

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Matthew Lock a prisoner at HMP Lewes on 24 September 2016

**A report by the Prisons and Probation Ombudsman  
Nigel Newcomen CBE**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

**We are:**

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

The office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Matthew Lock died at Royal Sussex County Hospital, on 24 September 2016 of a probable heart attack, which the inquest will look to confirm. He was 39 years old. I offer my condolences to Mr Lock's family and friends.

Overall, we conclude that Mr Lock received a satisfactory standard of care at the prison and do not consider that prison staff could have prevented his death.

We are concerned that prison staff at HMP Lewes initially restrained Mr Lock when they took him to hospital for his back operation. We do not believe that the decision to use restraints was justified in the circumstances.

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

**Richard Pickering**  
**Deputy Prisons and Probation Ombudsman**

**May 2017**

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# Summary

## Events

1. On 15 August 2016, Mr Matthew Lock was remanded to HMP Lewes for sexual offences. On arrival, Mr Lock told a nurse that he was on medication for depression. Prison GPs arranged for him to continue with this medication.
2. Mr Lock complained about back pain to wing staff. A prison GP prescribed pain relief for it on 12 September.
3. On 16 September, Mr Lock complained that his back pain was getting worse. A prison GP examined him the following day and decided he needed to go to hospital. Surgeons performed a spinal operation on 18 September. Mr Lock returned to Lewes on 23 September.
4. At 9.26am on 24 September, Mr Lock was found unresponsive in his cell. A healthcare assistant called for assistance; another healthcare assistant pressed the emergency alarm but did not use a radio emergency medical code. Prison nurses treated Mr Lock until paramedics arrived and took him to hospital. Mr Lock died later that morning at 10.54am.

## Findings

5. The clinical reviewer was concerned that healthcare staff issued medication without seeing Mr Lock. The record shows that a GP and a nurse issued medication in his absence.
6. When healthcare staff found Mr Lock collapsed, no one used an emergency medical code, as should have happened. They waited for prison officers to arrive and make the radio call. This meant that there was a short delay in calling an ambulance. While there is no evidence this affected the outcome for Mr Lock, such a delay in other cases could be critical.
7. Although Mr Lock had very limited mobility and was not a high security risk, prison managers decided he should be restrained for the journey to hospital for his operation. The medical section of the security risk assessment did not fully reflect Mr Lock's limited mobility and poor condition at the time.

## Recommendations

- The Head of Healthcare should ensure that:
  - all clinicians assess and appropriately examine the patient, take clinical observations as appropriate and record their assessments, in line with national guidelines.
  - all staff are aware of and adhere to the Nursing and Midwifery Council standards for the administering of medication.
- The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. All staff should use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically.

- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position for restraints, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.
- The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.

## The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator visited HMP Lewes on 4 October 2016. She obtained copies of relevant extracts from Mr Lock's prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Lock's clinical care at the prison. The investigator conducted one telephone interview with a member of staff on 2 November 2016 and with the clinical reviewer interviewed five members of staff at Lewes on 3 November.
11. We informed HM Coroner East Sussex of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Lock's parents, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Lock's parents had a number of concerns for the investigation to consider including:
  - Whether the prison delayed Mr Lock's admission to hospital.
  - When had the prison doctor seen him, and what action was taken.
  - Whether he was allowed to exercise and was he locked up for 23 hours.
  - Whether Mr Lock's healthcare needs were met when he was located in healthcare.
  - Could these factors have contributed to his death.
13. Mr Lock's family received a copy of the initial report. They raised two factual inaccuracies, which have been amended in the report. They also raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies and their action plan is annexed to this report.

# Background Information

## HMP Lewes

15. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Sussex Partnership NHS Foundation Trust provides primary care services.
16. HMP Lewes has an inpatient unit in healthcare, for prisoners who present with acute physical and/or mental health issues. It has two landings and can house 12 prisoners at any given time. There are 10 beds on the upper landing and two, including the disabled cell, on the lower landing. Healthcare staff are on duty at the prison at all times, including two qualified nurses at night and two during the day.

