

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Justin Gallagher a prisoner at HMP Lewes on 16 June 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.

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 Justin Gallagher, also known as Peter, died at hospital on 16 June 2016 from a hypoxic brain injury (a brain injury from oxygen deprivation) caused by a heart attack brought on by laryngeal cancer. Mr Gallagher was 50 years old. I offer my condolences to Mr Gallagher's family and friends.

I am concerned that Mr Gallagher did not receive care at HMP Lewes equivalent to that he would have expected to receive in the community. Healthcare staff did not request his full medical records, so were unable to confirm his previous medical history and the prison inappropriately cancelled and postponed various hospital appointments. I concur with the clinical reviewer's conclusion that, if Mr Gallagher had attended any of these appointments, his laryngeal cancer might have been detected earlier.

I am troubled that prison staff admitted to falsifying documents and retrospectively signed that staff had completed checks on Mr Gallagher's welfare, after he had been found unresponsive. The governor needs to ensure that staff are made aware that these are potentially serious disciplinary matters.

I am also concerned that when prison staff found Mr Gallagher unresponsive, they called the wrong emergency code and control room staff delayed calling for an ambulance. As I have identified in previous investigations, HMP Lewes did not appoint a family liaison officer promptly.

This investigation has identified a number of serious deficiencies in the treatment given to Mr Gallagher at HMP Lewes, it is essential that the governor takes robust action to ensure that lessons are learned from this sad case.

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

January 2017

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Summary

Events

1. On 29 March 2016, Mr Justin Gallagher was remanded to HMP Lewes on charges of theft. Mr Gallagher had been treated for laryngeal (voice box) cancer in 2015 and was being monitored in the community. He also had a history of mental health and substances misuse issues.
2. Mr Gallagher had several follow up appointments with hospital specialists to monitor his throat which had been booked prior to his arrival at Lewes. He did not attend any of these appointments while in custody because Lewes either cancelled or rearranged them. On numerous occasions, Mr Gallagher told prison staff that he was concerned that his cancer had returned and requested to see a hospital specialist.
3. On 1 April, Mr Gallagher made cuts to his wrist and staff placed him on suicide and self-harm prevention procedures, known as ACCT. Five days later, Mr Gallagher set fire to his cell and staff moved him to the segregation unit. He stayed in the segregation unit for 17 days and began to display increasingly bizarre and manic behaviour. A nurse visited Mr Gallagher on 23 April and was concerned about his mental and physical health, so arranged for him to move to the prison's inpatient unit.
4. On three occasions in April and May, Mr Gallagher informed staff he had been coughing up blood. On the third occasion, Mr Gallagher was sent to hospital, although he refused to undergo medical tests and discharged himself from hospital care. He was located in the healthcare unit until 19 May, when he was relocated to the segregation unit for damaging his cell.
5. At approximately 5.05pm on 24 May, two officers found Mr Gallagher unresponsive in his cell in the segregation unit. One of the officers called an emergency code and a nurse started cardiopulmonary resuscitation (CPR). An ambulance was called five minutes later. Paramedics attended and took Mr Gallagher to hospital where he was admitted.
6. Mr Gallagher did not regain consciousness and he died on 16 June with his family with him.

Findings

7. We agree with the clinical reviewer that the care Mr Gallagher received was not equivalent to the care he would have expected to receive in the community. We are concerned that Mr Gallagher missed important hospital appointments, at least one of which appears to have been cancelled for entirely inappropriate reasons, his medical records were not obtained and he did not have a named clinician in charge of his care.
8. We are concerned that prison staff moved Mr Gallagher to the segregation unit while he was on suicide and self-harm prevention measures and continued to hold him there without considering whether there were exceptional reasons that meant he could not be located elsewhere in the prison.

