Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Patrick Foley a prisoner at HMP Lewes on 7 June 2016

A report by the Prisons and Probation Ombudsman
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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.

My 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 Patrick Foley died on 7 June 2016 of a heart attack in the grounds of HMP Lewes. He was 85 years old. I offer my condolences to Mr Foley's family and friends.

Prisons have a duty to protect all prisoners from violence and a particular responsibility those known to be vulnerable, yet when Mr Foley alleged that his cellmate had assaulted him prison staff did not treat these allegations with the seriousness they required. As a result, I am very concerned that HMP Lewes failed to support Mr Foley appropriately after he made these allegations. Moreover, the prison appears not to have disclosed the full details and seriousness of the allegations of assault to the police and I consider that these full allegations should be referred again to the police.

As well as identifying a need for better investigation and support for victims of alleged violence, the investigation also found that healthcare staff did not act quickly enough when Mr Foley's condition deteriorated. Restraints were used, inappropriately, when Mr Foley attended some hospital appointments.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **June 2017**

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Summary

Events

1. On 22 December 2014, Mr Patrick Foley was sentenced to 15 years in prison for sexual offences and was sent to HMP Lewes. He was 83 years old. Mr Foley had a history of arthritis, type 2 diabetes and heart disease. He had had an operation for the partial removal of his intestine and was on the hospital waiting list for shoulder and hip operations.

2. On arrival in the prison, a nurse completed a medical assessment and, due to Mr Foley's complex medical conditions, arranged for him to be admitted to the prison's inpatient unit. Mr Foley remained there for four days and was then moved to the vulnerable prisoners' wing. His cell sharing risk assessment noted that he was significantly vulnerable to assault.

3. In December 2015, a 28 year old prisoner moved into Mr Foley's cell. In February 2016, wing staff said they had investigated complaints that Mr Foley and his new cellmate did not get along and found that the claims were unsubstantiated.

4. In late May 2016, Mr Foley told healthcare staff his cellmate had been assaulting him over several months. Healthcare staff helped him report this to the police. A prison GP found extensive bruising across Mr Foley's body and arranged for him to be admitted to the healthcare unit for observations. Wing staff took no action to support Mr Foley.

5. On 1 June, Mr Foley's condition deteriorated, and he suffered chest pain. A nurse noted that his blood sugar level and temperature were low. A prison GP saw Mr Foley shortly after and prescribed pain relief. Mr Foley made further allegations that his cellmate had made threats against his family, stolen his medication, urinated on him and made him eat faeces.

6. Prison GPs referred Mr Foley to hospital on 3 June. Hospital staff admitted Mr Foley to the intensive care unit. They diagnosed pneumonia and gave him intravenous antibiotics.

7. On 7 June, hospital staff discharged Mr Foley. On the journey back to Lewes, he became unresponsive in the taxi as it arrived in the prison forecourt. The escorting officer asked another officer to call a code blue emergency (which indicates that a prisoner is unconscious or not breathing). Healthcare staff arrived and began cardiopulmonary resuscitation until paramedics arrived. The paramedics pronounced Mr Foley dead at 5.55pm.

Findings

8. The investigation found that staff missed several opportunities to recognise that Mr Foley was the victim of bullying. We consider that he should have been managed under Prison Service violence reduction procedures. We are very concerned that Lewes failed to support Mr Foley appropriately after he complained his cellmate assaulted him.

9. We are particularly concerned at what appear to have been a number of missed opportunities to investigate Mr Foley's allegations and that the prison did not fully disclose the serious allegations of assault to the police as further details emerged.

10. The clinical reviewer said the care Mr Foley received between 1 and 3 June was below the standard he should have received. He said that clinical staff did not complete or act promptly enough on physical observations. We agree with the clinical reviewer's concerns that the observations and scoring, taken as part of an early warning system to check any deterioration in Mr Foley's condition, were not always accurate. We are satisfied that the emergency response on 7 June, when Mr Foley went into cardiac arrest, was appropriate.

