safer cell and that he should be observed constantly (when a member of staff sits outside the cell all the time). The following day, the man told the Registered Mental Health Nurse (RMN) that he was not suicidal and had merely become depressed the previous day thinking about his sentence and his family. In interview, the RMN recalled that the man had calmed down a lot and realised that his actions the previous evening were not a reflection of his general feelings. He returned to the wing the same day.

26. The man asked for the ACCT to be closed at the case review meeting on 7 October and said that he had no further thoughts of self-harm. At the post-closure review meeting held on 14 October, the man reported feeling very happy with the progress he had made over the previous week.

27. On Friday 24 October, the Senior Officer (SO) called the CARATs department to tell them the man had said that he would like to see a CARATs worker. CARATs (Counselling, Assessment, Referral, Advice and Throughcare) works with prisoners with drug problems. The man's CARATs worker described the service as follows:

> "… when the prisoner comes into the prison they are referred to the CARATs team and then all the way through their custody. We look at what we need to do with them and we work with them, doing the cell packs, doing group work. We support them all the way through their sentence."

The CARATs worker described the cell packs to my investigator by saying, "It teaches them about the effects of heroin, what it does to their body, the learning that they get from it. It's a bit like a little homework pack really".

28. On that Friday, the CARATs worker was on leave so it was her colleague who went to see the man. During their conversation the man told her that he had been using heroin on the wing. He expressed a desire to stop using the drug, and the second CARATs worker told the man she would contact the drug treatment team to help arrange this. The second CARATs worker also gave him some CARATs documents and material. The second CARATs worker then rang the Lead Drug Treatment nurse and told him that the man was withdrawing and feeling unwell.

29. The Lead Drug Treatment nurse was going off duty at this point and so was unable to see the man. He advised the second CARATs worker to arrange an appointment with a doctor so that the man could receive medication to relieve his symptoms if necessary. Before going off duty, the Lead Drug Treatment nurse advised his colleague that she might get a call regarding the man over the weekend.

30. No doctors were available over the weekend and so on Monday 27 October the drug treatment nurse went to see the man in response to the requests from the CARATs worker and wing staff. When the drug treatment nurse saw the man he did not show any obvious signs of withdrawal from heroin. He admitted to the drug treatment nurse that this was because he had been using heroin for about five weeks and had just used again. The drug treatment nurse took a urine sample which tested positive for opiates, and told the man that she would need to see him in a state of withdrawal before she could progress with any treatment. The drug treatment nurse visited the man the next day when he was showing signs of heroin withdrawal. In interview, the drug treatment nurse said:

> "He was sweating, his skin was clammy, his pupils were dilated whereas the day before they were really quite small indicating that he had just used but they were dilated and he was sweaty and clammy."

31. Following confirmation of withdrawal and discussion with the prison doctor, the man was placed on a 14 day methadone detoxification programme. He

remained in his usual cell having refused to move to the detoxification wing (B Wing). His friend said that the man did not want to leave his friends behind and have to familiarise himself with the different regime on B Wing.

32. When a prisoner asks for detoxification, provides a positive urine sample, and exhibits withdrawal symptoms, the nurse must also check the medical record. A discussion is held with the doctor to ensure they are satisfied that methadone should be prescribed. The standard 14 day prescription begins on 20 mgs (a slightly lower dose to avoid potential overdose), before rising to 25mgs and then stabilising on 30mgs for two days before reducing again. The methadone is in liquid form and must be drunk in front of the nurse at the treatment hatch. The nurses observe the prisoner while the methadone is drunk, looking out for drowsiness or slurred speech that could indicate problems. This also presents an opportunity for the prisoner to report any problems with their detoxification. Engagement with the CARATs service is also offered throughout the detoxification programme. The man did not report any concerns about his prescription to the drug treatment nurse or to the CARATs staff.

33. The CARATs worker saw the man on Monday 27 October and recalled in interview that he seemed focussed and keen to continue his detoxification regime. The CARATs worker told my investigator that she had no concerns about him.