9. Mr Gallagher's father wrote to the prison on two occasions raising concerns about his health. On the first occasion, he appears not to have received any reply; on the second the reply he was sent was inaccurate, incomplete and misleading.
10. Although an officer called an emergency code and a nurse quickly started CPR after finding Mr Gallagher, the wrong code was used and an ambulance was not called for five minutes.
11. We are also extremely concerned that during interviews, prison staff admitted that they falsified documents in the segregation unit and retrospectively signed forms to say that staff had completed checks on Mr Gallagher's welfare.
12. Finally, we are concerned that Lewes did not appoint a family liaison officer until the day after his death.

Recommendations

- The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners and offer prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.
- The Governor and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.
- The Governor should ensure that prisoners at risk of suicide and self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, and their responsibilities during medical emergencies so that:
 - The nature of the emergency is efficiently communicated; and
 - An ambulance is called immediately after an emergency call is received, without waiting for further confirmation
- The Governor should ensure that all staff fully understand that alteration of documents, including retrospective entries, can amount to a serious disciplinary matter.
- The Governor should ensure that correspondence from prisoners' families is treated with appropriate seriousness and receives timely, accurate and informative replies.
- The Governor should ensure that there are sufficient trained family liaison officers who keep in touch with the families of seriously ill prisoners and inform them promptly when they are admitted to hospital.
- The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible.
- 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

13. The investigator issued notices to staff and prisoners at HMP Lewes informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
14. The investigator obtained copies of relevant extracts from Mr Gallagher's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Gallagher's clinical care at the prison.
16. Another investigator and the clinical reviewer interviewed four members of staff at Lewes on 6 September 2016. The investigator interviewed two members of staff at Lewes on 29 September and one member of staff on 4 October.
17. We informed HM Coroner East Sussex of the investigation. Our investigation was suspended for nearly a month until we received the cause of death from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.
18. One of the Ombudsman's family liaison officers contacted Mr Gallagher's father, to explain the investigation and to ask if he had any matters he wanted the investigation to consider. Mr Gallagher's father had a number of concerns for the investigation to consider including:
 - Whether Mr Gallagher's previous medical records had been requested from the local GP and if staff were aware of his prescribed medication in the community.
 - Whether Mr Gallagher's healthcare needs were met when he was located in healthcare.
 - Whether the prison were aware of Mr Gallagher's hospital appointments and which appointments he did and did not attend.
 - Whether the Governor received his letters sent detailing Mr Gallagher's health issues and the family's concerns, and what action was taken.

Background Information

HMP Lewes

19. 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.
20. 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

21. 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

22. 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

23. Mr Gallagher was the fifth prisoner to die of natural causes at HMP Lewes since January 2015. We have made a recommendation about family liaison before.

Assessment, Care in Custody and Teamwork

24. Assessment, Care in Custody and Teamwork (ACCT) is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should be irregular to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves drawing up a care map to identify the prisoner's most urgent issues and how they will be met. Regular multidisciplinary reviews should be held. The ACCT plan should not be closed until all of the actions on the care map have been completed. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Segregation units

25. Segregation units are used to keep prisoners apart from other prisoners. This can be because they feel vulnerable or under threat from other prisoners or if they behave in a way that prison staff think would put people in danger or cause problems for the rest of the prison. They also hold prisoners serving punishments of cellular confinement after disciplinary hearings. Segregation is authorised by an operational manager at the prison who has to be satisfied that the prisoner is fit for segregation after an assessment by a member of healthcare staff. Segregation unit regimes are usually restricted and prisoners are permitted to leave their cells only to collect meals, wash, make phone calls and have a daily period in the open air. The segregation unit at Lewes has 16 cells.

