

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the circumstances surrounding the
death of a man in January 2013**

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 investigation report into the death of a man who was found unresponsive in a custody vehicle in January 2013, after being transferred from HMP Isle of Wight to HMP Lewes. A post-mortem examination was unable to establish a conclusive cause of death, but respiratory failure appears likely. He was 40 years old. I offer my condolences to his family and friends.

A clinical review of the clinical care and treatment the man received at HMP Isle of Wight was undertaken. Both prisons and GEOAmey, the transport provider, cooperated fully with the investigation.

The man was one of ten prisoners who travelled in individual cells on the escort vehicle that day. He had a long history of substance misuse and had been prescribed methadone, a heroin substitute, for some years. The clinical review found that he received good treatment for his substance use problems at the prison. He had been assessed as fit for transfer and appeared to be well when he started his journey to Lewes. When his cell was unlocked after arrival at Lewes he was found unconscious. Efforts to try to resuscitate him continued for over 30 minutes, without success.

The GEOAmey officer who travelled in the back of the transport vehicle did not make the checks on prisoners during the journey that he was required to do. This was a serious omission. We cannot say whether the man's death could have been prevented if checks had been made but there is a need to ensure that escort officers check the welfare of prisoners confined in small spaces on cellular vehicles, periodically throughout journeys.

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 was born in March 1972. Much of his adult life was spent in prison, serving short sentences. His final period in custody started in March 2011, when he was recalled to HMP Lewes.
2. After nine months at Lewes, the man transferred to HMP Isle of Wight (Camp Hill site). He had longstanding problems of substance misuse and was prescribed a high dose of methadone and was also prescribed diazepam. He admitted to using other illicit substances in prison in addition to his prescribed medication.
3. On 2 December, the man reported to staff that he had lost consciousness for around 90 minutes. He was moved to the healthcare inpatient unit at the Albany site for overnight observations and returned to Camp Hill the next day after a settled night.
4. In January 2013, the Ministry of Justice announced the closure of several prisons, including the Camp Hill site of HMP Isle of Wight. This meant the prisoners in Camp Hill had to be transferred elsewhere. (Camp Hill was for category C prisoners and the other two sites forming HMP Isle of Wight were for category B prisoners convicted of sex offenders.) The man was told that he would be transferring on 28 January. He was pleased to learn later that he would be going to Lewes as this was close to where his parents lived.
5. On the morning of his transfer, the man had a standard strip search before being taken to the escort van and locked in one of the cells on the van. He talked to another prisoner during the journey but stopped shortly before they arrived at Lewes. The other prisoner assumed he had fallen asleep. When the van arrived at Lewes, he was found unresponsive. Prison and escort staff attempted to resuscitate him and ambulance paramedics later took over. Sadly, their efforts proved unsuccessful and he was pronounced dead.
6. The investigation found that the man was apparently fit and well when he was placed on the escort van. Checks that should have been made on prisoners' wellbeing during the journey were not made, although it is uncertain whether his death could have been prevented had they been made.
7. At a post-mortem examination, the man was found to have concealed a package of tablets in his rectum. We are satisfied that there was no reason for staff at Camp Hill to have suspected that he had an item hidden in his anal area and conducted a closer visual inspection as part of the strip search. The post-mortem did not determine a definitive cause of death, but the pathologist suggests the possibility of respiratory failure.

THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Isle of Wight informing them of the investigation and inviting them to contact the investigator if they had relevant information. No one responded.
9. In February and March 2013, the investigator visited HMP Isle of Wight, HMP Lewes and GEOAmeys Eastleigh site. He met managers from these services and inspected the vehicle on which the man had travelled. He obtained copies of his prison and health records as well as CCTV footage taken from on-van cameras, which he later viewed in detail. He subsequently interviewed 12 members of staff and two prisoners who had known him, one of whom had travelled with him.
10. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.
11. West Sussex Primary Care NHS Trust (now NHS England) appointed a clinical reviewer to review the clinical care the man received at HMP Isle of Wight.
12. One of the Ombudsman's family liaison officers contacted the man's parents to inform them of the investigation and to offer the opportunity to identify issues for the investigation to consider. His mother asked about the observations and checks made during the journey on the prison van and whether her son had told anybody that he was feeling unwell. His father said that he understood that after his son's death he was found to be in possession of drugs. He asked how this was possible as his son was strip searched before leaving Camp Hill. His father had also heard that prisoners on the van had been drinking alcohol and asked whether this was true.
13. Soon after the man's death, Sussex Police asked the Crown Prosecution Service (CPS) to consider prosecuting a GEOAmeys escort officer. Our investigation was suspended in the meantime. We were informed on 23 October that the CPS had decided that there would be no criminal prosecution.
14. The man's family received a copy of the draft report. They did not identify any factual inaccuracies in the report, but his mother was surprised about her son's methadone treatment: she thought that it was a high dose and had continued for a prolonged period of time.

HMP ISLE OF WIGHT

15. HMP Isle of Wight was the organisational amalgamation of three prisons Camp Hill, Albany and Parkurst. In January 2013, the Ministry of Justice announced the closure of the category C Camp Hill site by March 2013. HMP Isle of Wight now holds mostly category B sex offenders.

GEOAmeY

16. GEOAmeY is a private company, contracted by the National Offender Management Service to provide prisoner escort and custody services across England and Wales. It manages more than 12,500 prisoner movements every week between police custody suites, courts and prisons.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Isle of Wight was in June 2012. With reference to Camp Hill, the Inspectorate found that:

“Random and suspicion drug testing procedure were poorly managed. The positive random drug testing rate for the previous months at Camp Hill was high, at 8%. Despite the evidence surrounding illicit prescribed drug and illegal drug use, suspicion tests were often not carried out within the appropriate time frame; those completed achieved a positive rate of only 28% ...

”We observed mainly positive interactions between staff and prisoners, and prisoners were generally complimentary about respectful engagement with most staff. At all sites, more prisoners than at comparator prisons had a personal officer, and ... said that their personal officer was helpful ...”

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure prisoners are treated fairly and decently. The 2012 IMB annual report did not cover Camp Hill as the IMB intended to publish a separate closure report. In the 2011 annual report the Board commented on the amount of illegal drugs available at Camp Hill.

Previous similar deaths in custody

19. The Ombudsman has not previously investigated any deaths that occurred while transporting prisoners between prisons.

KEY EVENTS

20. The man was born in March 1972. He was first convicted as a youth. He then spent much of his adult life in custody, mainly serving comparatively short sentences for offences such as theft, robbery and motor-related offences. In March 2011, he was recalled to prison custody at HMP Lewes after committing further offences while on licence¹.
21. In December 2011, the man transferred from Lewes to Camp Hill, one of three prison sites making up HMP Isle of Wight. At a consultation on 8 December with a substance misuse nurse, he disclosed that he had started abusing substances from around the age of ten and by the age of 15 was using heroin. He said that since 2005 he had been receiving methadone (a prescribed synthetic opiate, used as a substitute for heroin), but admitted that in the community he took other drugs and alcohol in addition to his prescribed methadone. His prescribed medication included methadone, 100ml daily (a high dose, but the amount he had been prescribed in the community) as well as pregabalin and citalopram for anxiety. He revealed that he had abused benzodiazepines while at Lewes.
22. Over the following months, the man received ongoing support from clinical staff and the prison's drug treatment team for his substance misuse problems. On 9 May 2012, a doctor reviewed his methadone dosage and noted his records to say: "... currently on 100mls addressed [him] again about reduction but I honestly don't think reduction is going to happen without him starting to [misuse] again". She also noted that he was receiving ongoing treatment for a foot ulcer. (He had chronic circulation problems in his legs.)
23. On 2 August, the doctor noted the following concerns in the man's records:

