

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in February
2013, while a prisoner at HMP Ford**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is the report of an investigation into the death of a man, who died in February 2013, while on temporary release from HMP Ford. A post-mortem examination indicated that he died of morphine poisoning combined with the effects of alcohol. I offer my condolences to his family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care in custody. HMP Ford cooperated fully with the investigation. There is a continuing police investigation into the circumstances of his death, focusing on events in the community, and our investigation is limited to the prison and the actions of prison staff.

The man had been released on temporary licence from Ford for resettlement purposes, usually referred to as home leave, when he was found dead in the street one morning in February. There had been no recorded problems on his previous periods of home leave. Just before his final home leave the prison had received uncorroborated intelligence that he might bring drugs back to the prison. The prison considered this was not sufficient to justify stopping his leave. There was no indication that he had used illegal drugs in prison.

The investigation found that the man, who suffered from epilepsy, received a good standard of care at Ford. Because his offences had involved alcohol he was advised about the risk of misusing drugs and alcohol but he declined more intensive specialist substance misuse support. Despite the sad outcome, I am satisfied that decisions to allow him to be released on temporary licence from prison were appropriate.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. The man had been in prison since June 2012. He was 31 years old and this was his first time in prison.
2. The man seemed to settle into prison life. He had epilepsy, but no other major health issues. In August, he was transferred to HMP Ford. He worked in the prison laundry and received positive reports about his work.
3. Ford is a category D open prison where, subject to risk assessments, prisoners approaching the end of their sentence can be released on temporary licence to help them to resettle into the community on release. The man had had previous periods of home leave and was released for a further period on Friday 8 February 2013. He was due to return to Ford on 12 February.
4. During the morning of Monday 11 February, the man's former partner informed the prison that he had died. The police confirmed that he had been found dead in the street a few days previously. The prison appointed a family liaison officer to contact and offer support to his family.
5. Sussex Police are conducting an investigation into the circumstances of the man's death and what happened in the community. We have completed our investigation based on his time and treatment in prison and decisions that HMP Ford made about him. We are satisfied that he received a good level of care at Ford and was appropriately allowed release on temporary licence.

THE INVESTIGATION PROCESS

6. This office was informed of the man's death on 11 February 2013. The investigator issued notices to staff and prisoners at HMP Ford informing them of the investigation and inviting anyone with relevant information to contact him. No one came forward.
7. The investigator obtained the man's prison and medical records. He visited the prison on 21 March 2013 and spoke to the Governor as well as other prison staff.
8. The local PCT commissioned a clinical reviewer to carry out a clinical review of the man's care and treatment in custody. The investigator liaised with the clinical reviewer and discussed his findings with him.
9. Sussex Police are conducting an investigation into the man's death. In line with our agreement with the police, we usually suspend the Ombudsman's investigation until the police have completed theirs. However, Sussex Police agreed that there was no objection to the Ombudsman's office completing our investigation as their enquiries are focused in the community and not the prison.
10. The investigator interviewed two members of prison staff. He also visited HMP Lewes to interview a prisoner who had shared accommodation with the man at Ford, and to speak to the prison family liaison officer. He gave preliminary feedback to the Governor of Ford during the investigation.
11. HM Coroner for Brighton and Hove was informed of this investigation and provided us with a copy of the post-mortem report. A copy of this report has been sent to the Coroner.
12. One of our family liaison officers contacted the man's mother to outline the purpose of the investigation and to give his family the opportunity to identify issues they wished the investigation to cover. She was positive about the support she had received from the prison family liaison officer. She was aware that the police were investigating the circumstances of her son's death, but she had no concerns about his time in prison. She made no comments in response to the draft report.

HMP FORD

13. HMP Ford is an open prison for category D prisoners. This means that it holds prisoners who only require a minimum level of security. It can hold just over 500 prisoners, who live in single or two-person rooms. Ford takes prisoners with less than two years left to serve. The emphasis is on resettlement, and after a period at Ford prisoners can apply for release on temporary licence for resettlement day release, resettlement overnight release, and release to undertake community work.

Her Majesty's Inspectorate of Prisons (HMIP)

14. The most recent HMIP report on Ford was of an inspection in August 2012. The report found that there was a clear resettlement ethos, services were well advertised and prisoners were aware of the help available and there was good use of temporary release to help resettlement. Security in relation to alcohol and drugs had improved since the previous inspection target but searches and suspicion mandatory drug tests were not always carried out quickly enough. Overall, HMIP assessed Ford as providing "a safe and decent environment where prisoners are kept busy with good quality activity".
15. The report noted that health services were similar to those provided by a good community GP practice and that prisoners were very positive about the support they received from the substance misuse service.

