# Investigation into the circumstances surrounding the death of a man at HMP Lowdham Grange in February 2007

**Report by the Prisons and Probation Ombudsman for England and Wales**

**August 2008**

This is the report of an investigation into the circumstances of the death of a man in February 2007. At the time of his death, the man was a prisoner at HMP Lowdham Grange. The post mortem report indicates that he died from an acute heart attack. He was 51 years old.

I would like to extend my condolences to the man's family and friends for their unexpected and sad loss.

The investigation was carried out on my behalf by one of my investigators. One of my family liaison officers provided liaison with the man's family. I am grateful to the Director of Lowdham Grange, and his staff for their ready co-operation with this investigation.

The man was a popular prisoner who was described as a pleasant, polite and generous man. His popularity was evidenced by the large sum collected by other prisoners for funeral flowers. Unfortunately, from time to time he appears to have succumbed to the temptation of taking drugs in prison, but this does not appear to have had any bearing on his death.

I make one recommendation relating to record keeping in respect of drug treatment.

**Stephen Shaw CBE**
**Prisons and Probation Ombudsman** **August 2008**

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**SUMMARY**

The man was 51 years old when he died at HMP Lowdham Grange in February 2007. His death was caused by an acute heart attack due to thrombosis of two of his coronary arteries.

The man had been received into custody at HMP Birmingham on 19 November 2002. On 9 February 2004, he was sentenced to ten years imprisonment and transferred to HMP Dovegate. On 14 September 2006, he moved to HMP Lowdham Grange. In spite of a slightly troubled history, once he moved to Lowdham Grange he formed some close friendships with other prisoners and seemed settled.

Staff who saw him on the evening of 8 February 2007, described him as being his usual self, talking and laughing with other prisoners on the wing. Prisoner A was a friend of the man who died. They had lived on the same wing for many months and worked together in one of the workshops. On the evening of 8 February, they sat and had coffee together, something they often did before evening lock up. Prisoner A described the man as his usual self, chatting and laughing.

The Prison Custody Officer (PCO) was responsible for H wing on the night of 8 and 9 February. In line with normal procedures, he completed his checks at midnight and began his next round of checks at 3.00am. When he came to the man’s cell he saw him through the observation hatch, slumped on the floor by his bed. The PCO called out to him and banged on his door trying to get his attention. He then got a colleague, the second PCO, to accompany him and they both entered the cell.

Staff started Cardio Pulmonary Resuscitation (CPR) and were soon joined by the nurse from the Healthcare Centre, who immediately requested an ambulance. Sadly, the man could not be resuscitated and he was pronounced dead by the ambulance crew.

Staff and prisoners affected by the death of the man were given support. The West Midlands Police were contacted and asked to attend the home of the man’s next of kin to inform the family of the sad news.

The clinical review does not identify any specific issues relating to the care of the man. It concludes that he received nursing and medical care comparable to that which would have been available in the community. However, the post mortem toxicology tests show that he had taken heroin, cocaine and cannabis within the previous 12 to 24 hours.

In previous reports, I have commented on the impact that drug-taking has upon prison life in general and the health of prisoners in particular. However, my investigator reviewed Lowdham Grange’s drug policy, and talked to staff involved in its implementation. I am satisfied that it offers a balance between support for those endeavouring to end their drug use and penalties for those who are still involved.

## THE INVESTIGATION PROCESS

This investigation was formally opened on 15 February 2007 when one of my investigators issued notices to staff and prisoners at HMP Lowdham Grange. The notices invited anyone who might have information relating to the man to make themselves known. No one came forward. However, the investigator did speak to two prisoners who had known the man.

The investigator also examined copies of the man's prison files, including his main prison record and his medical records.

The investigator visited Lowdham Grange prison on 18 April 2007. She met the Director and also informally interviewed staff in the healthcare department and on the wing where the man had lived.

She also spoke to the Chair of the Independent Monitoring Board (IMB). She confirmed that the man had made no applications to the IMB nor raised any concerns about his health.