Key Events

26. On 29 March 2016, Mr Gallagher was remanded into custody on charges of theft and was sent to HMP Lewes.
27. At his initial health screen, Mr Gallagher told a nurse that he had been diagnosed with laryngeal (voice box) cancer two years earlier and he was concerned that he also had lung cancer. The nurse measured his blood pressure, which was normal, and pulse rate, which was slightly high.
28. The next day, Mr Gallagher told a nurse he thought he had lung cancer, although this had not been diagnosed. She booked a GP appointment. Later that day, a prison GP examined Mr Gallagher, who asked for the throat cancer medication prescribed in the community. The GP prescribed nebido (a testosterone replacement therapy) and a salbutamol inhaler (used to treat asthma and other lung diseases). The GP recorded that Mr Gallagher was only expected to be in custody for two weeks, so he could follow up an appointment with the endocrinology clinic with his community GP.
29. In the early hours of 31 March, Mr Gallagher complained to a nurse that he had not been prescribed medication for his throat cancer. The nurse gave Mr Gallagher paracetamol and referred the matter to a prison GP. Later that day, the GP prescribed Mr Gallagher with the medication he received in the community, which included accrete D3 tablets and thiamine (for vitamin deficiencies) and clenil modulate (to prevent inflammation and irritation in the lungs).
30. On the afternoon of 31 March, prison staff requested an emergency assessment of Mr Gallagher. A psychiatric nurse saw Mr Gallagher, who had covered his face and neck in toothpaste which he said was to symbolise his ancient Sumerian Gypsy ancestry. Mr Gallagher told the nurse that his throat cancer had affected his voice and this caused him to sound aggressive. Mr Gallagher said that he was worried about his physical health and that he may have lung cancer. The nurse thought Mr Gallagher presented as though he was withdrawing from alcohol so asked the drug misuse services to review him. Later that day, a substance misuse nurse reviewed Mr Gallagher, who denied alcohol dependency. She did not find any indication that Mr Gallagher was withdrawing from alcohol.
31. On 1 April, a nurse saw Mr Gallagher after he made a superficial cut to his forearm. Mr Gallagher told her that he wanted to see his hospital specialist or he was going to kill himself. He was also verbally abusive towards her. She opened an ACCT plan, which required staff to speak to Mr Gallagher every hour.
32. On 3 April, a nurse examined Mr Gallagher on the exercise yard because officers thought that he had used a new psychoactive substance (NPS). Mr Gallagher's clinical observations were high so the nurse admitted him to the prison's inpatient unit. There is no other suggestion that Mr Gallagher used NPS or other drugs while at Lewes.
33. On 6 April, Mr Gallagher set fire to his cell. He said that he had done this in order to have staff attend to his healthcare needs. He said he told healthcare staff that he was very ill, had issues with his throat and thought he had lung

- cancer. A nurse assessed him after the fire and determined that he did not require medical treatment. Officers moved Mr Gallagher to the segregation unit.
34. Prison Service Instruction (PSI) 64/2011 has a mandatory instruction that prisoners being managed under ACCT procedures should be held in segregation units only in exceptional circumstances. It states that the reasons must be clearly documented in the ACCT plan. A prison manager held an ACCT case review, on 7 April, following Mr Gallagher's segregation, which a Senior Officer (SO) also attended. Neither Mr Gallagher nor a healthcare representative attended the case review. No one recorded the reasons for the exceptional circumstances justifying segregation, although the manager changed the level of observations to two conversations daily and two observations at night.
 35. Mr Gallagher's father sent a letter to the prison, received on 7 April, asking the prison to ensure that he attended a hospital appointment with his endocrinologist, scheduled for 11 April. There is no record that the prison responded to this letter.
 36. On the same day, a healthcare secretary contacted the hospital and rearranged Mr Gallagher's endocrinology appointment from 11 April to 27 June. There was no record of why the endocrinology appointment was rearranged. The hospital also told the secretary that Mr Gallagher had two appointments with the maxillofacial and ear, nose and throat (ENT) departments on 6 May and 1 June respectively.
 37. On 8 April, segregation staff requested healthcare staff to examine Mr Gallagher, as he had been coughing up blood. A nurse attended and Mr Gallagher told him that he was coughing up little lumps of blood, which he said was a clear sign of cancer. The nurse took his blood pressure and his oxygen levels (which were normal) and his pulse (which was slightly high). He also gave Mr Gallagher a sputum pot in order to show the GP what he was producing. The GP saw Mr Gallagher later on that morning. The GP noted that he was coughing up sticky white sputum. There was no record to show that the GP made a diagnosis or a plan to investigate Mr Gallagher's symptoms further.
 38. The psychiatric nurse saw Mr Gallagher, on 12 April, for his mental health assessment. Mr Gallagher said he was angry about being in prison and his lack of medical treatment. The nurse noted that Mr Gallagher was struggling to breathe and needed his inhaler to help breathe. However, later that day, a nurse examined Mr Gallagher but noted that he did not have a cough or shortness of breath. Mr Gallagher said that he was worried about his breathing so the nurse arranged an appointment with the doctor.
 39. A prison GP saw Mr Gallagher, the following day, and noted he was unkempt and shouting about his care needs. The GP determined that Mr Gallagher needed further psychiatric assessment and referred him back to the mental health team. However, on 14 April, an occupational therapist recorded that Mr Gallagher's referral to the mental health team had been rejected as the psychiatric nurse had assessed him on 12 April.
 40. Mr Gallagher complained of breathing difficulties to a nurse on 15 April and reiterated that he had throat cancer. She took his blood pressure and his oxygen levels but noted that Mr Gallagher was not struggling to breathe.