34. On the evening of Sunday 2 November, the personal officer answered the man's cell bell. The man asked if he could get him some paper to write letters. The personal officer returned to the man's cell at approximately 6.15pm with the paper, and discussed the climax of the Formula One season with him. In interview, the personal officer said, "… the night before he was absolutely fine, and he was just chatting to me … he seemed very upbeat."

35. The personal officer told my investigator that the evening role check was carried out at approximately 8.30pm and normal practice was to do another at around 5.30am.

3 November

36. At approximately 8.00am, the personal officer began opening the cells on the fourth floor of the wing. When he reached the man's cell he opened the door and saw him lying on his mattress on the floor apparently asleep. The personal officer called to the man and then moved on to the next cell. (My investigator was told that finding a prisoner on the floor was not in itself unusual as some prisoners choose to sleep on the floor.) However, before the personal officer reached the next cell he became concerned as to his knowledge the man had never before chosen to sleep on the floor. The personal officer returned to the man's cell and called to him again. Having got no response, the personal officer went into the cell and called out again. The personal officer crouched in order to try to shake the man and noticed a filmy liquid surrounding his head and what appeared to be vomit in his mouth and nostrils. The personal officer immediately called out to his colleagues on the

landing for urgent medical assistance. He checked the man's pulse and believed that he felt a faint pulse.

37. One of the officers on the wing radioed for healthcare assistance and the duty governor was also informed. Wing Officers went to the cell in response to the personal officer's calls for assistance and also checked the man's pulse. They too believed that they might have felt a faint pulse. Soon after they checked the man's pulse, the healthcare staff arrived at the cell.

38. The prison nurse and Healthcare Assistant (HCA) had run to the cell from the first floor landing on the in-patients healthcare centre and arrived at the man's cell at approximately 8.04am. They carried the resuscitation bag which they had collected from the treatment room on the landing. The resuscitation bag contains a variety of medical equipment including oxygen. The officers vacated the cell to allow more room for the resuscitation attempt, and began to lock other prisoners back in their cells.

39. The prison nurse checked the man and described this process to my investigator as follows:

> "I checked his vital signs first, checked for breathing, pulse and checked his pupils for reactivity and when there was none of those and his GCS [Glasgow Coma Scale which rates the level of consciousness of an individual] was nil then I started CPR [cardio-pulmonary resuscitation]".

40. Having done this, the prison nurse shouted out that she needed an ambulance. There were many staff standing around the cell entrance and the request for an ambulance was immediately radioed through. A facemask and ambu bag (a manual ventilation bag) was applied to the man to establish regular oxygen supply, and CPR was undertaken with a ratio of 30 compressions to two breaths (this is the correct ratio). The prison nurse asked for a defibrillator and it was passed to her by one of the officers outside the cell. The defibrillator was attached to the man but it did not advise that he should be shocked. (A defibrillator provides an electric shock to the heart to try to get it started again. The machine itself advises the operator whether to deliver a shock. It does not do so when the heart does not have sufficient rhythm as it would not have any effect.)

41. The ambulance arrived at 8.15am and paramedics and prison healthcare staff continued CPR. The paramedics administered Naxolone, an opiate blocker, in case the cause of the man's collapse was due to a drug overdose. Adrenaline and Atropine were also administered which resulted in a slight pulse. A second ambulance was requested by the paramedic crew in order to bring further equipment. The paramedics' defibrillator was put onto the man but it too advised that a shock should not be given. At 9.20am, the decision was made to take the man to hospital.

42. When the paramedics reached the ambulance with the man, he suffered another arrest and paramedics had to resuscitate him again before they could

leave for the hospital. Two officers accompanied the man as escort staff when the ambulance left the prison at approximately 9.30am. The man was moved to the Intensive Care Unit (ICU) following an initial assessment in a resuscitation room in the Accident and Emergency (A&E) department. The risk assessment judged it unnecessary to apply restraints to the man since, in the words of the first escort officer:

> "… it wasn't necessary because the inmate was obviously incapacitated in more ways than one … we were sat near a door … about twenty-five, thirty foot away but we could see the man and we could see the family."