My investigator contacted the Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. A copy of this investigation report will be sent to the Coroner to assist him in his enquiries into the man's death.

One of my family liaison officers contacted the man's family to inform them of this investigation and to provide an opportunity for them to contribute. The family asked a number of questions such as his exact cause of death, where he had died, and if he had rung his cell bell the night he died. They also said they had heard various rumours about his death. My investigator talked to the family during the course of the investigation to answer their questions. I hope this report provides further detail.

## HMP LOWDHAM GRANGE

Lowdham Grange opened in February 1998. It is a Category B closed training prison for long-term prisoners, privately managed and operated by Premier Custodial Group Ltd, part of Serco plc. The prison has an operational capacity of 524 prisoners, providing single cell accommodation in two identical houseblocks. Each houseblock has four wings which are divided into two landings. The wings are arranged in a cruciform shape around a central control room.

The healthcare centre does not have an in-patient facility. Nursing staff are directly employed by the prison and work a 12 hour shift. Out of hours cover is provided by a nurse based overnight in the healthcare centre. Patients requiring specialist healthcare are identified and referred to the National Health Service. A doctor attends the healthcare centre for 15 hours per week and provides out of hours advice.

HM Chief Inspector of Prisons carried out an unannounced inspection of Lowdham Grange in March 2004. Her subsequent inspection report described Lowdham Grange as providing “a secure but respectful environment for prisoners and staff” and said that healthcare was delivered “in a respectful and professional way”.

There have been four deaths at Lowdham Grange since April 2004 when I began investigating all deaths in prison custody. Three, including that of this man, have been the result of natural causes. I have found no similarities between the circumstances of the man’s death and the other deaths at Lowdham Grange.

## KEY FINDINGS

The man was received into custody at HMP Birmingham on 19 November 2002. He went though the usual first night in custody procedures without reporting any concerns. The Cell Sharing Risk Assessment (CSRA) carried out at the time shows that he said he had abused drugs and was dependent on heroin at the time.

The First Reception Risk Assessment, completed the next day, noted that the man said it was his first time in prison. He said he felt 'fine', and when asked if he had any dependency on drugs or alcohol he said no. He was also seen by the Counselling, Assessment, Referral, Advice and Throughcare (CARAT) team (the specialist drugs team) that day.

The man's record shows that he saw all the agencies and departments relevant to him when he entered Birmingham prison. The next entry, on 25 January 2003, shows that he was working in the kitchens. On 1 March, a note says that the man was no problem on the wing and continued to work in the kitchens. However, later that month (on 18 March 2003), he gave a positive drug test for morphine. He was removed from his job and given a warning about his behaviour. About a month later, the man failed another drug test, this time for cannabis. He was again given a warning about his actions.

On 9 February 2004, the man was sentenced to ten years imprisonment (which, on appeal, was later reduced to nine years) and transferred to HMP Dovegate. The CSRA completed at Dovegate, with information supplied by the man, indicated that he had not used drugs or alcohol in the past and was not addicted to anything at the time.

On 24 May, the man was interviewed by a member of the CARAT team. A brief note said that no intervention was necessary. The records available do not show whether this was at the man's request or otherwise.

Between January and May 2005, there are several entries in his security file indicating suspicion of his involvement with drugs. These included a positive drug test and two instances of positive indications by drug dogs on his visitors.

The man made an application on 27 September 2005 to see the CARAT team. He was seen by a CARAT worker two days later. An assessment was carried out during which he said he had been using heroin on a weekly basis since April 2005. The man had referred himself to the group as he wanted to become drug-free and re-establish his links with his family. He told staff that he had acquired his drug habit while in prison. A care plan was completed on 7 November 2005 which indicated that the man would be assisted to make an application for detoxification and would attend AA meetings. He was then placed on a subutex detoxification programme from December 2005 to February 2006 and was also prescribed anti-depressants.