11. We also found that it was unnecessary for prison staff to restrain Mr Foley for some of his hospital appointments.

Recommendations

- The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected and staff should document and photograph their injuries.
- The Governor should commission an investigation into the circumstances surrounding the allegations of assault disclosed by Mr Foley and the actions which were taken as a result of those allegations to satisfy himself that staff acted appropriately and professionally.
- The Governor should re-refer Mr Foley's allegations of assault and mistreatment to the police, ensuring that all relevant materials and information are included in the referral.
- The Head of Healthcare should ensure that Early Warning Scores are fully embedded into practice and used consistently.
- The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of 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 Investigation Process

12. 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. An officer responded, who was subsequently interviewed.

13. The investigator obtained copies of relevant extracts from Mr Foley's prison and medical records.

14. The investigator interviewed 17 members of staff at HMP Lewes on 4 October, 19 October, 17 November, 5 December and 21 December 2016. She interviewed the taxi driver on 17 November and conducted one telephone interview on 29 December.

15. NHS England commissioned a clinical reviewer to review Mr Foley's clinical care at the prison. He conducted joint interviews with the investigator on 19 October and 17 November.

16. 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.

17. We suspended this investigation for five months to accommodate a police investigation into the allegations that Mr Foley's cellmate had assaulted him. We resumed our investigation again when we received information that the Crown Prosecution Service decided not to pursue charges. A manager emailed a series of further questions to Lewes asking about the management of Mr Foley's allegations and the sharing of information with the police. He received no reply.

18. One of the Ombudsman's family liaison officers contacted Mr Foley's wife to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not have any specific concerns for the investigation.

19. Mr Foley's family received a copy of the initial report. They did not make any comments.

20. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

Background Information

HMP Lewes

21. 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.

22. HMP Lewes has an inpatient unit 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

23. The most recent inspection of HMP Lewes was in January 2016. Inspectors found that the number of older prisoners was rising. Inspectors said the complex mix of older and younger prisoners presented considerable challenges and risks. Staff allocated prisoners wherever there was space. Inspectors said the level of violence was high and oversight was poor. The number of assaults was higher than at other prisons they had recently inspected. Many violent incidents were not investigated. The safer custody structures to understand and address prisoners feeling unsafe were lacking, violence reduction procedures were not being implemented and safer custody staff had no time to undertake the role. Inspectors recommended that the prison should take a rigorous approach to identifying, investigating and dealing with violence.

24. Inspectors also said that there was little systematic support for prisoners with protected characteristics and outcomes were poor for some disabled and older prisoners. Inspectors said that the prison found it difficult to manage vulnerable and at risk prisoners.

25. Inspectors also said that health services were reasonably good. 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

26. 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. The IMB also noted that there were low staff levels during much of the year along with a restricted regime. This meant that there was a lack of continuity for both staff and prisoners. They said prisoners had told them that relationships were hard to maintain and basic daily tasks were often not carried out.

Previous deaths at HMP Lewes

27. Mr Foley was the third prisoner to die of natural causes at HMP Lewes since January 2015. There have been five subsequent deaths. We have made previous recommendations about the inappropriate use of restraints on two occasions.

Key Events

28. On 22 December 2014, Mr Patrick Foley was sentenced to 15 years in prison for sexual offences and arrived at HMP Lewes that day. He was 83 years old.

29. Mr Foley had complex medical problems including arthritis in his neck, shoulder and back, diabetes and heart disease. He told a nurse that surgeons had removed three quarters of his intestine and he was a smoker. He declined help to stop smoking. He was on waiting lists for operations for hip surgery and a right shoulder replacement.

30. The nurse arranged for Mr Foley to be admitted to the healthcare unit for a period of observation. Doctors prescribed several medications for his medical conditions. Healthcare staff also created over 60s, diabetes, mental health wellbeing and emotional needs care plans.

31. On 26 December, prison staff allocated Mr Foley to the vulnerable prisoners' wing and noted that he had a good relationship with his cellmate, at the time, who helped him. He was registered disabled and spent the majority of his time in his cell.

