

**Investigation into the circumstances surrounding the
death of a man at HMP Swaleside in April 2008**

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

March 2010

This is the report of an investigation into the circumstances of the death of a man, on 4 April 2008 at HMP Swaleside. I would like to extend my condolences to the man's family and friends and to all those touched by his death.

The man became unconscious just after the evening association period. He had taken a large quantity of MDMA (more commonly known as Ecstasy) immediately beforehand. When prison staff became aware of his condition, their reaction to the circumstances was swift and determined but ultimately unsuccessful. After resuscitation attempts at the prison, the man was taken to Medway Maritime Hospital where he died shortly afterwards. The post mortem confirmed that the man died of the toxic effects of a high dose of MDMA.

The investigation was led by an Investigator from my office. An independent review of the man's medical care in prison was commissioned from the Director of Prison Health at Eastern & Coastal Kent Primary Care Trust (PCT), and carried out by a Doctor from the local PCT. I am grateful for their assistance. I would also like to thank the management and staff at HMP Swaleside for their co-operation during the course of this investigation.

Kent Police conducted their own investigation into the circumstances surrounding the man's death and the Ombudsman's investigation was suspended during their enquiries. Kent Police gave authority to resume this investigation in October 2008 but the interval inevitably delayed the completion of this report.

I conclude that prison staff acted promptly and appropriately in their attempts to save the man. However, I make three recommendations. Two suggest raising awareness of and dealing with the impact of drug misuse and the third draws attention to the need to follow best practice in notifying families of a prisoner's death.

I am pleased that two of my recommendations have been fully accepted and the third partially accepted.

I commend the Officer in charge of A1 landing for her intervention and swift action when the man's plight came to her attention. She remained undeterred and fearless when a prisoner asked her to leave the man's cell and subsequently attempted to prevent her from re-entering.

Jane Webb
Acting Prisons and Probation Ombudsman

March 2010

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SUMMARY

The man, a prisoner at HMP Swaleside, died of MDMA (Ecstasy) poisoning on 4 April 2008. He had been remanded in custody in October 2002. He was convicted in September 2003 for importation and supply of drugs and firearms offences, although he maintained that he did not use drugs. He did not appeal against his conviction or sentence and his release date would have been 12 May 2008.

The man moved around a number of prisons. His relationship with staff was often challenging, mostly linked to his possession and use of illicit mobile telephones. He transferred to Swaleside in July 2007, where his father was also a prisoner, and settled well. He appeared to abide by the local regime and staff thought he was progressing. However, by early 2008, he was again found in possession of forbidden items and also appeared to be associated with the prison drug sub-culture.

On the evening of 4 April 2008, a landing officer locking up cells intercepted a prisoner carrying the man draped across his shoulders. She realised that he was unwell and called for medical assistance. Healthcare centre staff quickly arrived and soon realised that the man was seriously ill, probably from misuse of drugs. This was quickly confirmed by other prisoners and the drug concerned was said to be MDMA. An emergency ambulance was called and efforts were made to stabilise the man by healthcare staff both before and after the arrival of ambulance service staff.

Ambulance staff decided to take the man to Medway Maritime Hospital but he suffered a cardiac arrest in the rear of the ambulance before it left the prison. The paramedics tried to stabilise the man and were able to continue the journey only after a member of the healthcare staff, a nurse trained in accident and emergency medicine, volunteered to go with them. The nurse and one of the escorting prison officers continued cardio pulmonary resuscitation throughout the journey, assisting the paramedic in the back of the ambulance. When they arrived at the hospital, the man was certified dead at 9.45pm by a hospital doctor.

The Swaleside death in custody contingency plan was activated. However, as the man's father was also a resident at Swaleside, notifying the family was complicated and his father was told first although his mother was his nominated next of kin. His partner had also been told by a prisoner using an illicit mobile telephone that he had been admitted to hospital. The man's mother first learned of her son's illness from another source before the prison was able to contact her officially about his condition. Both his mother and partner telephoned Swaleside at different times during the evening and the news of the man's death was confirmed to his mother at about 10.45pm when she telephoned the prison. A post mortem was performed on 8 April and toxicological tests later revealed that the man died of MDMA poisoning.

A memorial service was held at Swaleside on 16 April, attended by the man's family, friends and prison staff. His funeral took place 22 April and was attended by his father, the Governor and two staff representatives. Swaleside made a contribution to the cost.

Kent Police carried out an extensive investigation into the man's death which was in part responsible for the delay in the publication of this report.

The clinical reviewer concluded that the man had no mental or physical ailments, and died from the toxic effects of MDMA. The reviewer judges that staff acted appropriately in responding to the emergency. I make three recommendations, two relating to awareness and handling of drug misuse and the other about notifying next of kin.

THE INVESTIGATION PROCESS

1. The investigator visited HMP Swaleside on 16 April 2008. He was given a full briefing about the circumstances surrounding the man's death by the Liaison Governor. The Investigator also met a representative of the Prison Officers' Association and was able to speak to the Chairperson of the Independent Monitoring Board.
2. Invitations were extended to staff and prisoners, inviting anyone who might have information relating to the man to make themselves known to the investigator. One prisoner took up the invitation and was interviewed at HMP Gartree. The investigator also met relevant prison staff, including members of the healthcare department.
3. One of the Family Liaison team from my office contacted the man's parents and partner to tell them about this investigation and to offer the opportunity to raise any concerns or questions that they wish to be addressed. The Family Liaison Officer and the Investigator subsequently met the man's mother and partner at his partner's home on 22 May 2008. His partner and mother raised a number of issues:
 - Could a head injury the man sustained during a search of his cell at Whitemoor prison about seven months previously have contributed to his death?
 - What was the cause and exact time of the man's death?
 - Did the staff that attended to the man know how to respond to and treat a possible drug overdose?
 - Why was the man's mother, as his listed next of kin, not notified directly by the prison of her son's death?

These issues are addressed on pages 25 – 27 of my report. I hope the findings of my investigation help the man's family better understand the events leading to his death.

4. Swaleside provided copies of the man's prison and medical records. The Deputy Director of Public Health, Eastern and Coastal Kent Primary Health Trust, was commissioned to provide a clinical review and a Doctor from the local PCT was appointed to undertake the review.
5. The investigator was made aware of the complexities of the police investigation at the outset of this case and, whilst their enquiries took place, this investigation was suspended. The Investigator initially found it difficult to gain information from the police. However, after reminding Kent Police of the Memorandum of Understanding between the Association of Chief Police Officers (ACPO) and the Prisons and Probation Ombudsman, the Police Liaison Officer at the Sheppey cluster of prisons, advised him on 24 September that there was no longer any police objection to the Ombudsman's investigation resuming.