The man made another application to the CARAT team on 4 April 2006. He said he needed to see them as soon as possible as he had seen the nurse and she had referred him back to them. A reply on 19 April said an appointment had been made for him, but that he would not be seen until the end of May. His CARAT file does not

make clear exactly what treatment or support he eventually received. Otherwise, his wing file shows that he had settled in well and was generally cheerful and sociable.

The man's security record shows that on 14 September 2006 he was moved to HMP Lowdham Grange following suspicion of drug dealing. Staff who saw him when he arrived at Lowdham Grange said he did not request the drug free wing or raise any concerns about drugs. Other staff who saw him daily described him as a pleasant and polite man who went to work every day.

The man's CARAT file from Dovegate did not arrive at Lowdham Grange until 5 February 2007, several months after his transfer. Staff from the Lowdham Grange CARAT team went to see him when they received his file. They spent about half an hour assessing him but he refused their offer of intervention.

**The night of 8 and 9 February**

Prisoner A was a close friend of the man. They had been on the same landing for several months and worked together in the workshop. Prisoner A said the man was a polite and generous man, constantly sharing his canteen and tobacco with him. Prisoner A said the evening before the man died he called him to have some coffee. The man made the coffee and they sat and talked together for about half an hour. He said that the man was his usual self, joking and talking amiably. At 9.00pm (the time for lock up), prisoner A told the man that his canteen order that had arrived that day did not include his chicken noodles. The man shared the packets he had received with prisoner A. He then offered prisoner A some yogurts and they joked about the man's love of yogurt.

The third PCO was on duty in houseblock 2, H wing, from 2.00 pm until 9.00 pm on 8 February 2007. He saw the man when he went to the servery to collect his evening meal at about 5.00pm. He said the man did not raise any concerns with him or his colleague, the fourth PCO. He also saw the man before the prisoners were locked up for the night. The third PCO said he was his usual self talking to other prisoners. The fourth PCO agreed and said the man was 'his normal self, laughing and joking with his fellow prisoners'. She said he again seemed fine later at lock up and did not mention that he was unwell or worried in any way.

The first PCO was the officer responsible for H wing on the night of 8 and 9 February. He told my investigator that at midnight he began a round of checks, checking the man's cell between 12.15am - 12.20am. He saw the man who was watching the television in his cell. During the next set of checks at 3.00am, he said he got to the man's cell at about 3.25am. When he looked though the observation hatch he saw the man sitting on the floor beside his bed, with his body slumped towards it. He said the man seemed to be 'taking deep breaths'. The first PCO said he thought the man was sleeping. He called out to him and kicked his door to get his attention. He then fetched the second PCO and they both returned to the man's cell.

The second PCO said the first PCO told him that he was concerned about the man. When they returned to the cell, the second PCO said he looked through the observation hatch and saw the man slumped on the side of his bed. He then requested Oscar 1 (the night orderly officer, the officer in charge of the prison) and

the nurse to attend the wing. He said he banged the door and shouted the man's name. At this point, he noticed that the man moved slightly. He and the first PCO then went into the cell and placed the man in the recovery position. The second PCO said he felt for a pulse but could not find one. The duty nurse then arrived.

The duty nurse was on duty in the healthcare centre when he received a call over the radio asking him to attend H wing, cell 18. He told my investigator that, at this point, he was not told it was an emergency. Nevertheless, he left the healthcare centre immediately, taking the emergency bag with him. When he was about half way there, he received another radio message asking if he was en route. He replied that he was and asked if it was urgent. He was told that it was and that the man was now unconscious. The duty nurse said he ran the rest of the way.

When he arrived at the cell he saw that the man had been put into the recovery position. He checked for respiration and a pulse, but could find signs of neither. He placed him on his back and began cardio pulmonary resuscitation. He asked the orderly officer to call an ambulance, ensuring they were told that the patient was not breathing. He continued to administer mouth to mouth, while the officers gave continuous chest compressions, until the ambulance arrived.

The duty manager said he was contacted at 3.27am and asked to go to houseblock 2, H wing. While making his way there, he was informed over the radio that a prisoner had collapsed in his cell. The first and the second PCOs and the duty nurse were already there when he arrived. He said he then contacted the control room and asked for an ambulance to be called and the duty governor to be informed.