## HM Inspectorate of Prisons

17. The most recent inspection of HMP Lewes was in January 2016. Inspectors found that health services were reasonably good but too many hospital appointments were cancelled because of a shortage of staff to escort prisoners. The inpatient unit provided compassionate care for patients with complex health needs but there were insufficient custody staff to deliver a therapeutic regime. Medicines management was reasonably good. Primary care services and management of long-term conditions were reasonably well managed. Clinical records were generally good.

## Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure prisoners are treated fairly and decently. In its latest report for the year to 31 January 2016, the IMB noted that there had been a sharp increase in older prisoners with complex needs.

## Previous deaths at HMP Lewes

19. Mr Lock was the sixth prisoner to die of natural causes at HMP Lewes since January 2015. We have made recommendations about the unnecessary use of restraints, hot debriefs and emergency responses before.

## Key Events

20. On 15 August 2016, Mr Lock was remanded into custody on charges of sexual offences and was sent to HMP Lewes.
21. At his initial health screen, Mr Lock told a nurse that he had been diagnosed with depression and was on medication (citalopram). The nurse measured his blood pressure and pulse rate, which were both within normal range. She arranged for him to continue to receive citalopram.
22. Prison staff allocated Mr Lock to the First Night Centre from 15 August until 23 September, as they waited for a place to become available on the Vulnerable Prisoners' Unit (due to the nature of his offence).
23. Mr Lock's prison record indicates that on 12 September a prison GP, completed a prescription for anti-inflammatory tablets (naproxen) to address his reported back pain. This is the first documented instance of Mr Lock's back pain.
24. On 13 September, Mr Lock's parents visited. They said that before the visit an officer told them that Mr Lock had a bad back and had difficulty walking. The next day someone from the prison (their identity is not recorded) rang Mr Lock's parents to tell them not to come for a scheduled visit at the weekend as Mr Lock's condition had deteriorated and he was unable to walk to the visits area.
25. On 16 September, Mr Lock told a nurse that he had back pain and the GP had prescribed naproxen. The nurse booked a GP appointment. Later that day, Mr Lock saw a nurse and told him that he could not move because of his back pain. The nurse arranged for the prison GP to see Mr Lock.
26. The next day, a prison GP examined Mr Lock. He was incontinent of urine, numb in his left leg, and could not lean forward because of pain. She suspected he had a severe type of spinal stenosis (narrowing of the spinal canal) and she made arrangements for him to go to hospital.
27. Staff completed a security risk assessment before they left the prison. A prison manager, decided that two officers should escort Mr Lock and use double handcuffs. (Double handcuffing means the prisoner has his hands cuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs.)
28. Just over an hour later, Mr Lock went to Royal Sussex County Hospital, Brighton. When hospital staff admitted him to hospital, the escort staff changed the double handcuff to an escort chain (a long chain with a light handcuff at each end, one of which is attached to the prisoner and the other to an officer).
29. An MRI scan showed that a disc protrusion was causing the back problems. On 18 September, Mr Lock had a spinal operation. The escorts removed the restraints for surgery and reapplied the escort chain. Hospital staff discharged Mr Lock back to Lewes on 23 September and scheduled a hospital review in six weeks.
30. On 21 September, a prison GP prescribed pain relief medication that morning for Mr Lock without examining him. Approximately fifteen minutes later a nurse

updated the medical record to show that the medication had been issued to Mr Lock. This could not have happened as he was still in hospital.