Independent Monitoring Board (IMB) report

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB report for Ford for the year to October 2012 noted that the healthcare unit was a well run and efficient service. The IMB was positive that the prison was beginning to manage risk rather than just containing it and also noted that the prison had developed a much more linked up system for drug prevention, treatment and education. However, the IMB was concerned about the high use of "Spice", a legal synthetic marijuana.

Previous deaths at Ford

17. The man's was the first death of a prisoner from Ford in over four years. There were no similarities between the circumstances of his death and previous investigations.

KEY EVENTS

18. The man was born in March 1981. On 29 June 2012, he was convicted on two counts of burglary and remanded to HMP Lewes. He had not been in prison before.
19. The man had a previous conviction for drink-driving and had been drinking at the time he committed the latest offences. His offender assessment report (OASys) noted this, but said that he had no history of drug or alcohol abuse.
20. The man had epilepsy for which he took medication. The clinical reviewer notes that when he arrived at Lewes this was clear to staff and he was prescribed the correct medication.
21. The man seemed to settle into prison without problems and, on 17 August, he was transferred to HMP Ford. The notes of his first night interview at Ford indicate some issue about a violent incident in prison, but there are no further details about this and it is not clear where the information came from. The notes from a routine health screen the next day show that there were no indications of drug use. He was referred to the healthcare department because of his epilepsy.
22. Because his offences involved use of alcohol, the man was referred to the prison's substance misuse service, although engagement with the service is voluntary. On 21 August, he had an initial meeting with a psychiatric nurse who specialises in substance misuse. The nurse said that a standard aspect of this initial meeting includes warning prisoners of the potential harm of substance misuse. This includes an explanation that, while they are in prison, their tolerance to substances will decrease and if they use drugs or alcohol when they are released their bodies may not be able to cope with the amount they were used to previously.
23. The man had a follow up meeting with the psychiatric nurse on 22 September. This meeting is designed to explore the prisoner's problems with drugs or alcohol in more depth, and to discuss what substances they have used. He said that he had not used heroin, methadone, opiates or other drugs. He said he had used alcohol socially in the past, but as he was on medication for epilepsy he no longer drank often. He explained that he had been convicted for drink driving after he had failed a test the morning after he had been drinking the night before. He said that he had no problems with drug or alcohol use. He signed a disclaimer to confirm that he did not want to engage further with the substance use service.
24. Records indicate that the man settled well at Ford. He worked in the laundry, and received positive reports for his work. His instructor in the laundry said that he was an even-tempered man who rarely caused any problems.
25. On 4 October, the man was assessed as suitable for resettlement overnight release or resettlement day release when he became eligible. He was granted release on temporary licence on the afternoon of 10 October to attend a medical appointment. On 19 October, initial approval was given for overnight release (home leave) from 26 to 30 November. On 23 October, in recognition

of his good behaviour, he was given enhanced prisoner status, which allowed him extra privileges.

26. While he was at Ford, the man had regular appointments with epilepsy specialists. On 24 October, a doctor noted that, in line with a recommendation from a recent medical appointment, his prescription of lamotrigine (anti-convulsant) was to be increased.
27. The man was granted release on temporary licence, home leave, from 26 to 30 November. This passed with no apparent problems. The computerised prison record (known as P-NOMIS) contains an entry on 30 November that he had been told before going on home leave that papers for his release on home detention curfew (HDC) were being processed. (HDC allows suitable prisoners to be released on licence to serve the remainder of their sentence in the community. They are usually confined to their home for a specified period of the day and wear electronic tags so that the curfew can be monitored. Prisoners are required to have suitable accommodation.) On 6 December, a further entry shows that the address he had provided was regarded as unsuitable and he was asked for another address. The alternative was also not regarded as suitable. He was offered housing which he rejected as it was too far from his family. His application for release on home detention curfew was therefore turned down. A note on his P-NOMIS record dated 9 December shows that home leave was approved for 4 to 8 January 2013, subject to checks. This also passed without any apparent problems.
28. The man was allowed temporary release for the afternoon of 16 January in order to attend a medical appointment in the community. On 6 February, it was agreed that he could be released on home leave from 8 to 12 February.
29. On 7 February, the security department at Ford received information that the man and another prisoner were planning to bring some heroin into the prison when they returned from their next home leave. The information suggested that they had smuggled in drugs previously. The information came from a new source so the likelihood of this being accurate was not known. As there was no other intelligence linking him to drugs, it was decided that there was insufficient evidence to justify cancelling his planned home leave.
30. At 9.15am on 8 February, the man left the prison on home leave. He was due to return on 12 February. At 10.30am on Monday 11 February, the prison received a telephone call from his former partner. She said that he had died over the weekend, and asked if she could collect his property. The prison contacted Sussex Police, who confirmed that he had been found dead in the street a few days earlier.