6. The Investigator contacted the investigating officer, for access to witness statements. This was agreed and the Investigator confirmed the request in writing on 5 October. After a number of progress checks, he was told on 22 April 2009 that the statements were with the Coroner's Officer. The Investigator contacted the Mid Kent Coroner's Officer on the same day, who confirmed that she had no such statements. On 13 May, she telephoned the Investigator to tell him that the investigating officer had said that no witness statements were taken from prisoners as they had declined to be interviewed.
7. Following the issue of the draft report on 25 September 2009 to interested parties a delay was experienced due to family requests for extra time to formulate responses. Difficulties were also experienced in securing delivery of the report to some recipients and eliciting subsequent responses from them. These and other delays have led to a late publication of this report which I regret.
8. An Inquest into the death of the man took place on 10 January 2013 and a verdict of accidental death resulting from the willing ingestion of MDMA was returned.

HMP SWALESIDE

9. HMP Swaleside is a category B training prison built in the late 1980's, holding sentenced adult male prisoners serving over four years. This type of prison provides opportunities for education and work on offending behaviour for prisoners for whom the highest security conditions are not necessary, but for who escape needs to be made very difficult. In April 2008, it had an operational capacity of 778 of whom 460 were life sentenced prisoners in the first and second stages of their sentence.
10. Healthcare at Swaleside is provided by the Eastern & Coastal Kent Primary Care Trust. Daily medical services are delivered by a primary care doctor and three nursing staff. At night, there is one qualified nurse on duty with access to a doctor through the local Medoc service. The clinical staff are all appropriately qualified. Sudden illnesses and treatments are managed by clinical staff.
11. The HM Chief Inspector of Prisons, made a full inspection of Swaleside between 31 March and 4 April 2008, the day the man died. Of relevance to this investigation, she wrote in her report:

“In our survey, 41% of respondents said that it was easy to get illegal drugs at Swaleside, significantly worse than the comparator of 28%. Security arrangements regarding the management of drugs appeared appropriate. In the six months before the inspection, there had been 50 drug finds, although many of these were very small. Hooch and alcohol related finds were low (nine), as were finds of drug-related paraphernalia (10). The prison had two drug dogs, one passive and one active, along with access to the area resource of a mobile telephone detecting dog.”
12. 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. Each Board produces an annual report for the Secretary of State. At the time of the man's death, the IMB report from Swaleside covered the period between 1 May 2007 and 30 April 2008. The Board drew attention to the availability of drugs and mobile telephones within the prison and the attendant debt problems they bring. They also reported that the number of Family Liaison Officers at Swaleside had reduced from three to one.
13. There were ten deaths in custody at HMP Swaleside between June 2004, when the Ombudsman was given responsibility for investigating deaths in custody, and the date of the man's death. Eight were from natural causes and the remaining two were as a result of self-inflicted injuries. None appear to be similar to the man's death.

KEY EVENTS LEADING UP TO 4 APRIL 2008

14. The man was remanded in custody on 19 October 2002 and spent time on remand at both HMP High Down and HMP Belmarsh. He was a provisional category A prisoner (a high security prisoner whose escape would be dangerous to the public). However on 4 August he was classified by the Prison Service as a category B prisoner (prisoners for whom the highest security conditions are not necessary but for whom escape must be made very difficult). The man was convicted on 8 September 2003 for the importation and supply of drugs and firearms offences. He was sentenced to eight years imprisonment on 24 October 2003 and transferred to HMP Swaleside on 27 November.
15. The man was fit and well when he first entered prison. His health screen for that time records that he had no drug or alcohol problems but smoked a few cigarettes daily. He had no mental health issues and was not at risk of harming himself.
16. Whilst at High Down in November 2002, the man asked for a consultation with a psychologist for emotional problems related to the loss of family and friends. He was assessed in January 2003 by a psychiatric worker, with whom he discussed his problems and appears to have resolved them. He often declined to see doctors or attend medical appointments during those years. During the following four years as his sentence progressed, the man transferred to a number of prisons where, apart from normal minor ailments and injuries caused by accident or fighting, he remained fit and well.
17. Records show that the man was held in the segregation unit at Dovegate from 31 August 2006 for persistent inappropriate behaviour towards female staff. During exercise in the segregation unit on 6 September, he told the Duty Chaplain that he might harm himself if he was transferred further north away from his family. An Assessment, Care in Custody and Teamwork (ACCT) document was immediately opened. (This procedure is used to assess, observe and support prisoners who are considered at risk of harming themselves. It highlights the problems and possible trigger points and delivers a multidisciplinary plan to give support through a period of crisis).
18. At the ACCT assessment interview later that day, he said that he was joking and regretted saying that he would harm himself, but remained opposed to moving further north. He was adamant that he had no intention of harming himself. The ACCT document remained open until the following day when it was closed by mutual agreement at the first review. The man's care map (a grid of current issues concerning the prisoner identified in an ACCT document, the goals to resolve those issues and actions required to achieve them) was updated and identified that attempts would be made to transfer him to Swaleside where his father was also serving a sentence. A post closure review was held on 14 September to confirm that the man had no intent to self-harm. He was refused parole on 26 September and remained in the segregation unit until 27 September when he transferred to HMP Rye Hill. He

was recorded as fit and well on reception and told staff that he had no thoughts of self-harm.

19. Nine weeks later, on 8 January 2007, the man transferred to HMP Whitemoor. On reception a registered nurse again recorded that he was generally fit and well with no medical or mental healthcare issues, and had no thoughts of self-harm or suicide. On 10 January, as part of his induction process, the man saw the prison doctor who noted that he was taking no medication and had no outstanding medical or mental problems. He completed the Whitemoor induction process.
20. On 13 March, the man was detained in the segregation unit for 14 days. He was offered an interview with a psychologist on 21 March but refused as he felt alright. His time at Whitemoor, in common with the earlier part of his sentence, is characterised by frequent disciplinary offences and periods of cellular confinement. The offences mainly involved illegally obtaining and using banned articles, principally mobile telephones, to contact his associates, family and others. Staff suspected him of secreting them in his rectum, (known as plugging), and he was frequently searched, causing friction between him and staff members. This resulted in the man threatening staff or trying to manipulate them in his favour.
21. The man was released from segregation on 26 March but within a few days was returned for refusing to sit on a Body Orifice Scanner (BOS) chair (a device to detect foreign objects hidden within body orifices). He consistently refused to sit on the chair, was challenging towards staff and expressed an intention to stay in the segregation unit until he was transferred from Whitemoor.
22. While located in the segregation unit, the man attended a risk assessment management board to review his position on 23 April. He told the board members that he did not expect to gain parole and would be leaving prison on his non parole release date on 12 May 2008. He said that he knew what to do to stay out of prison and said that courses would not help him. He had not completed any offending behaviour work and saw little reason to do so. He was however willing to undertake enhanced thinking skill (ETS) courses at Whitemoor to avoid having to do one in the community on his release. The man requested a reduction in his security category from B to C (prisoners who cannot be trusted in open prison conditions but who would not have the ability or resources to make a determined escape). This was not granted. The board advised him to undertake some re-offending behaviour work and, after a sustained period of positive behaviour, the decision would be reconsidered. In the meantime, he was to remain in the high security estate.
23. While the man was still located in the segregation unit, on 26 April, staff asked him to sit on a BOS chair in an attempt to detect a mobile 'phone. He initially refused, claiming that he had a bullet lodged in his right buttock which would give a positive indication. When he eventually complied, the scanner gave a strong indication that a foreign object was concealed in his body. A mobile telephone battery was later discovered outside the segregation unit near his