"... additional illicit use on wing for past 3 weeks ... Using ... whatever he can get his hands on ... States he has some outside stressors ... in a complete state now. My concerns are that he is on [many prescribed medications with central nervous system] effects and respiratory depression ... Examination: Slurred speech, off his face ..."
24. That afternoon, the man was moved to the healthcare inpatient unit at the Albany site. (Camp Hill did not have an inpatient unit.) It seems that he continued to take illicit drugs, which he again said was due to problems outside the prison. At a consultation with a nurse on 9 August, he said that there was no real trigger for his misuse of drugs apart from their availability. He was discharged back to Camp Hill on 15 August.
25. The man was prescribed diazepam (an anxiety reliever) on 27 September. He told a nurse the next day that his anxiety had reduced once this medication had been prescribed as he no longer needed to worry about acquiring illicit diazepam and he did not have to worry about being caught with illicit drugs. However, a search of his cell on 16 October found he had medication that had not been prescribed to him.

¹ A person sentenced to more than 12 months in prison may be released early on licence. If the person breaches their licence conditions they will be recalled to custody.

26. At a review with the nurse on 24 October, the man said that he was feeling well on his dose of 8mg of diazepam and would like to start reducing his methadone dose. (A reduced dose of 98ml was started on 30 October with periodic reductions of 2ml in the following weeks.)
27. On 2 December, the man reported that he had lost consciousness for a time. He said that he had collected his lunch at around midday and had woken 90 minutes later having possibly hit his head against a table. He was found to have a slight swelling to one side of his head and he had also bitten his tongue. He was admitted to the Albany healthcare inpatient unit for overnight observations and returned to Camp Hill the next day after he was reported to have had a reasonably settled night.
28. The plan to reduce the man's methadone dose continued through November and by 11 December, the dose had been reduced to 90ml.
29. On 11 January 2012, the man telephoned his father and they chatted about the recent news that Camp Hill prison would be closing. He said that prisoners would start transferring out from the following Monday, but he did not know when he would be leaving, or which prison he would be moving to.
30. On 16 January, the man told a nurse that he wanted to remain on his existing daily levels of methadone (90ml) and diazepam (8mg) pending his transfer to a new prison. The nurse agreed to this plan. He was told on 25 January that he would be leaving Camp Hill on 28 January, but it was still not known which prison he would go to.
31. On the afternoon of 26 January, a nurse noted in the man's records that he was fit for transfer. She explained to the investigator that these assessments were based on a review of prisoners' notes to identify any reason to suggest the prisoner might not be fit to travel. She was aware of the occasion when he had apparently fainted, but said this had been almost two months before so it would not have indicated he was unfit to travel. She added that, in any case, she knew him and had seen him that morning when he collected his medication.
32. The man was told later that afternoon that he would be moving to Lewes. When he telephoned his parents with the news, he said he was pleased to be going to Lewes as it would be easy for them to visit.
33. At around 8.15am on 28 January, the man received his morning medication, methadone and pregablin, from a nurse. She said that he was in a good mood, they shook hands and he thanked her and the other nurse for their care. After the prisoners had received their medication, they were taken to a holding room in reception. They were then strip searched, one by one, in a separate room.
34. One of the two officers who carried out the strip-searches that morning told the investigator that the process for strip searches is for the prisoner to first remove clothing from the waist up. Once the upper half of the body has been checked, the prisoner replaces the upper clothing then removes that below the waist. He said that the man had a leg bandage, but he was aware that he had been receiving treatment for a leg condition. He explained that the search took around five minutes and all seemed in order. Prison officers do not have lawful authority to conduct searches involving intrusion into a bodily orifice. A prisoner

can be asked to squat during a search if there is reasonable intelligence that he has illicit articles concealed. There was no intelligence about him, so he was not asked to squat during the strip search. After they had been searched, the prisoners then went to another holding room where they waited to be taken to the transport vehicle.