2015

32. On 10 September, Mr Foley's cellmate told healthcare staff that he was worried as Mr Foley was depressed. A community psychiatric nurse completed a mental health assessment. She noted that Mr Foley was low in mood and tearful as he felt he would not leave prison alive due to his age and sentence. Six days later, Mr Foley's cellmate was released from prison.

33. In December, a new 28 year old prisoner was moved into Mr Foley's cell. On 22 December, Mr Foley was tearful and told the community psychiatric nurse that he did not get along with his cellmate as he would "have a go at him". She told wing staff about this and she noted that an officer said it might be possible for Mr Foley to transfer to another wing with a single cell the next month.

2016

34. On 4 January 2016, Mr Foley had a pre-operation appointment for his hip and shoulder surgery. Ten days later, Mr Foley had hip and shoulder surgery. For both hospital visits, two officers escorted Mr Foley and restrained him with single handcuffs. He returned to prison on 15 January.

35. On 18 January, a prison GP examined Mr Foley. She noted his shoulder was healing well but, with his arm in a sling, it was difficult for him to care for himself. She concluded Mr Foley needed increased care and could benefit from admission to the inpatient unit. However, the inpatient manager said there were no available beds so she said there should be ongoing carer support and monitoring on the wing.

36. The following day, the community psychiatric nurse completed an adult social care referral to the local authority in accordance with the Care Act 2014. She was concerned that Mr Foley could not mobilise due to fear of using a walking aid and that he had no support. On 26 January, Social Services agreed a care

package and, from 29 January, carers visited him twice a day to help him shower and dress himself.

37. On 11 February, a prison manager noted that a concern had been raised that Mr Foley's cellmate was bullying him. At interview, he could not recollect how this was brought to his attention but said that he had spoken to both prisoners. There was no evidence of this. He concluded that the bullying allegations were untrue.

38. On the same day, an officer noted that Mr Foley had a few arguments with his cellmate but "it had all been sorted now". At interview, he was unable to recall any details.

39. On 7 March and 6 and 22 April, Mr Foley told the community psychiatric nurse that his cellmate was bullying him. He said that his cellmate told him off for smoking and eating too noisily, and told him to be quiet in the mornings and clean the cell (even though he was aware that Mr Foley had ongoing health problems). On all three occasions she spoke to officers, but could not recall who.

40. During this period, an officer said that Mr Foley's cellmate had told her that he wanted to change cells because of the age gap. She said that she and other officers had tried to facilitate a move, but then Mr Foley's cellmate had said that he did not want to move. She said his reasoning was that Mr Foley was asleep for most of the time so he could remain in the cell with him.

41. On 27 May, Mr Foley was tearful and in pain when he saw the community psychiatric nurse. He said he was in pain after his operation and could not sleep. She offered emotional support and said she would arrange for the nursing team to see him to discuss the pain. Later that day, Mr Foley told a nurse that he was in pain so the nurse scheduled a GP appointment for a review for pain relief.

42. On 31 May, the nurse planned to take routine blood tests for Mr Foley but noticed significant bruising on Mr Foley's hands, arms and face. Mr Foley was tearful and upset, and said he had fallen. The nurse referred him to a GP.

43. The same day, a prison GP examined Mr Foley. He told her that he had fallen in his cell the previous day but was unsure when or how. She asked him if someone had injured him but he denied this. She noted that he had chest pain and coughed white sputum. His pulse was regular (114bpm). She found extensive bruising on Mr Foley's head, temple, ears, cheeks, left hand, arms, chest, back, legs and knees. She concluded that the pattern of bruising of various ages did not fit in with falls but were consistent with pinching. She admitted Mr Foley to the inpatient healthcare unit to monitor his blood pressure and pulse, and establish the cause of the bruising.

