Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Neale James a prisoner at HMP Lewes on 22 July 2017

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*

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.

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

Mr Neale James died on 18 July 2017 of a heart attack at HMP Lewes. He was 57 years old. We offer our condolences to Mr James' family and friends.

Although Mr James did not show any symptoms of cardio vascular disease while he was in prison, his family history of the condition, elevated blood pressure and cholesterol levels should have prompted healthcare staff to assess his risk of developing it.

Mr James' care was not therefore equivalent to that which he could have expected to receive in the community.

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

Elizabeth Moody
Acting Prisons and Probation Ombudsman March 2018

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Summary

Events

1. On 24 November 2011, Mr Neale James was sentenced to life imprisonment for murder and was sent to HMP Lewes. He had originally arrived at Lewes on 26 March 2011 as a remand prisoner.

2. A nurse conducted Mr James' first night screen at Lewes and although she recorded his blood pressure as 152/89 (ideal is 120/80) and that he was a smoker, she did not follow up on his blood pressure or offer smoking cessation advice. There were further occasions where Mr James' blood pressure was well beyond the ideal parameters but staff did not follow up on them. Mr James' blood pressure was last taken on 5 August 2015, with a reading of 149/79.

3. On 24 August 2012, a prison GP recorded that Mr James' cholesterol reading was 5.4mmol/L (millimoles per litre of blood). Although not significantly high, a desirable reading should be below 5 and anything higher should have prompted staff to perform a cardiovascular risk assessment and consider the benefit of a cholesterol reduction regime. Staff did not take any further action.

4. On 22 July, at approximately 10.52am, an officer found Mr James on the floor of his cell. He called an emergency radio code and started resuscitation. Other officers and a nurse attended as did paramedics but they were not able to resuscitate Mr James. Paramedics confirmed Mr James' death at 11.18am.

Findings

5. The clinical reviewer found that Mr James' care was not equivalent to that which he could have expected to receive in the community. Staff should have followed up on his high blood pressure readings and assessed him for cardiovascular disease.

Recommendations

- The Head of Healthcare should ensure that staff are aware of and understand NICE guidance and undertake cardiovascular risk assessments when appropriate.
- The Head of Healthcare should ensure that staff know how to detect and manage hypertension**.**

The Investigation Process

6. 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.

7. The investigator obtained copies of relevant extracts from Mr James' prison and medical records.

8. NHS England commissioned a clinical reviewer to review Mr James' clinical care at the prison.

9. We informed HM Coroner for 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.

10. The investigator contacted Mr James' next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond.

11. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Lewes

12. 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. HMP Lewes has a health care centre with a full time senior medical officer, which makes use of specialist NHS facilities when needed. Health care is provided on a 24-hour basis; there is a 12 bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

HM Inspectorate of Prisons

13. The most recent inspection of HMP Lewes was in January 2016. The inspectors found that staff in the healthcare inpatient unit provided prisoners with complex health needs with care, but a lack of custody staff affected the development of a therapeutic regime.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to July 2017, the IMB reported a number of problems including a very restricted regime, a steady flow of drugs, an increase in violence to staff and prisoners and cancellations of appointments and clinics because of low staffing levels. In December 2016, due to its ongoing problems, Lewes was designated a failing prison and put into special measures.

Previous deaths at HMP Lewes

15. Mr James' was the eighth death from natural causes at HMP Lewes since the beginning of 2016, although the first this year. There are no similarities with those cases.

Key Events

16. On 24 November 2011, Mr Neale James was sentenced to life imprisonment for murder and was sent to HMP Lewes. Mr James had originally arrived at Lewes on 26 March 2011, as a remand prisoner.

17. On 26 March 2011, a nurse conducted Mr James' reception screen at Lewes. He had no significant history of ill health. She noted that Mr James smoked cigarettes, his weight was 11 stone (although his height is not recorded) and his blood pressure was 152/89 (120/80 is the ideal). There is no evidence to show that she followed up Mr James' elevated blood pressure reading or offered him smoking cessation advice.

18. On 28 March, a prison GP saw Mr James and he complained of a constant headache. His blood pressure was 167/102 and he reported that he was very stressed. Mr James was prescribed amitriptyline (for physical pain and depression) and his mental state was monitored. Again, there is no evidence to indicate that anyone followed up or investigated Mr James' high blood pressure.