35. GEOAmev provides prisoner transport services to and from Camp Hill. One Prison Custody Officer (PCO) was the van driver and the other (the PCO escort) travelled in the back of the van. Ten prisoners boarded the van and it left Camp Hill just after 9.00am, arriving at the ferry port around 15 minutes later. The prisoners remained in their individual cells during the ferry crossing and throughout the journey. At 9.28am the PCO driver gave each prisoner a sandwich for lunch. The ferry reached Portsmouth at 10.00am and the van continued to Lewes. During the journey, the PCO escort should have checked the prisoners twice more. The investigator viewed a CCTV recording which showed that the PCO escort made no checks on the second leg of the journey and remained seated for the entire journey between Portsmouth and Lewes. As the van approached Lewes, the PCO escort made two entries on each prisoner's Person Escort Record (PER) form. (PER forms are used to record prisoners' risks and events during transfer between prisons and other custodial settings.) The PCO escort's entries on the man's PER form indicated that he had made one check at 10.43am and a second at 11.08am, neither of which were done.
36. The investigator spoke to one of the prisoners who travelled with the man that day. He said that they had chatted through most of the journey until the man fell silent in the final ten to 15 minutes before reaching Lewes. He assumed that he had fallen asleep. He confirmed that the PCO escort made no checks during the journey.
37. The van reached Lewes at 11.30am and an operational support grade (OSG) went onto the van and counted the prisoners. (This check was solely to ensure that the correct number of prisoners were in the cells.) The CCTV recording shows that the OSG completed the count and appears to have noticed nothing untoward. The prisoners then waited on the van for 30 minutes or so while property was taken off and reception staff completed administrative procedures.
38. At around 12.00pm, the GEOAmev staff started to escort prisoners from the van. When the PCO escort unlocked the man's cell, he fell to the floor. The PCO driver told the investigator that his colleague called to him that a prisoner had collapsed, so he ran to the prison reception area to alert the staff. He then returned to the van and saw his colleague carrying out cardiopulmonary resuscitation (CPR). The PCO escort said he needed help so the PCO driver went back to reception to get staff.
39. An officer told the investigator that he was working in reception when he heard a shout that one of the prisoners had collapsed. He and two other officers ran to the van, placed the man in the recovery position and checked for a pulse, without success. He had vomited, so he and another officer tried to clear his mouth and windpipe. A radio call had already been made for healthcare staff to attend and nurses began to arrive.

40. A nurse later wrote in the man's healthcare records a summary of the attempts to resuscitate him. When he arrived, an officer was carrying out CPR and healthcare staff then helped with the resuscitation efforts. He noted that the man was checked with a defibrillator², which advised that no shock should be given. Paramedics arrived at about 12.25pm and took over the efforts which continued for around 35 minutes. Despite the resuscitation efforts he was pronounced dead just after 1.00pm.
41. One of the prison's family liaison officers found the addresses for the man's parents (his parents were divorced and living at separate addresses) and she and a colleague, visited both of them at their homes to break the news of their son's death. She told them that the prison would assist with the funeral costs.

Post-mortem findings

42. After his death, the man's body was taken to Brighton and Hove mortuary for post-mortem examination. The mortuary technician who examined him found a plastic pouch, containing a number of tablets, part way into his rectum.
43. A post-mortem examination by a consultant histopathologist³ was unable to establish the man's cause of death, but considers it possible that it was due to respiratory failure. Toxicological analysis of his blood, urine and stomach contents revealed presence of methadone and diazepam in keeping with his prescribed doses, as well as quetiapine (an antipsychotic medicine), which had not been prescribed to him. The level detected was within the range normally prescribed and the pathologist does not suggest that it could have contributed to his death. No traces of alcohol were detected.

² An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about management of the patient, including whether or not an electrical shock should be given to re-establish an effective heart rhythm.