- cell. The man was told that, as a result of this incident, he would be the subject of closed visits. (This is a visit at which the prisoner and visitor are separated by a glass screen to prevent physical contact between them. They might be subject to a period of closed visits because of suspected, attempted or actual smuggling of banned items.) He consented on 1 May to an x-ray which showed no foreign body, either a bullet or a telephone in his pelvic area.
24. The man completed a formal complaint form on 1 May, alleging that he was being victimised and bullied by dedicated search team and segregation unit staff. The complaint was investigated and a reply given to him on 8 May. He completed an appeal against the response to the complaint on 12 June making further allegations including sexual assault. A response to the appeal was given on 18 June, informing him that the formal complaint procedure was inappropriate in this instance and he should take the matter up with the Governor.
 25. The man made a further formal complaint on 13 June about an individual member of staff, again alleging sexual assault. The Prison Police Liaison Officer, responded on 18 June. He explained the local protocol between police and prison in such cases and advised the man to make a complaint to the Governor. (Whitemoor was unable to provide information regarding the resolution of this complaint and no reference to the outcome is evident in his prison record, although it is recorded that he made further enquiries about contact with the police a few days later.)
 26. As a result of information received that a mobile telephone was in his possession, the man was returned to the segregation unit on 11 June. A search of him and his cell was authorised using a Control and Restraint (C&R) Team because of his non compliant and threatening behaviour. (C&R is the approved method of restraining violent prisoners.) At the start of the search, prison staff told him to remain still. As they approached him, he made a sudden movement and the C&R Team moved to restrain him using a protective shield to do so. The Prison Doctor, was present throughout the process. He noted in the Continuous Clinical Record that, following the restraint, the man complained of facial injuries and said that he had been assaulted. The doctor examined him and noted that he found abrasions on his forehead as well as his right arm and forearm. He also recorded that the man wanted photographs to be taken and wanted to involve the police. The doctor informed the Duty Governor of those requests.
 27. A Officer, who was also present during the incident, recorded on a Report of Injury to Inmate form that he saw a small abrasion to the man's face. Security reports at the time indicate that the man and his associates intended to disrupt the running of the unit. The man's associates contacted his family so that they would report the allegations to solicitors and police in an attempt raise pressure on Whitemoor to get him transferred to another prison. The man's partner, mother and the police telephoned the segregation unit the following day. On 15 June, the man spoke to his family and legal representatives on the telephone.

28. The man remained in the segregation unit and was seen every day by healthcare staff, which is a requirement of the segregation procedures. On 26 June at 4.30pm, a Nurse assessed him as fit for segregation. Just before midnight the same day, he told a member of the night staff that he could not cope with closed visits and being in the segregation unit, and felt suicidal. An ACCT document was opened and he was visited five times hourly during the remainder of that night. The following morning at 8.15am, he was assessed by the prison doctor, who again found him fit for cellular confinement. The man was monitored throughout the morning and his frequent complaints of intimidation by staff were noted in the ACCT ongoing record.
29. At 12.15pm, the man took part in an ACCT assessment interview with medical and unit managers where he told them that he was feeling depressed because he was located in the segregation unit for refusing to sit on the BOS chair. However, he said that he would not harm himself and would co-operate with staff. At 2.45pm, he complained that police had not yet been to see him. Two hours later at 4.45pm, after an interview with the man, the ACCT document was closed by agreement between him and his unit manager, in consultation with nursing staff.
30. On 28 June, during his round of the segregation unit, the man asked the Duty Governor when police would be interviewing him. The governor undertook to find out and, his record shows that at lunch time on 29 June, he had an opportunity to present his allegations of assault to police.
31. The man remained in the segregation unit until 11 July and continued to present challenging behaviour to the staff dealing with him. Segregation safety assessment algorithms were regularly completed by medical staff to ensure that he was medically and mentally fit for his continued detention in the unit.
32. The man transferred to Swaleside on 11 July where on reception he was recorded as being fit and well. He was initially located in E wing and, on 15 July, moved to D wing. He settled well and was allowed visits with his father who lived on C wing. On 1 August, the man agreed to be assessed for courses aimed at reducing offending behaviour. He asked not to be considered for parole and signed a document to this effect.
33. Staff consistently reported that the man complied with the wing regime and did not present any problems. He spoke to a Listener (prisoners trained by the Samaritans to provide confidential emotional support to other prisoners in distress) during mid-September. In October, the man intervened to calm down a fellow prisoner during a tense situation which was specifically commented upon by staff in his Record of Events. However, his own behaviour began to deteriorate in mid-November when he received warnings about his actions and attitude towards staff. The man reverted to a much more polite and compliant disposition. On 30 November, information was found during a cell search that implicated him in the illicit use of mobile telephones and association with the prison drug culture. He applied for the

restoration of 38 days which were added to his sentence as a result of disciplinary procedures on 10 December. (His request was later rejected.) The man successfully applied on 27 December for a transfer to A wing. He occupied cell 1-18 (A1-18) and, because he knew a number of the other prisoners on the wing, settled quickly.

34. On 19 January 2008, the man was subject to a disciplinary charge for being in possession of a mobile telephone charger and denying prison staff access to his cell. He was also found, a week later, in possession of a television set (not his own) for which he was also warned. He was further warned on other occasions about his non-compliance with prison rules. On 28 January, he complained of flu like symptoms for which he was treated by healthcare staff with a flu pack of relevant medication to alleviate the symptoms. The man continued to receive warnings about his behaviour and disregard for prison rules during February and March.

4 April

35. During a routine cell fabric examination on 4 April, the man was revealed to have a quantity of plastic (cling film) and petroleum jelly. Both are commonly used to conceal illicit items. (Cell fabric checks are a daily procedure in which staff inspect the locks, bolts and bars and the fabric of cells for damage indicating preparation for an escape attempt or attempts to hide illicit items.) In the late afternoon at around 4.45pm, a small wrap of what appeared to be class A drugs was found on the floor of a common area of the wing by a prisoner and handed to prison staff.
36. The man normally took full part in the daily association periods on A wing and did so on the evening of Friday 4 April. At interview, the A wing supervising staff said that nothing out of the ordinary happened during that evening. One member of staff, a Officer, did however remember that the general interaction between prisoners seemed livelier than normal. He also noticed that there were an unusually high number of prisoners congregating on A2 landing. He was unable to see an obvious reason for this. He saw the man there but his attention was not drawn to him specifically.
37. During the evening of 4 April, the Officer who is a trained first-aider and was in charge of A1 landing, working with another Officer. She was carrying the radio for the landing. The Officer in charge of A1 landing recalled nothing remarkable and normal interaction took place between staff and prisoners along the spurs and in the association room. At around 7.35pm, the Officer in charge of A1 landing announced, as is normal, to the prisoners that there were five minutes to go before lock up. This is a general signal to the prisoners to gather their property, get a drink and any other items they might need during the night.
38. Following a radio message from the Communications Room at 7.40pm, signalling the start of lock up, the Officer in charge of A1 landing started to lock landing 1 prisoners in their cells. She started locking up on the second spur, from cell 15 towards cell 20 with the other officer on an adjacent spur.