Contact with the man's family

43. The duty governor told my investigator that, once the man left for hospital, he ensured the care team was fully apprised of his condition. The duty governor then went through the man's records for contact details. I understand that next of kin details for the man were incomplete and that this prevented immediate contact with his family. The only Family Liaison Officer (FLO) at Lewes at that time was absent from the prison and so the duty governor asked the prison chaplain to help contact the family. This was at approximately 10.30am.

44. The prison chaplain looked at the man's next of kin records and discovered that he had a son at HMP Deerbolt. The chaplain told my investigator that he called his counterpart at Deerbolt and attained the telephone number for the man's mother. The prison chaplain called the family but there was no response to his first two calls. Between 12.00noon and 12.30pm, the prison chaplain telephoned for a third time and managed to speak to the man's stepfather. He advised him of the seriousness of the man's condition and suggested that he and the man's mother should go to the local hospital as soon as possible. The prison chaplain also called the man's former partner and told her that the man was in hospital.

45. The man's family arrived at the hospital and asked questions of the escort staff, many of which they were unable to answer as they did not know him. The Principal Officer (PO) contacted the prison FLO at 5.00pm to ask her to go to the hospital to support the escort staff. It appears that the escort staff felt uncomfortable trying to deal with the questions that the family were asking them. The second escort officer told my investigator:

> "If you haven't got the information to give someone you just keep saying the same thing over and over again … Whether they thought we were keeping something back from them I don't know but that just wasn't the case, we just didn't have the information."

46. The prison FLO arrived at the hospital at 6.00pm and went to see the escort staff. The man's family were at his bedside. At 6.30pm the man's stepfather approached the prison FLO and told her that they were waiting for other family members to arrive and were planning to turn off life support at 8.00pm. The

man's stepfather asked if all contact with the family could go through him and the prison FLO agreed. Family members arrived at approximately 7.00pm and gathered around the man's bed. The hospital staff began to turn off his life support at 8.00pm and the hospital doctor declared the man dead at 8.15pm.

47. After some time at the man's bedside the family went into another room. The prison FLO waited for a short time and joined the family at 9.00pm to pass on condolences on behalf of the prison. At 9.15pm, the man's son arrived with his girlfriend. At 9.20pm, the prison FLO left the family. She promised to contact them in the next few days if they did not contact her first.

48. The prison FLO telephoned the man's former partner, the mother of the man's children, at 9.10am on 4 November. The former partner told the prison FLO that the man's mother had already informed her of his death. The prison FLO left her contact details with the former partner.

49. At 12.50pm on 4 November, the prison FLO spoke to the man's sister, to respond to questions that she had rung with earlier that morning. The man's sister expressed dissatisfaction that a governor from the prison had not contacted the family. The prison FLO raised this with the Deputy Governor who called the man's mother at 3.00pm. During their conversation, the man's mother asked the prison to contact the man's pen-friend in HMP Downview and his former brother-in-law in HMP Wormwood Scrubs to inform them of his death. The family also wished the family of the man's victim to be told. The Deputy Governor agreed to these requests.

50. The man's mother called the prison at 9.50am on 7 November to ask whether the prison would consider increasing their offer towards the funeral expenses. Following discussion with the Deputy Governor, the prison FLO spoke to the man's mother the next day and told her that the prison would not increase their contribution. The man's mother told the prison FLO that the family did not want anyone from the prison at the funeral, and they did not want flowers sent either. The man's funeral took place on 14 November.

51. At 3.30pm on 20 November, the prison FLO and the Senior Officer visited the man's stepfather and mother's home to return his property. The prison FLO agreed to provide the man's mother with an envelope to send some of the man's CDs to other prisoners. The man's mother expressed unhappiness with the prison's refusal to increase its offer towards the funeral costs, and the prison FLO advised her to write to the Governor. The man's mother chose not to do so and did not raise the issue with the prison again. On 28 November, the prison sent a cheque for the funeral expenses to the funeral directors.