44. A nurse saw Mr Foley after the GP appointment. He said that his cellmate had regularly assaulted him since they had started sharing the cell. Mr Foley said his cellmate had also threatened his family. Mr Foley wanted the police contacted and the nurse reported this to the wing managers. The nurse helped Mr Foley ring the police and noted that the police requested that prison staff should take photographs of his injuries. The nurse contacted security staff and noted that the person in security with the camera was not in the prison until the next day. The

nurse completed an injury to prisoner form (F213). No photographs were taken subsequently.

45. The wing manager said the first he knew of any problems was after Mr Foley had left the wing and he did not take any action.

46. Nurses checked on Mr Foley hourly. The evening of 31 May, Mr Foley told a nurse that his cellmate had assaulted him and stolen his food and medication.

47. A wing manager completed a violence reduction investigation on 31 May. He said a nurse had spoken to Mr Foley and that he had been helped to call the police. He also noted that prison staff had moved Mr Foley's cellmate, amended his cell sharing risk assessment to show that he was considered a high risk, placed him on violence reduction measures and placed him on Governor's report. He concluded that appropriate action had been taken and the safer custody manager agreed.

48. During the night, a ward manager issued Mr Foley with an antihistamine. Mr Foley said he had chest pain. The ward manager said it was from the chest bruising.

49. On 1 June, a nurse noted that Mr Foley's oxygen saturation was low (less than 75%) and he was so short of breath he could not blow into a peak flow meter (to check for narrowing of the airways). She also checked Mr Foley's blood sugar level and temperature, which were low, and his pulse, which was irregular. Mr Foley complained of chest pain and pain on exhaling. She used the Modified Early Warning Score (MEWS) to determine the degree of Mr Foley's illness and scored him ten (a score above five should generally result in hospital admission). She referred him to the GP.

50. A prison GP examined Mr Foley 20 minutes later. He noted the massive bruising over Mr Foley's arms, legs and chest. He also noted that his sternum, left side of his chest and ribs were tender from an assault. He prescribed an opiate patch and codeine tablets.

51. Later that morning, the community psychiatric nurse saw Mr Foley and asked why he had not told her about being assaulted. Mr Foley said his cellmate had threatened to hurt his family if he told anyone, had urinated on him and made him eat faeces. She reassured Mr Foley that he would not return to the cell with the cellmate and would remain in the healthcare unit until he was physically fit. She said any decision about a single cell needed to be weighed up with his ability to cope alone in a cell.

52. The Head of Healthcare contacted a security officer for an update into the allegations of alleged abuse. He told her that the police had listed the matter as a common assault and they had no plans to interview Mr Foley or take photographs. She emailed the police and said that Mr Foley had suspected fractured ribs and was vulnerable and frail.

53. A nurse noted that she reported the matter to East Sussex County Council as a safeguarding issue and was told this should be through the Prison Service. She was unable to get a response from the Prison Service number that the council gave her.

54. On 2 June, the community psychiatric nurse met Mr Foley. He said he wanted to return to his wing as he felt alone in the healthcare unit, though he was in a lot of pain and was having difficulty sleeping. He also described further episodes of abuse so she emailed these details to staff in the Safer Custody team. There is no record of any response.

55. Mr Foley remained in the healthcare unit and healthcare staff checked him hourly. He was in pain with restricted mobility, due to the suspected fractured rib.

56. On 3 June at 12.12pm, a prison GP examined Mr Foley and noted he had significant chest trauma with probable fractured ribs. He felt that Mr Foley had deteriorated so took his observations and noted that his resting pulse and blood pressure were low. He decided to send Mr Foley to hospital. Officers accompanied Mr Foley but did not restrain him.

57. Hospital staff diagnosed pneumonia and gave him intravenous antibiotics and noted he had chest and kidney injuries following the assault.

Events on 7 June 2016

58. On the morning of 7 June, hospital staff told Officer A, an escorting officer, that they would discharge Mr Foley from intensive care to prison. He told the prison and asked for a nurse to accompany Mr Foley back to the prison. A nurse said it was the hospital's decision to discharge and they could not send a nurse to accompany him.