After completing that section, she crossed the spur to cell 21, closed that door and went towards cell 22. As she did so, a prisoner, came through the gate onto the spur with the man draped over his back with his arms over the prisoner's shoulders. The man's feet were dragging along the floor behind them. The Officer in charge of A1 landing met the prisoner outside the man's cell, A1-18. He went inside and she followed, after making the door bolt safe. There were four other prisoners there at the same time with the man. The prisoner that was carrying the man laid him on his back on the bed. One of the Prisoners and the Officer raised the man's feet using blankets and pillows. The prisoner that arrived with the man told the Officer to leave the cell at that point, but she refused.

39. The Officer in charge of A1 landing saw that the man's face and body were rigid and he appeared to be having a seizure. His arms and hands were rigid and white, he had foam at his mouth, his skin was hot to the touch and his eyes were not focussed. Another of the Prisoners in the room fetched a wet flannel, put it over the man's face and left the cell. The Officer also left the cell and went to the end of the spur to call for help. When she returned, the prisoner that was carrying the man initially tried to stop her re-entering, telling her that the man was alright. She ignored him, went into the cell and opened the window to get some cool air inside. She and the Prisoner that previously helped raise the mans feet loosened the man's clothing. The same Prisoner also took off and looked after the man's wrist watch. Another of the Prisoners with man joined them and all three tried to get a response by talking to the man.
40. The Senior Officer (SO), in charge of A wing, was on A2 landing. She heard the Officer in charge of A1 landing's initial shout for assistance and went immediately to cell A1-18. When she looked inside, she saw the man lying on the bed, which was on the right side positioned along the wall. His head was towards the rear of the cell. Two of the prisoners were still in the cell, with the Officer trying to comfort and reassure the man. The SO told, another A wing Officer, to contact the healthcare centre (HCC) to go to the cell. She, in turn, called to the Officer that had previously notice the men acting more lively than usual, who was standing on A2 landing, telling him to "get healthcare to the 1's immediately". He went to the nearest telephone and spoke to control room staff. They, in turn, informed the officer designated as "Hotel 1", who at Swaleside is the first point of contact in the event of a medical problem arising in the prison. The Officer later explained at interview with the investigator, that it was easier to speak directly to the control room staff because he did not know what was wrong, who was involved or the appropriate coded message for the medical emergency.
41. The Senior Healthcare Worker and Registered Mental Nurse (RMN), was on duty in the healthcare centre in-patients department on 4 April. He carried a radio and was "Hotel 1". The medical code system for communicating and identifying the seriousness of injuries sustained involves the use of code numbers one to four:
 - Code 1 = Not breathing / hanging

- Code 2 = Severe cuts / epileptic fits
 - Code 3 = Serious sports field injury
 - Code 4 = Non urgent
42. The Senior Healthcare Worker received a radio call from the communications officer, who recorded it at 7.42pm, asking him to attend an incident on A wing. (The Senior Healthcare Worker later incorrectly noted in his incident notebook as a telephone call). No details or identifying code number were used to categorise the severity of the incident. The Senior Healthcare Worker and the Senior Healthcare Officer left the inpatient department with the “Hotel1” response bag and quickly made their way to A wing. The response bag contained a small oxygen bottle, a blood pressure machine, a pulse oximeter, a blood sugar monitor and general minor injuries dressings and medical supplies.
 43. The Duty Governor heard the radio messages and went to the control room to monitor events. A Principal Officer (PO) was the orderly officer in operational charge of the prison and was asked at 7.52pm to go to A wing. A SO was working on C wing during that evening. The Orderly Officer and his assistant were handling separate incidents and needed someone to take over the orderly officer role while they were resolved. The SO handed over control of C wing to one of her staff and went to the operations room where the orderly officer temporarily handed his duties over to her.
 44. The healthcare staff, a Nurse and the Senior Healthcare Worker soon arrived at cell A1-18 and went inside. They asked the two prisoners present, if the man had taken any drugs but they were unable to provide any information. The SO in charge of A wing told the two prisoners to return to their own cells. They were reluctant to do so but complied. The Senior Healthcare Worker asked staff if they knew whether the man was epileptic or what he might have taken, but they too were unable to advise.
 45. The Senior Healthcare Worker tried to communicate with the man, but he was incoherent. He put a pulse oximeter on the man’s finger and saw that his blood oxygen saturation level (sats) was low and his pulse was erratic. He and the Nurse turned the man on his left side facing the wall to drain any fluid and keep his airway open. The Senior Healthcare Worker described the man as very hot to the touch. He gave oxygen and attempted unsuccessfully to measure the man’s blood pressure. He was unable to take a blood pressure reading because the man was in spasm and his body was rigid. They cut the front of the man’s tee shirt to expose his chest and cool him down. The Senior Healthcare Worker said at interview that the cell was very hot and the Officer who was in charge of A1 landing tried to cool the man with cold wet towels. The Orderly Officer had arrived on A wing and took charge of the incident.
 46. The Senior Healthcare Worker continued to try to get a response from the man and to take some clinical observations such as his pulse and temperature to assess his condition. He realised that the seizure was taking a long time to ease and it was apparent to him that the man’s condition might be

drug induced. In the meantime, the Nurse went to the nearest telephone and called a fellow Nurse a health care worker on duty in the healthcare centre. He told him to look at the man's medical record for evidence of epilepsy or any other indications that might help treat him. The fellow Nurse confirmed that there was no relevant history in the records. The man was apparently a fit young man who was not prescribed any medication. The Nurse went back to the cell where they briefly discussed the facts as they knew them and decided to call an emergency ambulance to take him to hospital. The SO in charge of A wing immediately sent an urgent radio message to the communications room at 7.55pm to call an emergency ambulance. Communications Room staff made the telephone call immediately on receipt of the radio message.