41. On the same day, prison staff closed Mr Gallagher's ACCT, as he no longer had thoughts of suicide and self-harm. They confirmed that he would remain in the segregation unit until a cell on a normal wing was available. In fact, he remained in segregation for a further 10 days.
42. Mr Gallagher continued to complain of suspected cancer, excess coughing and shortness of breath, but all healthcare staff who reviewed him recorded that he was not coughing and had no difficulty breathing. He also displayed more bizarre behaviour. No further investigations were completed or planned.
43. On 25 April, a nurse saw Mr Gallagher, who said that he was coughing up blood and pus. She noted that he appeared chaotic and confused so she arranged for his admission to the inpatient unit (rather than a cell on a normal wing as staff had planned) for further physical and mental health assessments.
44. Later that day, Mr Gallagher told a nurse that the central heating in the inpatient unit made his breathing difficulties worse. She explained that she had no control over the heating but asked a doctor to examine him. The following day, a prison GP saw Mr Gallagher and noted that his sputum was clear. She referred Mr Gallagher for an urgent chest x-ray. There was no evidence this was completed.
45. On the same day, Mr Gallagher's father wrote to the prison to ask about his son's mental health and whether his hospital appointments had been cancelled. The prison responded, on 4 May, and explained that Mr Gallagher had been referred to the mental health team but did not provide any information about his cancelled appointments. At that time, Mr Gallagher's mental health referral had been rejected.
46. On 3 May, a healthcare manager contacted the Macmillan team, as he had concerns about Mr Gallagher's physical health and wanted them to review him. This was a different appointment to the planned appointments with endocrinology, maxillofacial or ENT.
47. A prison GP saw Mr Gallagher on 4 May. She noted concerns about his physical health, weight loss, hoarse voice and previous diagnosis of throat cancer. She noted he was not suffering from breathlessness and his chest was clear so diagnosed him with a cough. She noted he was due an oncology appointment, and to await the results from this unless Mr Gallagher presented with any new concerns. There is no record to confirm if this was Mr Gallagher's rearranged endocrinology appointment.
48. On the same day, the healthcare secretary contacted the hospital to rearrange Mr Gallagher's maxillofacial and ENT appointments that were booked for on 6 May and 1 June. She rebooked the appointments for 25 July and 24 August. We have been unable to determine why these appointments were rearranged. The following day, she noted that a task had been raised for the prison to contact Macmillan nurses to bring Mr Gallagher's appointment forward. An appointment was arranged for 11 May.
49. On 10 May, another healthcare secretary cancelled Mr Gallagher's hospital appointment with the Macmillan team, as the prison could not facilitate the

appointment without cancelling existing appointments for other prisoners. The appointment was rearranged for 18 May.