The fifth PCO attended H wing and was asked by the duty manager to go to the gate and escort the ambulance through to the wing. He told my investigator the ambulance arrived at about 3.50am and he escorted the two paramedics through the wing to the man's cell. He said he then took his turn helping to administer CPR by relieving other staff who had been doing it for some time. The staff were informed at 4.22am that there was no sign of life.

The sixth PCO was on duty in the main control room and completed the incident log that night. It shows that a medical response was called for at 3.27am and an immediate response was made by the nurse saying he was on his way. The log notes that at 3.29am the prisoner was unconscious and the ambulance was called at 3.30am. The ambulance is recorded as arriving at the prison at 3.37 and at the cell at 3.50.

The toxicology report prepared by a forensic pathologist identifies that the man had taken cocaine, heroin and cannabis within the 12 to 24 hours before his death. However, in the opinion of the forensic pathologist, the levels present neither caused nor contributed to his death. The forensic pathologist goes on to say that in his opinion that the man died as a consequence of an acute heart attack due to thrombosis of two of his three coronary arteries.

## Events after the man's death

The control room log shows that the duty director was called at 3.38am and arrived at the prison at 4.30am. Lowdham Grange implemented its contingency plan for a death in custody. This included contacting the National Operations Unit, the Independent Monitoring Board, and the police. It appears that the contingency plans were activated and followed appropriately. The relevant staff were informed and the staff involved were debriefed and supported.

The man had named his son as the person to be notified in an emergency. The prison spoke to West Midlands Police at 5.00am. They initially had some problems obtaining the details of the next of kin. The man's son was finally told of the death of his father at 1.00pm on 9 February.

The family liaison officer (FLO) at Lowdham Grange, contacted the man's son that evening at 5.30pm. She also spoke to the man's sister and brother, and arranged to visit them on Monday 12 February. During that visit, it was agreed that the man's brother and sister would be the points of contact for the family. The FLO advised that the prison would contribute to the cost of the funeral and agreed she would speak to the Director.

The FLO contacted the family again on 19 February to let them know that Lowdham Grange would contribute £1,100. This was received with thanks by the family. At the family's request, this contribution was later increased to £1,400. A collection by prisoners raised £261 and at the family's request this was used to purchase flowers for the funeral.

The man's funeral was held on 2 March. On 5 March, the FLO returned the man's personal effects to his family. The family subsequently sent a card of thanks to the prison, expressing their gratitude for the support given to them following the death of their brother. They also thanked the prisoners for their floral tribute.

## ISSUES

### What help did the man receive when he referred himself to the CARAT team at Dovegate?

The man told staff that he had developed an addiction to heroin while he had been in custody, particularly at HMP Dovegate. However, there is evidence that he used heroin before his imprisonment. Equally, several security reports indicate his involvement in the drug culture of each prison in which he was located. Notwithstanding this, when he referred himself to the CARAT team for support in April 2006, it is unclear from the documents available what, if any, treatment or support he was given.

**The Director of Dovegate should ensure that complete and accurate records are kept of treatment or support given to prisoners referred for drug treatment.**

### Drug use at Lowdham Grange

The man's death was a shock to prisoner A. He said he had always seemed content and healthy. He had never complained of ill health, or of feeling unwell on the night before his death or at any point over the months they had known each other. Prisoner A was equally taken aback to hear that the man might have used drugs the night before he died. He was adamant that the man had never spoken about drug use. Prisoner A explained that during his time in prison he had come to identify those prisoners who continued to use drugs and the man was never one of those'. He was also upset to learn of rumours going around the prison that the man had a large amount of drugs on his person when he was found in his cell.

Another prisoner, prisoner B, spoke in confidence to a member of staff the day after the man died. He said he had seen the man the evening before and his speech had been slurred. When my investigator spoke to prisoner B he said he could not remember if the man had been slurring his speech. However, he did say that he was confident that the man had taken drugs that evening as it was obvious by his appearance.