47. Whilst healthcare staff were working with the man, the SO in charge of A wing went up onto A2 where she and other staff spoke to the man's friends and associates asking if they knew what he might have taken. They were unable to help. The Prisoner that helped raise the man's feet said that the man had been "partying" but gave no information to further questions. The SO left A2 and, on the way down to A1, was told by the Officer that was also on A1 wing at the time that a prisoner wanted to see her (the prisoner that was originally found carrying the man). She went to his cell, A2-19, and spoke to him through the door. He passed a piece of paper out of a gap between the door hinges and the frame on which was written the initials MDMA. The SO in charge of A wing rushed the note down to the healthcare staff in cell A1-18. The Nurse that arrived on the scene told the investigator that neither he nor the Senior Healthcare Worker had treated patients who had used that drug, and they asked for more equipment from the Nurse they contacted in the Healthcare centre in the healthcare centre. They also asked the Orderly Officer, to pass the new information to the ambulance service, which was done at 8.05pm.
48. MDMA (methylenedioxyamphetamin), commonly known as Ecstasy, is classified as a class A drug. Medical texts suggest it produces feelings of increased energy, euphoria, emotional warmth, and distortions in time perception. In high doses, MDMA can interfere with the body's ability to regulate temperature which can lead to a sharp increase in body temperature and can result in liver, kidney, and cardiovascular system failure, and death. Repeated doses within a short period of time can be harmful.
49. During that period, there was a lot of noise from prisoners in their cells who were shouting to each other and activating their cell call bells as they wanted to know what was going on. The officer who was on A1 landing, who was late patrol duty, spoke to a prisoner in cell A3-35. He said that he could not believe that no-one else was co-operating with the staff. He disclosed that the man had taken up to two grams of MDMA. The Officer immediately relayed the information to the SO in charge of A wing. She, in turn, told him to telephone the assistant orderly officer in the Operations Room to pass on this information.
50. A short time later the Nurse that they contacted in Healthcare arrived at the cell from the healthcare centre with an oxygen bottle on a trolley and a

defibrillator. The Nurse that attended to the man at the scene sent him back to collect more equipment to set up intravenous access to the man's bloodstream.

51. The Nurse that was initially on the scene attached the defibrillator pads to the man's chest and allowed the machine to run automatically. It found no shockable rhythm (a shockable rhythm is the rapid and chaotic beating of the many individual muscle fibres of the heart, known as fibrillation, to which the defibrillator administers an electric shock in an attempt to normalise the rhythm) and was left in place for use as a heart monitor. The Senior Healthcare Worker replaced the oxygen cylinder after which the man's sats showed a marked improvement. The healthcare staff turned the man on his right side to clear his airway of fluid, pushed an artificial airway into his mouth to support his breathing and rolled him onto his back again.
52. The second Nurse arrived back at the cell (by his own estimate ten minutes elapsed between leaving A wing and returning with the equipment). After a brief discussion with his colleagues, they decided that they should introduce one litre of five per cent saline solution into the man to support his system. The same Nurse, who had up to date training on this aspect of medical care, inserted a fine tube into the man via a vein in his right forearm in readiness for use by ambulance staff. They then attached the saline drip and hung the bag of saline solution from the picture board above the bed. The man remained very hot to the touch and healthcare staff continued to use a tepid sponging technique in an attempt to reduce his temperature. The Officer in charge of A1 landing remained in the cell trying to comfort the man.
53. At 8.17pm, a local ambulance service paramedic and ambulance technician arrived in an ambulance and were taken immediately to A wing. The Nurse first on the scene gave a verbal handover to the ambulance personnel who took over the man's care with the assistance of the healthcare staff. The ambulance staff changed the oxygen cylinder for one of their own and removed the Prison Service defibrillator, replacing it with one of their own. One of the ambulance crew members attempted a further defibrillation cycle but again found no shockable rhythm. The ambulance staff decided to transfer the man to hospital.
54. The Nurse first on the scene and the Senior Healthcare Worker and the ambulance crew transferred the man from his bed onto a wheeled stretcher. He was taken to the ambulance where the Nurse gave a written handover document to the crew. The ambulance left the wing for the hospital at 8.48pm with the Officer that contacted healthcare and another Officer as the escorting officers. A Officer was a walking escort opening access gates as necessary en route to the main gate. The Nurse initially on the scene and the other healthcare staff collected their equipment from the man's cell and went back to the healthcare centre where they replenished the response bag and wrote up notes in the man's medical record. The cell was secured by a Officer, on the Duty Governor's instructions, in the event of later police enquiries.

55. Following the man's departure from the wing, the Orderly Officer, who is also Swaleside's Family Liaison Officer, and a Governor (who were aware that the man's father was resident on C wing) decided that the Orderly Officer would tell the man's father of the events involving his son. The Orderly Officer was told that the man's partner had telephoned the prison. She had already been contacted by another prisoner and told that her partner had been taken to hospital. The Orderly Officer went to C wing where he saw the man's father in his office. He told him that his son had been taken to hospital and that it was likely that he had taken drugs. The man's father disagreed and expressed the opinion that his son did not take drugs. During that interview, the man's partner telephoned and the Orderly Officer told her what he knew. She was very upset. The man's father returned to his cell after the call.
56. At about 8.50pm shortly after leaving A wing and just before leaving the prison, the paramedic told the driver to stop because the man had gone into cardiac arrest. The Officers escorting the man got out and the driver got into the back. The paramedic used a heart monitoring machine and his colleague started chest compressions. A radio message was sent to the communications room to notify them of the situation.
57. The Duty Governor advised the Governor, of the developing situation, and at 9.05pm, he told the duty Independent Monitoring Board (IMB) member. He also left a message for a Senior Officer who was a member of the Care Team, (that trained to support staff during times of stress) who called back later and was briefed by him.
58. A Officer and a SO had prepared the Prison Escort Record (PER) and collected the necessary escorting documents and equipment. (The PER is a form that accompanies all prisoners being escorted to and from prison. It provides a chronological record of the escort, e.g. meals served, times journey started. It also serves as a communication tool about any risks a prisoner poses on escort or transfer.) Once the escort pack was complete she took it to the main gate for collection by the escort before the ambulance and escorting staff left the prison. She was aware from the radio messages that the ambulance had stopped within the prison because the man's condition had deteriorated. She and the SO left the gate lodge and went to the ambulance to offer help. They joined the escorting officers at the back of the ambulance where the doors were open. The crew members were administering cardio pulmonary resuscitation (CPR) to the man.
59. At about 8.50pm, the Senior Healthcare Officer, the Senior Healthcare Worker and the second Nurse to arrive on the scene's shift had finished and they handed over the healthcare centre to the night staff. They left healthcare to go to the main gate past the kitchen and into the main gate sterile area. As they did so, they saw that the ambulance was stationary by the prison workshops. They went directly to the ambulance where the technician was performing chest compressions and attempts were being made to stabilise the man's condition. They offered assistance and initially the crew declined. However as the Nurse had previous experience as an accident and emergency nurse he joined the ambulance crew and took over chest

compressions. The ambulance driver was then free to continue out of the prison and on to hospital. The escorting Officers and the Nurse were in the rear of the ambulance when it left the prison at 9.15pm. The Senior Healthcare Officer and the Senior Healthcare Worker went to the operations room, before leaving the prison at 9.30pm.