50. Mr Gallagher spoke to the healthcare manager on 14 May, and asked to be taken to hospital as he had coughed up blood. The manager contacted a prison GP, who advised that staff should monitor Mr Gallagher overnight. A nurse recorded that the samples of blood he said had coughed up were minimal and staff had not observed where the blood had come from.
51. The following day, the healthcare manager sent Mr Gallagher to hospital, as he continued to cough up blood. While in hospital, Mr Gallagher had a chest x-ray, which showed what was presumed to be an infection but doctors could not rule out an underlying malignancy. Doctors prescribed him antibiotics and informed his prison GP. However, Mr Gallagher self discharged from hospital after refusing a CT scan or an intravenous cannula.
52. A nurse saw Mr Gallagher, on 17 May, and noted that his physical health had deteriorated. She noted his throat was very hoarse and that he had little voice left so found it difficult to express himself. There was no record that she took any further action.
53. On 18 May, the healthcare secretary noted that an operational manager had cancelled Mr Gallagher's Macmillan appointment, as the security department felt Mr Gallagher was 'a danger to society' due to his behaviour in his cell. There was no record that this appointment was rearranged for a second time.
54. The following day, Mr Gallagher was taken to the segregation unit after smashing up his cell and observation panel. On arrival in the segregation unit, Mr Gallagher reiterated that he had lung cancer and was frustrated about his treatment. Two nurses agreed that Mr Gallagher was medically fit to be held in the segregation unit.
55. Mr Gallagher reported wheezing and difficulty breathing to a nurse on 23 May. The nurse measured his oxygen levels at 98% (a normal reading is above 95%), gave him an inhaler and noted his speech was not affected. The on call GP prescribed steroids.

Events on 24 May 2016

56. At 6.59am on 24 May, a nurse examined Mr Gallagher, as he complained that he was unable to breath. She measured his oxygen levels at 98% and noted that he was talking to demand oxygen. She gave him with a new asthma inhaler.
57. At 1.00pm, a prison GP saw Mr Gallagher. He told her that he had pneumonia and had taken all of his antibiotics in one go. She took his observations and noted that he had a widespread chest wheeze.
58. Between 3.17pm and 4.26pm, Mr Gallagher rang his cell bell on nine occasions, all of which were answered by prison staff. An officer answered the last call at 4.28pm and Mr Gallagher requested some paracetamol. The officer contacted healthcare twice to get the paracetamol.

59. While in the segregation unit, staff were required to check on him every hour and record that they had done so in a segregation document. At approximately 5.00pm, an officer found that staff had not made these entries since 9.00am that morning, so completed the missing entries in Mr Gallagher's segregation history sheet.
60. At approximately 5.05pm, two officers accompanied a nurse to Mr Gallagher's cell to give him two paracetamol. After unlocking the cell, the officers found Mr Gallagher slumped over his bed. One officer attempted to wake him but could not gain a response. He then called a code red at 5.07pm. The nurse began cardiopulmonary resuscitation (CPR) until the Matron arrived with the resuscitation bags and a defibrillator. The defibrillator did not advise any shocks so CPR continued. Another nurse arrived and inserted an airway into Mr Gallagher's throat.
61. The communication log showed that an ambulance was called at 5.10pm; records from the South East Coast Ambulance Service confirmed they received a request for an emergency ambulance at 5.12pm. Paramedics arrived at the prison at 5.17pm. Paramedics took over control of the CPR and, at 6.30pm, they took Mr Gallagher to hospital. Two officers escorted Mr Gallagher but did not restrain him.
62. Mr Gallagher remained at hospital but he never regained consciousness and died on 16 June. His family were present.

Contact with Mr Gallagher's family

63. On 17 June, Lewes appointed an officer from HMP Swaleside as the family liaison officer because they did not have any trained family liaison officers at the prison. On the same day, she contacted Mr Gallagher's brother and offered her condolences and support. Over the following days, she appropriately supported Mr Gallagher's family.
64. Mr Gallagher's funeral was held on 25 July, and Lewes contributed towards the costs, in line with national instructions.

Support for prisoners and staff

65. The prison posted notices informing other prisoners of Mr Gallagher'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 Gallagher's death.
66. After Mr Gallagher's death, there was no record that managers debriefed the staff involved in the emergency response to review what had happened and to support them. At interview, staff said they were not offered support.