59. At approximately 3.00pm, hospital staff discharged Mr Foley back to prison. Officer A noted that Mr Foley was very frail and trying to catch his breath so he again asked for a prison nurse to accompany them back to Lewes. The nurse repeated that it was the hospital's decision to discharge. He expressed his concerns to the prison duty manager and asked for healthcare staff to be the prison's forecourt, with a wheelchair, when they returned.

60. At approximately 4.00pm, Officer A helped Mr Foley into the back of a taxi for the journey back to Lewes and spent time making him comfortable. Mr Foley told him that he had been incontinent and that he felt hot. During the journey, Mr Foley used the officer's shoulder as a headrest, though the taxi driver said that Mr Foley was awake.

61. The taxi journey took approximately 40 minutes and the taxi arrived at the prison around 5.00pm. When Officer A opened the passenger door, he saw that Mr Foley's head was slightly back, his mouth was open and he looked very pale. He could not see any chest movement, so asked a HCA to check. The HCA said that Mr Foley was not breathing and he started cardiopulmonary resuscitation (CPR). At 5.05pm, another officer called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and asked for a defibrillator.

62. At 5.06pm, a nurse arrived with the defibrillator, which showed that Mr Foley was in cardiac arrest. Officer A helped lift Mr Foley out of the taxi onto the prison forecourt and the nurse and HCA continued with CPR. A paramedic rapid response vehicle arrived at 5.20pm and they took over attempts to resuscitate Mr Foley. At 5.55pm, a paramedic confirmed that Mr Foley had died.

Contact with Mr Foley's family

63. On 7 June at 2.00pm, Mr Foley's wife visited him in hospital. After he died, staff at the hospital contacted his wife by telephone to break the news of Mr Foley's death.

64. At the time of Mr Foley's death, Lewes did not have any trained family liaison officers in the prison. The prison contacted other local establishments to ask for support and HMP Ford agreed to release one of their officers. On 9 June, an officer was appointed as the family liaison officer. He visited Mr Foley's wife that day to offer condolences and support.

65. Mr Foley's funeral was held on 27 June 2016. The prison contributed to the costs, in line with national policy.

Support for prisoners and staff

66. After Mr Foley's death, two prison managers debriefed the prison staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

67. The prison posted notices informing other prisoners of Mr Foley'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 Foley's death.

Post-mortem report

68. A post-mortem examination concluded that Mr Foley died from left ventricular failure (the heart failed to pump enough to maintain blood circulation) and coronary heart disease due to diabetes and high blood pressure.

69. A consultant forensic pathologist noted that there was extensive bruising predominantly over Mr Foley's chest. He said that the features were not typical of a fall but were consistent with blunt force trauma assault, most likely from forceful punches. However, he found that Mr Foley's pneumonia had been treated so there was no direct causal link between the alleged assault by Mr Foley's cellmate and his death.

Findings

Allegations of bullying and assault

70. Guidance on the effective management of violent prisoners is contained in Prison Service Instruction (PSI) 64/2011 'Safer Custody'. The national instruction states, "Every verbal or physical act of violence must be challenged. Appropriate sanctions for perpetrators must be applied robustly, in a fair and consistent manner. Victims must be supported and protected".

71. The prison's local violence reduction policy, which was issued June 2015, said the prison had a rigorous approach to managing antisocial behaviour by recording all incidents of violence in NOMIS (the prison computer record) whether the acts be physical or verbal. The policy also said that staff would refer all incidents to the custodial manager of the area and states that all cases of serious violence within the prison will be referred to the police for investigation and possible persecution. The policy states that the staff priority is to support the victim.

72. Despite the content of the national PSI and Lewes' local violence reduction policy, we are not satisfied that prison staff responded appropriately to Mr Foley's serious and regular allegations against his cellmate.

73. Initially, on Mr Foley's cell sharing risk assessment, prison staff noted that he was significantly vulnerable to assault. While he had a good relationship with his first cellmate, prison staff clearly overlooked Mr Foley's vulnerability when deciding to allocate a 28 year old prisoner to share with a vulnerable 85 year old man.