52. The man's mother also complained of the difficulty that the family had had in arranging a visit with the man prior to his death. The prison FLO said that she would bring this to the attention of the Governor.

Care for prisoners and staff

53. The Governor issued a notice for each prisoner telling them what had happened to the man. The prison chaplain, with his Muslim colleague, organised a memorial service on the following Friday afternoon.

54. The officers who discovered the man were offered a hot debrief to talk through their role in the resuscitation attempt, but they said that they did not feel it was necessary. The care team visited as soon as the officers left the man's cell and offered support. The prison nurse told my investigator:

> "I actually spoke to the officers myself to see if they were okay because sometimes it is helpful to speak to somebody who was actually there so I just offered my support to the officers who found the man."

55. One officer said that he felt there was plenty of support available should he have needed it.

56. The prison nurse attended a debrief with some healthcare staff and the PCT but not with the officers involved. She felt well supported by the prison. Unfortunately, the prison nurse learnt of the man's death from the Governor's notice to prisoners.

57. All of the staff involved in the resuscitation attempt spoke highly of the care and support offered by the prison. The care team quickly approached the staff, and the chaplaincy was also available to any who needed it. I am pleased to acknowledge that Lewes takes such matters seriously.

ISSUES

Medical issues

Clinical care

58. The man was transferred to Lewes from Kingston because Lewes has 24 hour in-patient healthcare facilities. The clinical reviewer notes that the man had fluctuating thoughts about self-harm which meant that it was difficult to manage his needs. However, the clinical reviewer writes that, "the man appears to have received a commendable level of support from the various drug and psychiatric agencies whilst in custody."

59. The clinical reviewer points out that it seems the man's back pain was never assessed by healthcare staff beyond the prescribing of painkillers. However, I understand that the man's focus was on the continued provision of painkillers, rather than a detailed assessment of his back problem.

60. With regard to the condition that caused the man's collapse, the clinical reviewer writes:

> "The man died suddenly and unexpectedly of a rare and serious medical problem Thrombotic Microangiopathy (TM). [This is a condition affecting the blood vessels that can cause organ failure. It presents non-specific symptoms.] His lifestyle and habits may have been contributory factors in the development of TM, but there appear not to have been any symptoms prior to his collapse that would have suggested to his carers that his demise was imminent.
>
> "I find no fault with the quality of care he received within the prison or hospital medical services."

61. The man's family questioned whether the staff who saw him at the time of his request for drug withdrawal treatment should have considered the possibility of him suffering from Thrombotic Microangiopathy. The symptoms that the man exhibited were entirely consistent with heroin withdrawal. The clinical reviewer found no fault with the medical care the man received and I do not think it reasonable to expect his underlying condition to have been noticed at that time.

62. The man's family told my investigator that the hospital consultant had told them that his blood contained Methadone and Gabapentin. The family were interested in the relevance of the Gabapentin in his blood. The man had been prescribed Gabapentin in the weeks leading up to his death. My investigator asked the clinical reviewer to provide an opinion on the prescription of both Methadone and Gabapentin. He wrote to my investigator with the following comments:

> "Methadone is an opioid analgesic frequently used in the detoxification of patients with a heroin and other illicit drug use. It has a low

incidence of side effects, and self harm with methadone is difficult. Gabapentin is an anti-epileptic drug also licensed for the treatment of neuropathic pain. I have looked at the literature concerning the concomitant use of these drugs and there appears to be no interaction between the two. Sedation can occur with both, but this can be regarded as an additive effect rather than an interaction. In my opinion the concomitant use of methadone and Gabapentin in this patient was entirely appropriate."

The attempted resuscitation

63. The man was found at approximately 8.00am on Monday 3 November by his personal officer when he unlocked the cells in the morning. The alarm was quickly raised and healthcare staff quickly reached his cell. CPR was immediately carried out and continued by paramedics when they arrived at 8.15am. The clinical reviewer raises no concerns regarding the resuscitation. I am also satisfied that staff made every effort to save the man.