Post-mortem report

67. A post-mortem examination found that Mr Gallagher died of a hypoxic brain injury due to cardiac arrest with underlying laryngeal carcinoma. (His brain was starved of oxygen due to a cardiac arrest caused by an upper airway obstruction from Mr Gallagher's throat cancer.)

Findings

Clinical care

68. Mr Gallagher was in Lewes for eight weeks before his collapse on 24 May. The clinical reviewer concluded that there was limited time to sort out Mr Gallagher's complex physical, psychological and substance abuse related problems and Mr Gallagher's early symptoms could be attributed to his pre-existing medical conditions. However, the clinical reviewer was not satisfied with various aspects of the prison's care, which included the failure to obtain Mr Gallagher's full medical history and the number of cancelled hospital appointments
69. By failing to obtain Mr Gallagher's full medical history, despite his confirmation that he had laryngeal cancer and forthcoming hospital appointments, the prison did not comply with Prison Service Order (PSO) 3050 'Continuity of Healthcare for Prisoners'. This PSO requires that healthcare staff should try to obtain relevant information from the prisoner's GP or other relevant health services the prisoner has recently been in contact with, when new prisoners arrive in reception. We agree with the clinical reviewer that if healthcare staff had obtained his full medical history, then this would have facilitated a more accurate assessment of Mr Gallagher's current and ongoing health needs. It would have helped healthcare staff to differentiate between his old and new symptoms.
70. In relation to Mr Gallagher's hospital appointments, the prison cancelled or rearranged all of them. The prison often failed to explain why the appointments were cancelled, though a lack of resources and security concerns were recorded as reasons for cancellation on 10 and 18 May respectively. There is no record to explain why all of Mr Gallagher's other endocrinology, maxillofacial and ENT appointment were cancelled or rearranged.
71. During an interview with a prison manager, he said that he could not recall cancelling Mr Gallagher's appointment on 18 May, although the healthcare secretary recorded in the medical record that the security department had cancelled it because he was a 'danger to society'. Mr Gallagher demonstrated challenging behaviour and had damaged his cell on at least two occasions but we did not find further evidence that Mr Gallagher had been violent while in custody. When Mr Gallagher went to court on 18 April and 9 May, security staff completed Person Escort Records but did not add any information to the boxes titled 'violence/ risk to others', 'hostage taker' or 'conceals weapons or other items'. Consequently, we are very concerned that the prison cancelled his appointment on 18 May for what seem to have been arbitrary and unsupported reasons which inappropriately overrode the clinical view that Mr Gallagher's health concerns justified the appointment.
72. For Mr Gallagher's other hospital appointments, we are concerned that healthcare staff did not view them as urgent, despite his history of laryngeal cancer. The clinical reviewer concluded that Mr Gallagher's laryngeal cancer could have been detected earlier had he attended any of his hospital appointments.

73. We agree with the clinical reviewer's conclusion that the care Mr Gallagher received was not the equivalent to the care he would have expected to receive in the community. We make the following recommendations:

The Head of Healthcare should ensure that healthcare staff routinely request community medical records for newly arrived prisoners and offer prisoners a full general health assessment within a week of their arrival, in line with PSO 3050.

The Governor and Head of Healthcare should ensure that prisoners do not miss hospital appointments unless there are properly justified, exceptional and fully recorded reasons.

Segregation

74. Prison Service Instruction (PSI) 64/2011 requires that prisoners assessed as at risk of suicide and self-harm should be held in segregation units only in exceptional circumstances and that the reasons must be clearly documented in the ACCT record and includes other options that were considered but discounted. Mr Gallagher was not in the segregation unit when the ACCT was opened, but moved there shortly afterwards. There was nothing in the ACCT document to indicate that staff recognised that his location in the segregation unit was exceptional, that any other options were considered, or that these exceptional reasons were reconsidered at any stage.
75. While Mr Gallagher completed his time in the segregation unit without any further episodes of self-harm, we are concerned that this situation may arise in the future and other prisoners may seriously harm themselves or commit suicide. We make the following recommendation:

The Governor should ensure that prisoners at risk of suicide and self-harm are not held in the segregation unit unless all other options have been considered and excluded and there are fully documented reasons to explain the exceptional circumstances.