### **Events on 24 September 2016**

31. Mr Lock was located in the inpatient healthcare unit, in a cell on the lower of two floors. Healthcare staff saw him hourly throughout the day and night, and reported no problems. At approximately 9.20am, two healthcare assistants on the upper level heard a shout. A healthcare assistant ran to the cell and found Mr Lock slumped unresponsive on his bed. The other healthcare assistant said she heard a shout for assistance.
32. The healthcare assistant said that she told her colleague to get a nurse and she pressed the emergency bell to alert prison officers and ran to get the emergency bag with the blood pressure equipment. She stayed outside of the cell as nurses arrived.
33. A nurse said that a healthcare assistant opened his office door and said that Mr Lock was slumped on his bed. He said he shouted "crash call" to the other healthcare assistant to alert her to the emergency. He said that a nurse was immediately on the scene, and then two other nurses attended, so he did not have to make a radio call for further nurses. He said officers attended but he could not remember whom.
34. A nurse began cardiopulmonary resuscitation (CPR) when Mr Lock was on the bed. He said he had asked prison officers to call an ambulance. A defibrillator was used. The defibrillator did not advise any shocks so CPR continued.
35. The communication log showed that the alarm bell in healthcare was activated at 9.26am. An ambulance was called at 9.32am. Paramedics arrived at the prison at 9.40am. Paramedics took over control of the CPR and, at 10.25am, they took Mr Lock to Royal Sussex County Hospital. Two officers escorted Mr Lock and did not restrain him.
36. At 10.54am a hospital doctor confirmed that Mr Lock had died.

### **Contact with Mr Lock's family**

37. When Mr Lock went to hospital on 17 September, prison staff did not contact his next of kin. The next day hospital staff arranged his operation and contacted his parents. Mr Lock's parents visited him after his surgery.
38. After Mr Lock collapsed in his cell on 24 September, Lewes appointed a prison manager, as the family liaison officer. She checked the next of kin details and saw that Mr Lock's parents were scheduled to visit him at the prison later that day.
39. While paramedics took Mr Lock to hospital the family liaison officer left the prison to go to Mr Lock's family home to tell them what had happened. On route, prison staff told her that Mr Lock had died. When she arrived at the family home there was no response so she returned to the prison. She waited in the prison visits area for Mr Lock's parents to arrive. When they arrived, she took them to a private area and broke the news. She offered her condolences and support and

accompanied Mr Lock's parents to the hospital in a taxi. At the hospital, they met nursing staff and were able to spend some time with Mr Lock. The family liaison officer and Mr Lock's parents returned to the prison. The family liaison officer remained in contact with Mr Lock's parents and arranged for them to visit the prison on 30 September when she arranged for them to meet the chaplaincy team, healthcare staff and prisoners who knew Mr Lock. Over the following days, the family liaison officer appropriately supported Mr Lock's family.

40. Mr Lock's funeral was held on 16 November, and Lewes contributed towards the costs, in line with national instructions.

### **Support for prisoners and staff**

41. After Mr Lock's death, there was no record that managers debriefed the staff involved in the emergency response or the officers who had escorted him to hospital to review what had happened and to support them.
42. The prison posted notices informing other prisoners of Mr Lock's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Lock's death.

### **Post-mortem report**

43. A consultant histopathologist, completed a post-mortem examination. He found that there was fluid in Mr Lock's lung. His heart had moderate narrowing of his left heart artery and the main pumping chamber was enlarged.
44. The consultant histopathologist said that as Mr Lock's heart was enlarged, the most likely cause of death was from arrhythmic cardiac arrest (an abnormality of his heart rhythm so the heart was unable to pump blood) but this should be addressed at the inquest.

# Findings

## Clinical care

45. The clinical reviewer said that it was difficult to compare the level of care Mr Lock received in his first month at HMP Lewes with that which he would have received in the community as he received no substantial treatment until he complained of back pain.
46. It is clear that wing staff were aware of Mr Lock's back problems from at least 13 September as they contacted his family when he had problems walking. However, there is no record of healthcare staff being aware of his pain before 12 September when a prison GP prescribed pain relief.
47. The clinical reviewer highlighted three occasions when prison GPs prescribed medication for Mr Lock without examining him. These were by prison GPs on 12 September, on 16 September and when Mr Lock was in hospital on 21 September.
48. A nurse updated Mr Lock's record to show that she had issued the prescribed medication. The investigation found she could not have issued the medication as Mr Lock was in hospital at the time, and there is no record of what happened to the tablets. These practices raise concerns about the safety and security of prescribed medication.
49. The Nursing and Midwifery Council standards (effective from 31 March 2015) for administering medication state "that a registered nurse must make sure that the care or treatment they advise on, prescribe, supply, dispense or administer for each person is compatible with any other care or treatment they are receiving". Healthcare staff did not adhere to these standards when they prescribed and issued medication when Mr Lock was in hospital. We make the following recommendation:

### **The Head of Healthcare should ensure that:**

- **all clinicians assess and appropriately examine the patient, take clinical observations as appropriate and record their assessments, in line with national guidelines.**
  - **all staff are aware of and adhere to the Nursing and Midwifery Council standards for the administering of medication.**
50. The clinical reviewer said that a doctor did not see Mr Lock in the week leading up to his hospital admission. He said that if he had been in the community he almost certainly would have sought medical help and it is therefore more likely that a diagnosis would have been made sooner. However, a prison GP examined him, made the correct diagnosis and correctly arranged his urgent admission to hospital.
  51. The clinical reviewer said that on Mr Lock's return from hospital it could be argued that, as he was in the inpatient unit, his level of medical attention was at an enhanced level. The clinical reviewer said when Mr Lock suffered his cardiac arrest he received quicker attention than he would have done in the community.

## Emergency response

52. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which ensures an ambulance is called automatically in a life-threatening emergency. It states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. The PSI makes it clear that there should be no delay in admitting and discharging an ambulance.
53. When healthcare staff found Mr Lock collapsed, they should have used their radios to call a code blue to indicate he had difficulty in breathing or was unconscious. Instead, they pressed the emergency alarm to summon officers, which meant that staff were not aware of the nature of the emergency. We have been unable to confirm who requested an ambulance. Once the emergency alarm was activated, it was at least another six minutes before the control room called an ambulance. While there is no evidence this delay affected the outcome for Mr Lock, such a delay in other cases could be critical. We make the following recommendation:

**The Governor should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies. Staff should use an emergency code immediately there are serious concerns about the health of a prisoner to alert control room staff to call an ambulance automatically.**

## Restraints, security and escorts

54. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. The judgment indicated that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.
55. Medical records indicate that Mr Lock's mobility was limited. Healthcare staff visited him in his cell on 16 September and noted that he felt he could not stand, with numbness in his left leg, and was in obvious pain.
56. Mr Lock's risk assessment concluded that his risk to the public was medium, but his risk of escape was low. His risk of hostage taking, escape potential and likelihood of outside assistance were all low. A nurse completed the medical section of the risk assessment and indicated that there were no medical objections to the use of restraints. He did not comment on Mr Lock's mobility. A prison manager who authorised officers to restrain Mr Lock with double handcuffs, said that someone informed him about Mr Lock's limited mobility and he told the escorts to use an escort chain. There is no record of this.

57. We are concerned, against that background, that the decision to use double handcuffs was not in line with the High Court judgement. Double cuffing is usually required for moving category A or category B prisoners in good health. Mr Lock was a category B prisoner but he was in poor health with limited mobility. It is difficult to conclude that Mr Lock had the ability to escape unaided from two escort officers and therefore required the additional use of restraints.
58. The Prison Service has a responsibility to protect the public, but security must be balanced with humanity and measures must be proportionate to a prisoner's individual circumstances. We are not satisfied that there was appropriate and considered healthcare input into the risk assessment, or that managers appropriately considered his condition at the time and how this affected his risk. We make the following recommendation:

**The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position for restraints, and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time.**

#### **Support for staff**

59. Our investigation confirmed that a prison manager did not hold a debrief following Mr Lock's death. PSI 64/2011 requires a manager to hold a debrief after a prisoner's death, for all staff involved, including healthcare staff. The purpose is to offer support, allow staff to support each other and to discuss any lessons from how the emergency was handled. We make the following recommendation:

**The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved are offered effective support.**

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