Family issues

Contacting the man's family

64. The man's family has raised several concerns with my investigator regarding liaison with the prison. The family was unaware of the prison's first attempt to call them as they were not at the family home at the time. The prison chaplain was asked to contact the family at approximately 10.30am but was unable to reach anyone at the man's parents' house until some time between noon and 12.30pm. I consider it a key responsibility for the prison to try to make contact with the family as soon as possible. The duty to contact the family following a death in custody is set out in Prison Service Order (PSO) 2710:

> "Governors/Directors of contracted prisons must have in place a local protocol explaining what support will be offered to a family bereaved by a death in custody. They must also:
>
> "Arrange notification to the next-of-kin and any other person reasonably nominated by the prisoner as soon as possible in a suitable manner giving an accurate factual account of what has happened."

65. PSO 2710 refers to deaths in custody but the same principles apply to cases when the severity of the situation requires the family to attend the hospital as soon as possible. It is unfortunate that the contact details for the man were not adequate for Lewes to contact his family any sooner. However, the prison clearly made efforts to obtain these details by contacting Deerbolt. The man's family said that Lewes did have their contact details, and would not have been able to get them from Deerbolt. The prison chaplain explained during interview how he got the contact details and I have no reason to dispute his account.

66. The man's family was also surprised that the initial telephone call came from the prison chaplain and not from a governor. It is for the prison to decide who would be the best member of staff to break such difficult news to a family. My investigator was told that the prison chaplain was asked to make the telephone call due to the pastoral care and experience he could bring to the role. The FLO guidance (supplementary to PSO 2710) explains the benefits of involving the chaplain in this role:

> "Traditionally Governors have asked a Chaplain to break the news of a death to a family. Chaplains are trained and experienced in bereavement issues and are ideally suited to this task."

67. Given this, I consider that the decision made by the duty governor to ask the chaplain to contact the family was both reasonable and proper.

68. The prison chaplain relayed the necessary information to the family but did not offer to arrange transport for them to the hospital. The family has not raised this as a concern with my investigator, but I would suggest to the Governor that such an offer might be considered in any similar situation.

The escort staff at the hospital

69. The man's family has raised concerns about the behaviour of the escort staff at the hospital. The family explained to my investigator that they felt that escort staff were flippant and unprofessional. My investigator interviewed a member of the escort staff who denied these allegations. He said that, although it was a very difficult situation, he was confident staff acted appropriately. He told my investigator that he and his colleague felt very isolated as the family asked many questions that they were unable to answer having had no involvement when the man collapsed. The escort officer said that he felt that the family was blaming him for the man's situation, and this was not helped by the lack of information that he was able to pass on.

70. It was this tension that caused the prison FLO to attend the hospital at approximately 6.00pm. By all accounts, her arrival helped matters as the family had someone able to liaise with them directly and answer more of their questions.

71. Given that the accounts of the family and the escort staff differ, I am unable to judge whether staff did or did not act appropriately during their time at the hospital. Small things such as body language matter hugely when people are under stress. According to the bedwatch documentation, a management visit was made by a Principal Officer at 5.20pm and this gives no indication that the escort staff were behaving other than entirely appropriately. However, without making any judgement about what happened on this occasion, it would be good practice for the Governor to remind escort staff of the sensitivity of escort duty and the absolute importance of maintaining a professional attitude at all times.

The Governor should remind all escort staff of the sensitivity of escort duty and the absolute importance of maintaining a professional attitude at all times.

72. I sympathise with the situation the escort officers were placed in and I consider it disappointing that the Family Liaison Officer or a suitable governor-grade was not at the hospital to meet the family on their arrival. Escort staff are not trained in family liaison skills and often have no knowledge of the prisoner they are escorting. When they are not provided with a point of contact at the prison, a family may erroneously believe that the escorts are being obstructive. One escort officer told my investigator:

> "I think as soon as the family arrived I'd been more than happy to sit there and let them ask me questions and what I could answer I would answer. Perhaps someone from the prison getting in contact sooner to explain to the parents what had happened and then after that point if we were able to base ourselves away from the ward, so as not to antagonise the situation which I felt us being there was doing."