74. After Mr Foley began to disclose allegations against his cellmate to the community psychiatric nurse, she passed this information on to a number of prison staff in the security and safer custody departments (although she could not recall all of the names of staff that she contacted). Despite passing on this information, Mr Foley was not moved to another cell and the apparent investigation undertaken by staff showed little attempt at challenging the alleged verbal and physical acts of violence or recording the incidents on NOMIS.

75. In May 2016, healthcare staff became fully aware of the extent of the injuries that Mr Foley had received. At this stage, the wing manager became aware of the problem, but took no further action. Also, no one from the prison photographed Mr Foley's injuries.

76. It is apparent that the police decided not to interview Mr Foley or to take photographs of his injuries, as the information supplied by the prison led them to classify the allegations as common assault.

77. At the end of May, a manager completed a violence reduction investigation, which appeared to concentrate on the scope for sanctions against the perpetrator rather than supporting Mr Foley, and did not elicit the information subsequently disclosed by Mr Foley of serious physical abuse by his cellmate.

78. We are concerned that healthcare staff felt unable to raise the safeguarding issue directly within Lewes or to escalate with the Prison Service through advertised routes and that a nurse did not pursue this again.

79. HMIP noted in their report of January 2016 that they were not assured that the prison investigated all incidents of violence, victimisation or self-harm sufficiently well, as the reasons why something had happened were overlooked. Fewer violent incidents were being investigated or monitored than during their previous inspection, despite a rise in violence at the prison. We agree and note that for Mr Foley there appeared to be under reporting of the bullying and assault incidents. We are particularly concerned that the prison did not deal with the issues effectively. There was insufficient evidence that prison staff investigated Mr Foley's allegations.

80. We are not satisfied that prison staff took appropriate action to support or protect Mr Foley. On two occasions, the community psychiatric nurse told security staff and safer custody staff about Mr Foley's allegations, yet we could find no evidence that either department took appropriate action to protect Mr Foley, instead relying upon a doctor's decision to admit him to the prison's inpatient unit.

81. While the pathologist could not find any causal link between the allegations of assault and Mr Foley's death, it is clear that the lack of support meant that Mr Foley lived in fear in his final few months at Lewes. It is important that staff are vigilant about any signs of potential bullying, particularly for vulnerable groups such as elderly prisoners. They should actively challenge and promptly deal with any antisocial and threatening behaviour. Prisoners identified as at risk of violence or threats from other prisoners should be effectively protected. In Mr Foley's case, we consider that the Governor should investigate why staff in the security and safer custody departments failed to take any action after being told of the allegations by the community psychiatric nurse. We make the following recommendations:

The Governor should ensure that allegations of violence, bullying or intimidation are taken seriously, investigated and dealt with in line with local and national policies. Prisoners identified as at risk of violence from other prisoners should be effectively protected and staff should document and photograph their injuries.

The Governor should commission an investigation into the circumstances surrounding the allegations of assault disclosed by Mr Foley and the actions which were taken as a result of those allegations to satisfy himself that staff acted appropriately and professionally.

82. We cannot be sure what information the prison supplied to the police, in particular whether the police were aware of Mr Foley's later allegations of serious assault; our requests have gone unanswered by the prison. Following the initial contact with the police, Mr Foley disclosed to healthcare staff that his cellmate had urinated on him, made him eat faeces, had threatened his family and had stolen his food and medication. Two prison GPs also found extensive bruising across Mr Foley's body. Taking into account these serious allegations, we believe that the prison should re-refer the matter to the police and ask them to consider a second investigation into the circumstances surrounding the

allegations of assault by Mr Foley's cellmate. We make the following recommendation:

The Governor should re-refer Mr Foley's allegations of assault and mistreatment to the police, ensuring that all relevant materials and information are included in the referral.