³ Histopathology is diagnosis through microscopic examination of tissue samples

ISSUES

The man's cause of death

44. The man's friend spoke to him during much of the journey until the man fell silent around 15 minutes away from Lewes. He thought he had fallen asleep.
45. Having considered all the evidence, including the toxicological results, the consultant histopathologist wrote that the man's cause of death should be regarded as unascertained, pending further information that might become available during the inquest.

The actions of the GEOAmeY escort officer

46. GEOAmeY's operating procedures on the roles and responsibilities of staff caring for prisoners during prison transfer state that prisoners should be checked, while in transit, at irregular intervals with a minimum of one check each hour. The checks are recorded on PER forms. The journey between Portsmouth and Lewes took around one hour and twenty minutes, which meant that there should have been two checks on each prisoner. The CCTV recording shows that the PCO escort remained seated throughout the journey and made no checks on the prisoners in his care. When the van was near Lewes, he made two entries on each PER form and timed each to suggest that he had made his checks in accordance with the operating procedures.
47. The PCO escort's actions were reported to GEOAmeY management, HM Coroner for Lewes and Sussex Police, who had carried out a preliminary investigation when the man's death was first reported. The Crown Prosecution Service considered prosecuting him for making a false statement when first interviewed by the police immediately after the man's death. They subsequently decided to take no action.
48. Once GEOAmeY had been informed of the PCO escort's actions, they suspended him from duty and later terminated his employment. We endorse GEOAmeY's decision to deal with him under its disciplinary procedures. We were concerned that there did not appear to be any management checks on CCTV to help ensure that officers carry out required welfare checks. We make the following recommendation:

GEOAmeY should conduct random periodic audit checks of CCTV recording on escort vehicles to help ensure that escort staff carry out on-board checks in line with its operating procedures.

Substances found in the man's possession

49. After the man's death, he was found to be in possession of a number of tablets which were in a sealed pouch inserted part way into his rectum. We do not know what these tablets were.
50. The man had been subject to a strip search before leaving Camp Hill, which was a non-invasive visual search. Although he had a history of acquiring drugs and medicines, there was no intelligence to indicate that he was in possession of illicit items on the day of his transfer. Therefore, it was reasonable for staff to

conduct the search as they did, rather than asking him to squat and observe his anal area more closely.

51. The man's father questioned whether his son had consumed hooch (illicit alcohol) on the day of his death. Toxicological investigations showed that this was not the case and there is nothing from the CCTV evidence to indicate that any of the prisoners on the escort vehicle were in possession of alcohol.

Findings of the clinical review

52. The clinical reviewer identified several areas of good practice in the provision of care to the man at Camp Hill, including his treatment for substance misuse problems. He made some recommendations for improvements including communication and follow-up after in-patient and out-patient consultations and treatments and prescribing practice. As these are not directly related to his death, we do not repeat them here. Although the Camp Hill has now closed, the Head of Healthcare at HMP Isle of Wight may wish to consider their relevance to the rest of the prison.

RECOMMENDATIONS

1. GEOAmey should conduct random periodic audit checks of CCTV recording on escort vehicles to help ensure that escort staff carry out on-board checks in line with its operating procedures.

ACTION PLAN: The Man - HMP Lewes and GEOAmeY - January 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	GEOAmeY should conduct random periodic audit checks of CCTV recording on escort vehicles to help ensure that escort staff carry out on-board checks in line with its operating procedures.	Accepted	<p>GEOAmeY will introduce a schedule of weekly random compliance checks by vehicle at each vehicle depot.</p> <p>GEOAmeY Area Business Managers will select vehicles that have undertaken journeys lasting over one hour in duration and view CCTV footage to confirm prisoner checks were completed in line with Standing Operating Procedures.</p> <p>All management checks will be recorded and filed for audit purposes.</p> <p>PECS will be updated on the implementation and the progress of the on-going checks, findings and outcomes.</p>	03 February 2014	