60. At the request of Night Orderly Officer at about 9.00pm the So in charge of A wing split the duty staff into teams of two who went to all the cells on A wing to talk to the prisoners in an attempt to find out if any of them had also taken the drug and whether they needed help. Together with the Night Orderly Officer and another Officer, she went to the prisoner that was found carrying the man's cell. He said that he had not known anyone to have taken so much of the drug and did not admit to having taken any himself. They also spoke to another of the prisoners that was there at the time who was upset and emotional about the man's serious condition and confirmed that he had not taken any of the drug.
61. The Officer in charge of the security aspect of the escort, and was one of the escorting officers confirmed at interview with the investigator that, because the man was in no condition to pose a threat no handcuffs were used.
62. During the journey to Medway Maritime Hospital the man was connected to the on board ventilator to assist his breathing. The second Nurse on the scene and the Officer in charge of the security of the escort alternated in performing chest compressions while the paramedic administered medication through the intravenous line and monitored his condition. They continued until the ambulance arrived at the hospital at about 9.35pm. On instruction from the paramedic, the Officer continued performing chest compressions in the A&E Department. The ambulance crew gave the hospital staff a handover and confirmed to the doctor that CPR had been performed for about 45 minutes. The man was declared dead by the duty doctor at 9.45pm.

After the man's death

63. Immediately after confirmation of the man's death, the Officer in charge of the security aspect of the escort notified the prison and the contingency plan for a death in custody was implemented. (All prisons are required to have a contingency plan in place specifying various actions to be taken following a death in custody.) The prison told the duty IMB member who decided to visit the prison early the next day. Duty Governor instructed that all prisoners living in the area of the man's cell and any identified friends in the prison should be informed of his death. He also ordered that any prisoners at Swaleside with an open ACCT document were to be seen and spoken to immediately.
64. The Duty Governor debriefed all the staff members before they went off duty. He concluded the debriefings by offering his and the Care Team's support and transport home for those who needed it. The debriefings were spread over several hours as staff finished their shifts at various times during the evening due to the course of events surrounding the man's death.

65. Prison Service Order 2710 Follow up to deaths in custody gives instructions on action to be taken following a death in custody. It includes immediate actions required, staff and prisoner needs and supplementary guidance outlines best practice in notifying next of kin and families.
66. On receiving the news of the death the Orderly Officer went to tell the man's father just after 9.45pm and also intended to contact his partner. The man's father was badly affected and asked the Orderly Officer to break the news to his son's partner. He returned to his cell and was comforted by a prisoner friend who remained with him in his cell for a short while. He refused the services of a Listener but was placed on an open ACCT document as a precaution. The Orderly Officer telephoned the man's partner to break the news of his death to her. She was extremely upset and ended the call suddenly by hanging up. She rang back at 10.05pm in a very distressed state, asking about the whereabouts of her partner and that information was given to her.
67. At about 10.45pm, the Orderly Officer took a telephone call from the man's mother who had been told of the death by a friend of her son's. The Orderly Officer explained what he knew, told her where the man had been taken and gave the hospital's contact number. He arranged to call her again the following day with as much information as he could gather and gave his own contact details.
68. Three officers from Kent Police visited Swaleside at 12.40am on 5 April and left the prison at 1.24am. At around 8.40am, a full staff briefing took place to explain what happened the previous night and the support available for them and any prisoner affected by events. The Duty IMB member was briefed at about the same time. One of the officers who had gone in the ambulance was affected by the events. He went off duty and later received counselling facilitated by the prison.
69. In the late morning of 5 April, the Officer in charge of A1 landing and the SO in charge of A wing were told by a prisoner on A wing, that the man had taken two and a half grams of MDMA the previous evening. He had first taken some at around 5.00pm and the rest later in the evening. He also said that, about an hour before lock up, he had been asked to look at the man because he was hyperventilating. He did so, but would not name the person who had asked. The Prisoner said that the man responded to the other prisoners at that time. The next time he saw the man was when he was being taken back to A1 landing. Soon after speaking to prison staff the prisoner passed what he described as a small sample of the drug to the Officer in charge of A1 landing. It was sent to the prison Security Department for analysis.
70. At 11.40am, the Orderly Officer spoke to the man's mother and arranged for her to speak on the telephone to the man's father. In a telephone conversation with her at 12.20pm, the Orderly Officer discussed the next steps regarding the funeral, the coroner's role and arranged to meet her and other members of the family. She felt unable to travel to Swaleside and asked

for the meeting to take place at her home. She told the Orderly Officer that she would let him know on Monday 7 April when she would be able to see him. He sent the prison's booklet "Information and Advice for Bereaved Families", to help explain the process and the roles of the people involved in a death in prison.

71. The following day, 6 April, the Orderly Officer arranged for the man's father to visit A wing to speak to his son's friends and collect his watch that one of them had held for safekeeping. The Orderly Officer again spoke to the man's mother and arranged for her and other family members to visit Swaleside.
72. The family visit took place the following day, 7 April, between 12.00 midday and 3.00pm. The family were met by the Orderly Officer and taken to the cell. A short religious service was held at the door, led by the Father. Afterwards, the family met the man's father in the chapel to discuss the funeral arrangements. The Governor met with them to give his condolences and sympathy cards. He offered assistance with the funeral expenses. The family asked if the man's father could be present at the house from which the funeral would start and invited the Governor and the Orderly Officer to be present.
73. A post mortem examination took place on 8 April at Medway Maritime Hospital and, after further toxicological testing on 23 October, the pathologist, concluded that the man died from MDMA poisoning. (I received his report on 28 February 2009.)
74. Swaleside held a memorial service for the man at their chapel on the afternoon of 16 April. Five members of the man's family attended, along with many of his friends and staff members who knew him. The family met and spoke with them after the service. The man's funeral took place in London on 22 April and was attended by the Governor, the Orderly Officer and one of the escorting officers. The man's father was there escorted by prison officers. Swaleside made a contribution to the cost of the funeral.
75. Kent Police conducted an extensive investigation into the man's death. The Detective Sergeant advised the investigator on 1 October 2008 that the investigation had concluded and there were no objections to the Ombudsman's investigation commencing. The Police provided copies of prison staff notebooks but there were no witness statements from any of the prisoners as they declined to be interviewed.
76. As the prison's Family Liaison Officer maintained a supportive role to the man's mother and partner for many months following his death. Both the man's mother and partner spoke positively to the Ombudsman's Family Liaison Officer about the support and help they had received from Swaleside and, in particular from the Prison's Family Liaison Officer. The man's mother's main concern after the funeral was the return of her son's property. The Police agreed to release it on 7 October and the Prison's Family Liaison Officer arranged with the man's mother for it to be collected a week later.