Clinical care

83. While the pathologist could not find any direct causal link between the alleged assault and Mr Foley's death, we note that the clinical reviewer said that the apparent bullying set up a chain of events that led to his death. The clinical reviewer considered that due to the presence of pre-existing coronary heart disease, it is probable that Mr Foley's death from left ventricular failure and coronary heart disease was a result of the events that occurred over the preceding week. Whether there was any causal link or not, we agree with the clinical reviewer that the standard of healthcare that Mr Foley received between 1 and 3 June was below the standard that he could have expected to receive.

84. The clinical reviewer said that on 1 June nurses noted that Mr Foley's oxygen saturation was low (less than 75%) and he was so short of breath he could not blow into a peak flow meter. Healthcare staff used the Modified Early Warning Score (MEWS) to determine the degree of Mr Foley's illness, but the clinical reviewer considered that Mr Foley's score was abnormal as blood oxygen levels below 80% may compromise organ function. The clinical reviewer felt that this should have been promptly addressed and that a prison GP should have considered an earlier emergency hospital admission.

85. The clinical reviewer was also concerned that a prison GP prescribed an opiate patch and codeine tablets for Mr Foley, despite the risk that opiates depress the respiratory centre and lead to low oxygen levels. It would have been safer to continue with frequent observations by measuring Mr Foley's oxygen saturation and respiratory rate. However, these were not taken on 1 or 2 June. We also note that healthcare staff took Mr Foley's observations on 3 June but did not record them on his MEWS chart.

86. These failings meant that Mr Foley was not sent to hospital until the afternoon of 3 June when a prison GP appropriately considered the seriousness of his condition. The clinical reviewer considered that Mr Foley's death may have been avoided by an earlier admission to hospital, as there would have been a more realistic prospect of him avoiding prolonged hypoxia and hypotension if he had been admitted to hospital on 1 June. We make the following recommendation:

The Head of Healthcare should ensure that Early Warning Scores are fully embedded into practice and used consistently.

87. While the care provided between 1 and 3 June was below the standard expected, we agree with the clinical reviewer that the response from prison and healthcare staff, when Mr Foley suffered a cardiac arrest, was appropriate. We note that the clinical reviewer has questioned whether the hospital's decision to discharge Mr Foley was appropriate. This is not within the remit of this investigation but we

understand that Brighton and Sussex University Hospitals NHS Trust was investigating this.

88. We note that Officer A had concerns about Mr Foley's condition and had wanted a nurse to accompany him back to the prison. While with hindsight the nurse's decision may have been unwise, we agree that the hospital had decided that Mr Foley was well enough to return to the prison and it was appropriate for prison healthcare staff to rely upon this decision.

Restraints, security and escorts

89. 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.

90. Mr Foley had hospital appointments on 4 and 14 January 2016 and, on both occasions, prison staff authorised officers to restrain him with a single handcuff. At the time of escort, the records noted that Mr Foley was frail, elderly and had reduced mobility. We are not satisfied that managers appropriately considered his condition at the time and how this affected his risk.

91. From June 2016, prison staff decided restraints were unnecessary, and they were never used again.

92. It was good to see that the decisions after June took into account Mr Foley's medical condition at that time. However, we do not consider that prison managers appropriately considered Mr Foley's risk when he attended earlier hospital appointments. We have previously raised this matter with Lewes. We repeat a recommendation about the use of restraints:

The Governor and Head of Healthcare should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of 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.

Contact with Mr Foley's family

93. Prison Rule 22 requires that if a prison dies, the Governor should "at once inform the prisoner's spouse or next of kin". In addition, PSI 64/2011 states that following a death in custody the prison must promptly notify the prisoner's next of kin.

94. Mr Foley died on 7 June, though due to a lack of trained family liaison officers at Lewes, no one from the Prison Service contacted Mr Foley's wife until 9 June.

Once a family liaison officer was appointed, we are satisfied that Mr Foley's wife was appropriately supported.

95. We are concerned that the lack of a trained family liaison officer meant that Mr Foley's wife was not supported for two days following his death. However, we do not make a recommendation to correct this as we have been assured that the prison had trained three family liaison officers following Mr Foley's death and were seeking further volunteers in 2017 to boost this number.

Prisons & Probation Ombudsman

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