19. On 18 April 2011, Mr James was transferred to High Down for a brief period but was transferred back to Lewes on 3 Jun 2011. On his return, a nurse noted that Mr James' weight was 10 stone 6 pounds and he was 5 feet 8 inches tall. He had lost some weight and his blood pressure was lower than previous readings at 132/80.

20. On 24 August 2012, a prison GP recorded Mr James' cholesterol as 5.4mmol/L (An ideal reading is below 5.) The higher reading should have prompted staff to conduct a cardiovascular risk assessment to consider a cholesterol reduction regime, but they did not take any further action.

21. Mr James continued to see healthcare staff about irritation with his eyes and aching in his neck and arms. He had minimal contact with healthcare staff until 23 July 2015, when he told a prison GP he was feeling lethargic all the time and was worried about his weight loss. Mr James declined smoking cessation advice but his other symptoms prompted a series of blood tests and investigations over the next two years. These included stool sample analysis and internal investigations but the results did not explain his symptoms.

22. On 5 August 2015, a prison GP reviewed Mr James as part of ongoing bowel investigations. He recorded that Mr James' blood pressure was 149/79, but did not investigate the matter further. A nurse took his blood pressure later that day and it was still partially elevated at 142/76. This was the last time Mr James' blood pressure was taken in prison.

23. On 22 July 2017, according to the Post-Mortem report, Mr James was seen at breakfast. Afterwards at approximately 9.30am, Officer H put Mr James' canteen sheet under his door. At 10.52am, an officer unlocked Mr James' cell, as he was needed in the servery. Mr James was naked, on his back and on the floor between the bed and the sink. His canteen sheet was on a table in the cell. The officer called Mr James' name and put his hand on his chest. Mr James was cold to the touch. The officer called a code blue on his radio (an emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing

difficulties) and started chest compressions. Staff in the control room called an ambulance at 10.53am.

24. A prison manager and another officer attended the cell and the officer who was already there asked them to get the defibrillator (an electrical device to aid resuscitation), which they got straight away from the wing office. When they attached it to Mr James, it advised them not to administer a shock so they continued with manual chest compressions.

25. A nurse was on F wing. At 10.53am, he received the code blue call asking him to attend L wing. He told the communications room that he was already dealing with a prisoner with chest pains but would be there shortly. At 10.56, staff in the communications room contacted him and asked that he go immediately to L wing as the situation was severe. The nurse went immediately to L wing and assisted staff with the manual resuscitation attempt. He consulted the defibrillator again but it still advised 'no shock'. Paramedics arrived at the prison at approximately 11.05am, and continued with resuscitation attempts. Mr James did not respond and at 11.18am paramedics confirmed he had died.

Contact with Mr James' family

26. On 22 July, at 12.00pm, the prison appointed a manager to be the family liaison officer (FLO). He found the next of kin's address on NOMIS (the prison's computer system) and arrived at the address at 4.30pm but the property was empty. The FLO called a number that had been on NOMIS and spoke to the next of kin who provided their new address. The FLO arrived at the new address at 5.30pm and gave the news that Mr James had died. He maintained contact with the family and offered advice and support.

27. Mr James' funeral was held on 15 August 2017. The FLO and an officer attended. The prison contributed to the costs of the funeral in line with national guidance.

Support for prisoners and staff

28. On 22 July, a prison manager held a hot debrief after Mr James' death in order to ensure the staff involved in the emergency response had the opportunity to discuss any issues arising and to offer support.

29. The prison posted notices informing other prisoners of Mr James' 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 James' death.

Post-mortem report

30. The coroner provided a copy of the post-mortem report which said the cause of death was 1a) cardiac arrest, 1b) ischaemic heart disease and 1c) coronary artery atherosclerosis.

Findings

31. The clinical reviewer found that the care Mr James received was not equivalent to that which he could have expected to receive in the community.

32. NICE clinical guidelines indicate that people older than 40 should have their estimated cardiovascular disease risk reviewed on an ongoing basis. This is standard practice in the community for patients with a family history of premature coronary heart disease. Mr James had such a history and there were other factors indicating that he might be at risk including his smoking habit and cholesterol levels.

33. Mr James' blood pressure was noted to be elevated on several occasions (in 2011 it was as high as 167/102). An ideal reading is 120/80 and Mr James' blood pressure was never within these parameters. Staff should have addressed this. We make the following recommendations:

    The Head of Healthcare should ensure that staff are aware of and understand NICE guidance and undertake cardiovascular risk assessments when appropriate.

    The Head of Healthcare should ensure that staff know how to detect and manage hypertension.

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