ISSUES CONSIDERED DURING THE INVESTIGATION

Use of illicit drugs

77. When the man was received into prison, his initial health screen records that he had no drug related history. He maintained throughout his sentence, and his family have supported the view, that he did not take drugs. He had, however, been convicted of the large scale importation of drugs and maintained close associations with other prisoners who were known to be involved in the prison drug subculture. Items commonly connected with the use of drugs had previously been found during searches of his cell, although insufficient evidence was available to charge him with a disciplinary offence. In the light of this background, I judge that although the man might not have used drugs on a regular basis, he was not unfamiliar with them and was likely to be aware of their effects.
78. On 8 April, following the man's death Swaleside staff contacted all the prisons where he had been previously held and asked for the results of any drug tests. Records kept by those prisons, including three tests performed during 2004 at Swaleside, show that he had been tested at reception or randomly on six occasions. The results of all the tests were negative.
79. On the evening of 4 April, after staff found the man was unwell, but before he had been taken to hospital, one of the man's friends said that he had been 'partying'. Soon after that, information came from another prisoner who handed over a piece of paper with the initials MDMA. After the man had gone to hospital, another prisoner told staff that he had not known anyone to have taken so much of the drug. Further confirmation was received on the following morning, again from a prisoner, that the man had taken up to a total of two and a half grams of MDMA during the evening. The prisoner gave a sample of the drug to prison staff. The same man told staff that he had been asked by other prisoners to look at the man an hour before lock up when he appeared unwell.
80. There is no evidence to suggest that the man was anything other than a young man who, within the last few weeks of a long sentence, voluntarily took a large, and ultimately fatal, dose of MDMA, the quality of which is unknown. The reasons for him taking the drug on this occasion are not known. During a conversation with staff from the Ombudsman's office, the man's mother speculated that he decided to act recklessly because he felt happy about his future. There is no evidence to suggest that the man was coerced into taking the drug or intended to harm himself or take his own life. His mother and partner both felt that he would have taken the drugs willingly and would not have been forced into doing so. It is a view I find persuasive.
81. The find of a small amount of drugs on the floor earlier in the day by a prisoner and the report by a landing officer that A wing was livelier than usual on the evening of 4 April may be linked. They might have been due to the presence of a substantial amount of the drug on the wing. It is not known how the drugs came to be on the wing, but both the IMB report for the year to April

2008 and the 2008 prison inspection report note that the availability of illicit drugs at Swaleside is high. The man's mother told the investigator that the man's father was worried about the wing where his son was placed as it was a renowned 'party/drugs wing'.

82. Part of the extensive police enquiry into the man's death focussed on the supply of drugs at Swaleside, but no prisoners were willing to co-operate. In any event, it is evident that the man had ready access to a substantial amount of the drug and took it. He is said to have taken the first dose early in the evening, at about 5.00pm, and then took several more doses relatively quickly, probably within the space of an hour and three quarters. He was described as 'partying' during that evening and was almost certainly accompanied by others. However, no other prisoners appeared to have been affected.
83. It is a tragedy that those who were aware of the man's condition did not attempt to bring the matter to the attention of prison staff any earlier. Had they done so, proper medical attention could have been provided as much as an hour earlier. Had the landing officer not seen the prisoner carrying the man back to his cell and intervened, it is likely he would have been left unattended in his cell. I believe that the amount of drugs he consumed and the delay calling for help were significant contributory factors in the loss of the man's life.
84. The Officer in charge of A1 landing acted very quickly. She remained undeterred when a prisoner asked her to leave the man's cell and then tried to stop her re-entering when she temporarily left the cell to summon help. I commend her actions.

The Governor should consider putting in place an education campaign for prisoners to highlight the dangers of using illicit drugs and emphasising the need to summon medical help in the case of misuse.

85. The post mortem toxicology report by the pathologist, records a "very high" concentration of MDMA in his blood which is likely to have caused severe toxic effects. The report also identifies a low concentration of morphine which, while it had no part in causing the man's death, indicates use of the drug many hours before his death. The pathologist concludes that the man's death was due to MDMA poisoning.

Medical treatment

86. The clinical review by a Doctor from the local Primary Care Trust (PCT) indicates that the man was fit and well with above average health. The doctor comments that he did not appear to misuse drugs either before or after coming into prison.
87. The Clinical Reviewer judges that the Officer in charge of A1 landing responded appropriately by assessing the man's condition and quickly calling for medical help. Healthcare staff responded equally quickly to the radio

message and reached the cell within a short time, taking an emergency response bag with them. A coded message was not used and so they were unaware of the circumstances. However, when they arrived, they assessed the man's condition and soon realised that what appeared to be an apparent seizure, might have been drug induced. They promptly decided to call an emergency ambulance to take him to hospital.

88. After the ambulance had been called, healthcare staff were told that the man had taken MDMA. They were not experienced in treating patients adversely affected by the use of that particular drug. The second Nurse on scene brought a second oxygen bottle, a defibrillator and equipment for gaining intravenous access to the man. They also passed the information about the drug to the ambulance service that arrived at the prison some ten minutes later.

The Head of Healthcare should offer staff regular refresher courses in the recognition of the signs of drug use as well as treatment of frequently abused drugs.

89. With the assistance of healthcare staff, the ambulance crew took control and worked on the man. Once stabilised, he was transferred to the ambulance but before it left the prison, the man suffered a cardiac arrest. The ambulance left Swaleside with a paramedic working on the man and the Officer in charge of security for the escort and the second Nurse on the scene alternately performing CPR on him. On arrival at the hospital he was declared dead by a hospital doctor.
90. The Clinical Reviewer observes in his report that when the man was seen by prison staff on the evening of 4 April he was already at the point of death. He comments that the prison healthcare staff and ambulance crew responded entirely appropriately when presented with a seriously ill patient. They carried out all the appropriate measures to sustain the man's life and transfer him to hospital. It is worth remarking that the Officer in charge of security to do with the escort, although not medically trained, made sustained efforts with the second Nurse on scene to prolong the man's life through the administration of CPR.
91. The Clinical Reviewer recommends that all prison staff in regular contact with prisoners have appropriate first aid training in cardio-respiratory resuscitation and in managing overdoses of frequently used drugs whether legal or illicit. He goes on to say that there is no evidence to suggest that the officers did not have the necessary skills to deal with the man.
92. HM Inspector of Prisons noted in her 2008 report that, "All (healthcare) staff received annual updating in cardiopulmonary resuscitation training as part of the cluster training arrangements."

Family concerns

93. The Family Liaison Officer from my Office, and the Investigator, met the man's mother and his partner on 22 May 2008 at his partner's home. During the interview, they raised a number of issues relating to his death.
94. They were concerned that a head injury the man sustained during a search of him and his cell at Whitemoor prison about nine months before his death could have contributed to his death. His partner thought that he saw a doctor but did not receive any medical treatment for his injuries. The man's family made a complaint to the local police station about the alleged assault. They also sought advice from a solicitor and wrote a letter of complaint to Whitemoor prison. The family said that the man complained of headaches in the last few months of his life. They questioned, because of the appearance of his ear after death, whether the damage he had sustained during the incident could have resulted in a serious injury which had gone undiagnosed.
95. A Report of Injury to Inmate form was completed following the incident and it identified a small abrasion to the man's face. Due to the use of a C&R team, the Prison Doctor, was present throughout. He noted in the Continuous Clinical Record that the man complained of facial injuries and said that he had been assaulted. The doctor examined him and noted abrasions on his forehead, right arm and forearm but no treatment for his injuries was considered necessary.
96. In the two weeks following this incident, the man was given Ibuprofen on two occasions, 19 and 21 June, but no reason was recorded. He complained of pain in the right side of his neck on 24 June and pain relief was given. No specific complaint of headaches was recorded whilst he was at Whitemoor. As a segregated prisoner, he was seen every day by healthcare staff until his transfer to Swaleside on 11 July. The man's partner told the Ombudsman's investigator that he would not take paracetamol and had bluntly refused when she suggested it during the bout of headaches.
97. Following the man's death, a post mortem was carried out on 8 April by a Home Office pathologist, at Medway Maritime Hospital. No injury to the man's head or brain was noted, either new or historical. The report does mention hypostasis (the settlement of blood in the body by the action of gravity) which might be responsible for the discoloration of his ear. The examination found nothing abnormal to suggest any undiagnosed injury, or that the injuries he sustained at Whitemoor contributed to his death.
98. The man's mother and partner were also unsure about the cause and exact time of the man's death. The toxicology report suggests that ingestion of a large amount of MDMA in a short period of time is the most likely cause of death but that conclusion is a matter for the inquest. This report sets out the circumstances and the course of events that led to his death and the timings are as accurate as the evidence allows.