73. On this occasion, the family asked questions of the escort staff they were in no position to answer. Such a situation can easily lead to tension and should be avoided where possible. Indeed, in other investigations I have commended prisons where a governor grade has met a family at the hospital. Therefore, I recommend:

The Governor should ensure that, when a prisoner is likely to die, a senior member of staff is identified to meet the family.

Funeral expenses

74. The man's family has explained that they were initially disappointed by the amount the prison offered with regard to payment of the funeral expenses. However, I have discovered that the sum offered was in accordance with Prison Service policy and properly balanced the duty to the family and to the public purse. I consider that the prison acted appropriately in this regard.

The man's property

75. The family was also initially confused by statements made by the prison with regard to the man's property. I understand that this was a misunderstanding relating to which property was in the man's cell and which was held in storage. I understand that all the property has now been returned to the family. The family also expressed some discontent with the answers provided to them by the Family Liaison Officer. This is unfortunate, and although I am unable to comment on it with any certainty, I would encourage the Governor to ensure that families are kept as fully informed as possible in any future death in custody.

Prison visits at Lewes

76. The man's family told my investigator that they were sent a visits booking confirmation on the afternoon of the man's death. Although I believe that the visits clerk had no idea that the man was in hospital at the time the confirmation was sent out, it was clearly most unfortunate and added to the distress of the family. Prison Service Order 2710 requires the visitors centre to be informed of any death in custody. Although the man was not dead by the time the email was sent out, I suggest that, where the prognosis is particularly poor (as with the man), consideration should be given to informing the visits clerk as soon as possible. This could help prevent a recurrence of this unfortunate situation.

Other issues

Use of heroin

77. It is self-evidently of concern that the man was able to acquire heroin while in Lewes, and to have used it on a presumably regular basis for a number of weeks. I am aware that the Governor and his staff take the matter very seriously. I also understand that, as in all prisons, there are measures in place to try to minimise the availability of illicit drugs. In support of the Governor, the Area Manager will wish to assure himself that all reasonable actions are being taken to prevent the ingress of drugs into Lewes.

Methadone treatment programme

78. It is to the man's credit that he came forward of his own accord and expressed a desire to detoxify from heroin. He was placed on a 14 day methadone detoxification programme starting on 20 mgs a day. As the clinical reviewer says in his report, there were no symptoms of any serious physical problem during the man's detoxification and he did not raise any concerns with staff.

79. Methadone is listed as a contributory factor on the post mortem report but no information is provided as to why or how it contributed to the man's death. The report states:

> "The pneumonia may therefore be related to the thrombotic microangiopathy in this case and the therapeutic levels of methadone, whilst unlikely to have been directly fatal, in this case may have been contributory."

80. Despite my investigator asking for his views, the clinical reviewer has been unable to comment on any link between methadone and the man's collapse. I consider that their decision to place the man on a methadone detoxification programme was entirely appropriate. The man himself actively wanted it to happen, his urine tested positive for opiates, and drug treatment staff witnessed him displaying physical signs of withdrawal. Given these factors, I do not see how staff could reasonably have acted any differently.

The possibility of the man taking other drugs the night before he died

81. The family and other prisoners raised the possibility of the man taking drugs from another prisoner on the night before he was found. A wing officer confirmed that he was told this but the prisoner in question denied the allegation. The post mortem examination did not find any drugs in the man's system other than the appropriate amount of methadone.

Conclusion

82. The man's death was entirely unexpected. I am satisfied that the clinical care the man received was satisfactory and that staff made appropriate efforts in an attempt to save his life. His family has raised several issues regarding contact with the prison that my investigator has looked into and they have resulted in my two recommendations. I hope that this report deals with all their concerns.

RECOMMENDATIONS

1. The Governor should remind all escort staff of the sensitivity of escort duty and the absolute importance of maintaining a professional attitude at all times.

2. The Governor should ensure that, when a prisoner is likely to die, a senior member of staff is identified to meet the family.