Emergency response

76. PSI 03/2013 'Medical Emergency Response Codes' explains that a code red emergency code indicates a prisoner is bleeding or burnt whereas a code blue indicates that a prisoner is unconscious or not breathing. On hearing either code, a control operator staff must immediately request an ambulance. Lewes has a local policy that reflects the content of PSI 03/2013.
77. One of the first officers on the scene called a code red. At interview, he explained he panicked and called the wrong code. Even though the wrong code was used, we would still expect that a control room operator would immediately call for an ambulance. However, there was a delay of between three and five minutes for the operator calling for an ambulance. While the ambulance quickly arrived, and healthcare staff and paramedics managed to revive Mr Gallagher, the outcome could be different in the future. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, and their responsibilities during medical emergencies so that:

- **The nature of the emergency is efficiently communicated; and**
- **An ambulance is called immediately after an emergency call is received, without waiting for further confirmation.**

Record keeping

78. At interview, the officer said had been present in the segregation unit on the morning of the 24 May, but escorted another prisoner to hospital after an earlier incident at Lewes. On his return to the prison, he noticed that Mr Gallagher's segregation checks had not been documented. He asked the staff present on the unit, during his absence, how Mr Gallagher was and other staff said that Mr Gallagher was fine but had requested two paracetamol. He then retrospectively signed the checks for 10.00am to 5.00pm.
79. Staff in the segregation unit should have been checking Mr Gallagher every hour, as required by the terms of his segregation. There was no evidence that staff actually completed these checks, and Mr Gallagher's segregation sheet had eight missing entries. While it was clear that Mr Gallagher was alive during this time because the automated system showed he had used his cell bell nine times, we are concerned that segregation unit staff should have been completing and documenting the required checks at the specified time. We are also extremely concerned that an officer admitted to retrospectively completing the segregation document, thereby falsifying the document. We make the following recommendation:

The Governor should ensure that all staff fully understand that alteration of documents, including retrospective entries, can amount to a serious disciplinary matter.

Contact with Mr Gallagher's family

80. Prison Rule 22 requires that when a prisoner becomes seriously ill, the Governor should "at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". In addition, PSI 64/2011 'Safer Custody' states that where prisoners suffer a rapid deterioration in their physical health, prisons must have in place procedures for supporting the prisoner and engaging with their next of kin.
81. Mr Gallagher was taken to hospital on 24 May after being found unconscious in the segregation unit. At this point, we would have expected the prison to appoint a family liaison officer to inform the family and provide support. However, Lewes did not have a trained family liaison officer and did not consider requesting the use of a family liaison officer from another prison until the day after Mr Gallagher died. We are concerned that the lack of a trained family liaison officer meant that Mr Gallagher's family were not supported for 24 days after his collapse. We make the following recommendations:

The Governor should ensure that there are sufficient trained family liaison officers who keep in touch with the families of seriously ill prisoners and inform them promptly when they are admitted to hospital.

The Governor should ensure, in line with Prison Rule 22 and PSI 64/2011, that the next of kin of seriously ill prisoners are informed as soon as possible.

82. Mr Gallagher's father wrote two letters to the prison about his son's mental health treatment and need to attend hospital appointments yet the prison only responded to the second letter, dated 25 April. We are concerned that the prison did not respond to the first letter and that the second letter failed to explain that Mr Gallagher's mental health referral had been rejected. The Governor should ensure that any information supplied to the families of prisoners is accurate.

The Governor should ensure that correspondence from prisoners' families is treated with appropriate seriousness and receives timely, accurate and informative replies.

Support for staff

83. Our investigation confirmed that a prison manager did not hold a debrief following Mr Gallagher's death. Additionally, during interviews with two officers, they said that they were offered little support by prison managers.
84. 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.

**Prisons &
Probation**

Ombudsman
Independent Investigations