99. The man's mother also queried whether prison staff would have known how to respond to her son, once they were aware he had possibly taken an overdose of Ecstasy. She felt it was important that staff were trained to respond under these circumstances, particularly if these kinds of drugs are getting into prisons. His partner just wanted to know that everything was done to try and save him.
100. I have commented on these matters earlier in this report but reiterate that the prison officer first on the scene was a trained first-aider who assessed the situation and quickly summoned help from healthcare staff. The healthcare staff arrived quickly and, after observing and examining the man were aware that his condition might be due to drug use and called for an emergency ambulance. The Clinical Reviewer, concludes that the prison healthcare staff and ambulance crew responded entirely appropriately and took all appropriate measures to sustain the man's life. I entirely agree with Clinical Reviewer's views. There is no suggestion that the man's treatment suffered as a result of a lack of knowledge by those attending him.

Informing the man's next of kin

101. I am satisfied that the Duty Governor and Swaleside staff made their best efforts under difficult circumstances to comply with the requirements of the death in custody contingency plan for the breaking of such news to next of kin. However his nominated next of kin, his mother, was not contacted directly as the situation unfolded.
102. The circumstances were complicated by the fact that the man's father was also a prisoner at Swaleside who, whilst not his nominated next of kin, was in a position to receive the news quickly from other prisoners. He was in fact the first to be notified by the prison FLO of his son's transfer to hospital and subsequent death. It was further complicated as the man's partner, also not his nominated next of kin, was told by another prisoner on A wing (apparently using an illicit telephone) that he was being taken to hospital. She contacted Swaleside after his transfer to hospital and was informed of his death soon after 9.45pm.
103. It is understandable that the man's father was informed soon after his son's collapse was discovered by staff because of the likelihood of him hearing about it on the prison grapevine. It is unfortunate that his partner was made aware of his condition in a way which was outside of the prison's control.
104. The man's mother had already been told by a friend of her son's that he had been taken to hospital. She then arranged with her son's partner to travel to the hospital. She telephoned the Swaleside Family Liaison Officer at 10.45pm to ask for more information about his whereabouts and the Family Liaison Officer gave the available details. The man's mother is concerned that had she been told earlier she would have had more time to get to the hospital and possibly speak to her son.

105. It is regrettable that the man's mother was not contacted directly when her son became seriously ill and, subsequently, when he died. It should be viewed as a distressing and serious lapse. However I believe that, in this unusual and fast moving situation, prison staff made the best possible decisions.

The Governor should remind staff of the best practice guidance given in PSO 2710 Follow Up to Deaths In Custody (paragraph 3.3) and the Guidance Supplementary to Chapter 4 (paragraph 4.7) about the notification of death to next of kin and the requirement for this to be followed.

CONCLUSION

106. The man was a healthy young man of 23 years when he came into prison in October 2002 and he remained so, reporting only minor ailments throughout his sentence. He was serving a long sentence but was no stranger to prison and its environment. His behaviour was challenging throughout and centred on his frequent involvement with the acquisition and use of smuggled mobile telephones. He often faced disciplinary action as a consequence of it. He also kept close company with other prisoners known to be dealing in drugs.
107. The man suffered a facial injury while he was being restrained by staff at Whitemoor in June 2007. The post mortem confirms that there was no damage to his head, and there is no evidence to support his family's fears that the injuries played a part in his death.
108. The man was some six weeks away from release from prison when he seems to have voluntarily taken MDMA. There is no indication that he intended to harm himself. It appears from the evidence offered that the man had taken a lethal dose that would have required immediate medical attention if he was to survive. Although prison staff reacted properly and promptly when they knew that the man was unwell, he did not get any attention until too late and the outcome was inevitable. I judge that the medical attention he received on the evening of 4 April was at least comparable with that he would have received had the same event occurred in the community.
109. Following the man's death, I judge that the actions of staff at Swaleside towards his family were supportive and sympathetic. The Swaleside FLO, was particularly helpful and is to be commended for the informative content of the information leaflet he devised.
110. Kent Police conducted a long and apparently exhaustive investigation into the circumstances of the man's death. The outcome of their investigation has not been fully disclosed to me. It is regrettable that they were not helpful in facilitating my investigation. It was only after the investigator resorted to drawing their attention to the Memorandum of Understanding between the Association of Chief Police Officers and the Ombudsman's office that progress was made, albeit much delayed. I will send a copy of my report to the Chief Constable for his attention.

RECOMMENDATIONS

1. The Governor should consider putting in place an education campaign for prisoners to highlight the dangers of using illicit drugs and emphasising the need to summon medical help in the case of misuse.

Accepted by HMP Swaleside who commented:

“As part of the new Induction process all offenders are now provided with important information, this is given verbally and in writing explaining that if you use drugs and are feeling unwell after taking them then please speak with a member of staff who will seek medical assistance. The briefing also advises prisoners how to seek medical help/intervention during the periods of time where prisoners are locked in cells.”

This action was completed by 8 October 2009.

2. The Head of Healthcare should offer staff regular refresher courses in the recognition of the signs of drug use as well as treatment of frequently abused drugs.

Partially accepted by HMP Swaleside who commented:

“As part of the establishments Integrated Drug Treatment System 20% of staff are given a 2.5hr refresher training session covering available drug treatment programmes with includes recognition of the signs of drug use. This recommendation has been discussed with the Head of Healthcare and the CARATS (counselling, assessment, referral advice and treatment).”

This action was completed by 8 October 2009 and is to be part of a rolling programme.

3. The Governor should remind staff of the best practice guidance given in PSO 2710 Follow Up to Deaths in Custody (paragraph 3.3) and the Guidance Supplementary to Chapter 4 (paragraph 4.7) about the notification of death to next of kin and the requirement for this to be followed.

Accepted by HMP Swaleside who commented:

“Governors Notice to staff reminding staff has been issued.”

This action was completed by 8 October 2009.