Liaison with the man's family

31. As managers believed there were no trained family liaison officers available in Ford on 11 February, an officer of HMP Lewes agreed to undertake the role. The officer telephoned the man's mother, who was his nominated next of kin. The officer and a senior officer then visited his mother at her home that afternoon. The officer arranged for her to visit Ford, to see where he had lived.

32. The funeral was held on 11 March 2013. Ford contributed to the costs, in line with national guidance.

Debrief

33. After the death of a prisoner it is usual to hold a debrief meeting with staff involved to ensure they have an opportunity to discuss any issues arising, and to provide them with support. Because no staff were involved in the actual circumstances of the man's death, an immediate debrief was not held. An operational debrief to identify any issues arising from his death was held later. It was noted at that meeting that there had in fact been a trained family liaison officer in duty at Ford on 11 February, but managers had been unaware.

Informing prisoners

34. Prisoners and staff were informed of the man's death by notices from the Governor on 11 February, although many prisoners had already heard rumours of his death by the time the notices confirmed this. A prisoner, who shared a room with him, was seen individually, although he said he had also already heard rumours. The prisoner was moved to different accommodation and told to ask for support if he felt he needed it. An operational manager checked how he was on 13 February, when the prisoner said that he had friends in the prison he could talk to. He also said that he knew that he could speak to members of staff for support if he needed it.
35. There were no prisoners at Ford who were being monitored because they were considered at risk of self-harm. However, anyone who had been monitored in the previous three months was offered individual support in case they had been adversely affected by the man's death.
36. A service was held in the prison chapel on 13 February, to allow prisoners to pay their respects. The man's mother also attended.

Post-mortem

37. A post-mortem examination showed the presence of morphine (of a type indicating heroin use) ethanol (alcohol) and cocaine in the man's system. Although the level of morphine was low, it was potentially severely toxic in someone not used to the drug, particularly combined with alcohol. The pathologist concluded that his death was due to:

- 1(a) Morphine poisoning
- 2 presence of ethanol.

ISSUES

The man's healthcare

38. The clinical reviewer was satisfied that the man received a good standard of healthcare at Ford. His epilepsy became well controlled while he was there, and the clinical reviewer considered that he appeared to have received careful and expert assessment by both an epilepsy nurse specialist and a neurologist who advised the prison medical staff on appropriate treatment. There was a slight delay with the introduction of a new epilepsy drug, but this was because the prison was waiting for a letter from a specialist. This did not affect his treatment and the clinical reviewer noted that the delay was not as long as it would have been in the community. The clinical reviewer concluded that his medical care was extremely thorough.

Monitoring drug use

39. All prisoners at Ford are subject to random drug tests and they are also liable to be targeted for testing where there is reasonable suspicion of drug misuse. During his time at Ford, the man was not selected for a random test. He told staff, including the substance use worker, that he did not take drugs. There was no suggestion during his time in prison that he was taking drugs, so he was not subject to any suspicion-based testing.
40. The only time the prison were aware of any information that the man might have been involved in drugs was the intelligence report received on 7 February, the day before he was due to go on home leave. The information came from an untested source and was the only piece of intelligence against him.
41. In the year up to April 2013, the security department at Ford processed an average of almost 200 security reports per month. Of these, approximately a fifth involved intelligence about drugs. The reliability of these reports can vary widely, from sound information to malicious claims from other prisoners. When the intelligence about the man came in, it was assessed. It was agreed that there was insufficient justification to cancel his home leave based on a single piece of unsubstantiated information from an untested source. The security department agreed that they would monitor the situation when he returned to the prison.
42. The man's room mate said that he was never aware that he had anything to do with drugs. He said he did not see him take any and saw no evidence that he was bringing drugs into the prison, either for himself or for anyone else, or that anyone else was pressuring him to bring them in.
43. There was nothing to suggest the man had any previous involvement with drugs and drugs did not play a part in any of his previous or current offences. We were told that there was insufficient time to arrange a drug test before he left the prison on home leave and, sadly, there were no further opportunities. We are satisfied that it was reasonable in the circumstances to allow his home leave to proceed.

Family liaison

44. Ford had two officers who were trained to act as family liaison officers. When the news of the man's death was received, managers in the prison thought that neither were on duty and so used a trained family liaison officer from HMP Lewes. It was later discovered that one of the trained family liaison officers had in fact been in the prison at the time. This was identified as a learning point at the operational debrief after the death and the contact list for senior staff was updated. The prison are also now working jointly with HMP Lewes to provide a combined family liaison service to ensure there is always a trained member of staff available.
45. Ford identified a problem with their contact list and rectified this. The man's family were very positive about the support they received from the family liaison officer and we are satisfied that using a family liaison officer from another prison did not impact on the service provided.