Lowdham Grange's drugs strategy has been examined in detail. My investigator also spoke at length to the manager responsible for implementation of the policy. Lowdham Grange appears to have run successful drug services. However, part of its funding was withdrawn some time ago just before the introduction of the Prison Service-wide Integrated Drug Treatment Strategy (IDTS).

Nevertheless, Lowdham Grange's policy is a thorough document that includes objectives to help prisoners resist drugs, stifle the availability of drugs in the prison and offer support services to those who struggle with their habit. The manager explained that the policy is designed to create a balance between detecting those who continue to use drugs by random testing, as well as regular screening of those subject to Mandatory Drug Testing (MDT). It also seeks to offer support and help to prisoners who test positive for drugs, and those who refer themselves to the CARAT services.

At the time of this investigation, there were three CARAT workers in post, plus another in training. This is the first time that Lowdham Grange has been able to offer a full drugs service since opening in 1998. The prison has increased its staff from one to three drug workers, as well as a CARAT manager and a senior practitioner. In spite of shortages in funding and staff, as soon as the man's CARAT file was received from Dovegate he was seen the same day by the CARAT team at Lowdham Grange. Regrettably, the man told staff he did not have any drug problems and did not need their services.

After the man's death, a prisoner on the same wing told a member of staff that the man had been a regular heroin user but had been reducing the amount he was using at the time of his death.

**Rumours circulated after the man's death**

The seventh PCO spoke to the prisoners who were in the cells either side of the man's cell. Prisoner C was in one of the adjacent cells. He told staff that he had not heard anything unusual until he heard the first PCO banging on the man's door trying to get his attention some time during the night. Prisoner D was in the cell the other side of the man's cell. He told staff the next morning that he heard a 'crash type noise' during the night but did not take much notice of it.

It is not unusual for rumours to surface in a prison after a death has occurred. Amongst those circulating in Lowdham Grange was that the man had been found with a large of quality of drugs on his person. A prisoner speaking to a CARAT worker the day after the man's death 'wondered if something had burst inside him?' When he was asked to explain his comment, he said 'you know', adding that it was impossible to overdose from smoking heroin. I have found no evidence to support the speculation by prisoners that drugs played a part in the man's death. Moreover, the post mortem found no evidence of drugs concealed in the man's body. Lowdham Grange followed the contingency plans for a death in custody, which included sealing the cell and calling in the police.

The Chair of the Independent Monitoring Board (IMB) was told by other prisoners that the man had been ringing his cell bell during the night and that it had not been answered. She therefore asked for the electronic bell log to be checked. The log showed that it had not been activated. My investigator also checked the electronic cell bell record to be sure there was no record of the man ringing his cell bell that evening.

**The man's healthcare**

I am satisfied that the man's care was appropriate, but as indicated above, there is a need for more comprehensive record keeping.

## RECOMMENDATION

The Director of Dovegate should ensure that complete and accurate records are kept of treatment or support given to prisoners referred for drug treatment.

The Prison Service responded:

The simplest, most effective and safest solution is of course to move to an IT based system which we are all aware of. The implementation of IT based systems is included within the LDP for Health next year. NMC and PCT guidelines on record keeping has been disseminated to all staff and carry out routine quality checks on clinical record entries from next month.

With regards to the Substance Misuse Team (SMuT), the following are now in place and working well:

- All practitioners fill in a daily contact sheet with prisoners name on and what intervention was carried out.
- Detox diary with prisoners names on and signed by the SMuT practitioner and nurse.
- Quality control checks on all SMuT files and the stamped and signed by me.
- DATA base is updated daily.

We will now be in a position to ensure full documentation is compliant and full written evidence of all treatment, and contacts made.

**In regards to the transfer of prisoners and files been sent on late, the following will be implemented:**

- Install a lids terminal in the SMuT office so the administrator can check on transfers on a daily basis.
- Daily emails from OCA.

Once these are in place we can ensure files are transferred when the prisoner is transferred.