Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Haines a prisoner at HMP Lewes on 18 March 2018

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.

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 Martin Haines died on 18 March 2018 of a cardiac arrest at HMP Lewes. The post-mortem examination found that he had high levels of prescribed medication and alcohol in his system, which, while not at fatal levels, were contributory factors in his death. He was 60 years old. I offer my condolences to Mr Haines' family and friends.

After Mr Haines' death, staff found notes in his cell saying that he was almost four years over his minimum tariff and could not take it anymore, and that he would rather end his life than have to stop smoking. (Lewes became smoke free six weeks after Mr Haines died.) We cannot, therefore, rule out the possibility that Mr Haines deliberately took an excessive amount of his prescribed medication with a view to ending his life.

I am satisfied that there were no indications that Mr Haines was at imminent risk of suicide or self-harm in the days leading up to his death and that staff could not have predicted his actions.

Mr Haines had type 2 diabetes and strong risk factors for cardiovascular disease. My investigation found that Mr Haines was not properly monitored and his clinical care was not equivalent to that which he could have expected in the community.

I am concerned that Mr Haines was clearly able to obtain alcohol easily in Lewes and have recommended that Lewes reviews its substance misuse policy so that the illicit production and consumption of alcohol is properly addressed.

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 **November 2018**

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Summary

Events

1. On 21 June 2011, Mr Martin Haines was convicted of arson and sent to HMP Lewes. On 25 July, he was given an imprisonment for public protection (IPP) sentence with a minimum tariff of 2 years and 332 days.

2. Mr Haines had a history of alcohol problems. He was also a heavy smoker and was overweight. In November 2017, he was diagnosed with type 2 diabetes.

3. Mr Haines remained in prison beyond his minimum tariff because he refused to attend group work to address his offending behaviour. He said this was because of his anxiety. Prison healthcare staff provided support for his mental health issues and he was prescribed antidepressants. Mr Haines expressed frustration that he was still in prison over three years after completing his minimum term.

4. On 18 March 2018, at around 8.50am, an officer looked through the observation hatch on Mr Haines' cell and unlocked the door. He thought Mr Haines was using the toilet as he saw his foot next to it, so he did not try to get a response and carried on unlocking the rest of the landing.

5. At around 9.10am, a prisoner told two officers that Mr Haines was unresponsive and they went to his cell. They found him lying on the floor and he was cold to touch. At 9.16am, one of the officers called a medical emergency code. Another officer arrived and tried to move Mr Haines but his body was too stiff. An officer attempted to start cardiopulmonary resuscitation (CPR), but the stiffness of Mr Haines' body meant he could not continue. Nurses arrived shortly afterwards and decided not to start CPR, as it was clear that Mr Haines had died.

6. The post-mortem examination found that Mr Haines died of a cardiac arrest caused by coronary artery artherosclerosis (hardening and narrowing of the arteries supplying the heart). High concentrations of prescribed medication were found in his blood, which were higher than therapeutic levels but lower than fatal levels. Alcohol was also detected. The post-mortem report said that the levels of medication and alcohol, along with Mr Haines' type 2 diabetes, were contributory factors in his death. It concluded that intentional or accidental overdose should be considered a possibility.

7. On 30 April, officers tasked with clearing Mr Haines' cell found two notes he had written. In one, he said he was fed up that he was still in prison nearly four years past his minimum term and that he had drunk alcohol every week during his time in prison. In the other, he appeared to refer to the prison's plan to go smoke free and said that he had been smoking for 51 years, that it was the only thing he had left and that the only answer was 'topping himself'.

Findings

8. Mr Haines gave no indication to staff that he was at risk of suicide and self-harm and we are satisfied that staff could not have predicted his actions.

9. Mr Haines had high levels of alcohol in his blood when he died, which was a contributory factor in his death. He said in one of his notes that he drank alcohol regularly in prison. The availability of illicitly brewed alcohol in Lewes needs to be addressed. We are concerned that Lewes' substance misuse policy is focused solely on drugs and does not address alcohol.

10. We are concerned that the officer who unlocked Mr Haines' cell on the morning he was discovered did not follow the correct procedure of obtaining a response from him and therefore failed to identify that he was unresponsive on his cell floor.

11. There was a delay of six minutes in control room staff calling an ambulance after the emergency medical code had been called. Although this did not affect the outcome in Mr Haines' case, it could be critical in future cases.

12. The clinical reviewer found that Mr Haines' care was not equivalent to that which he could have expected to receive in the community. Staff did not follow up on Mr Haines' high blood sugar levels, complete care plans for diabetes and hypertension, or consider the risks associated with prescribing antidepressants to patients with high blood pressure and cardiovascular disease.

Recommendations

- The Governor should review the prison's substance misuse strategy to ensure that it contains measures to reduce the availability and use of illicitly brewed alcohol.
- The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency is called.
- The Head of Healthcare should ensure that:
  - healthcare staff know how to detect diabetes and hypertension;
  - long-term conditions such as diabetes and hypertension are managed in line with National Institute of Care Excellence (NICE) guidelines; and
  - reviews of repeat antidepressant medication comply with NICE guidelines.

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 Haines' prison and medical records.

15. NHS England commissioned a clinical reviewer to review Mr Haines' clinical care at the prison.

16. The investigator and clinical reviewer interviewed six members of staff at Lewes on 21 May 2018.

17. 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.

18. There was no family involvement in this investigation. Mr Haines had no next of kin.

19. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Lewes

20. 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 healthcare centre with a full time senior medical officer, which makes use of specialist NHS facilities when needed. Healthcare 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

21. The most recent inspection of HMP Lewes was in January 2016. The inspectors found that although levels of self-harm were relatively low, staff had not had refresher training on self-harm prevention measures in three years. There was no formal personal officer scheme, but staff usually made regular entries about a prisoner's behaviour on the prison's IT system. Inspectors found that the prison had an appropriate range of primary care services and that staff managed long-term conditions relatively well.

Independent Monitoring Board

22. 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 31 January 2018, the IMB expressed concern about the healthcare department's ability to provide adequate care to prisoners due to consistently low staffing levels.

Previous deaths at HMP Lewes

23. Mr Haines was the 13th prisoner to die at Lewes since March 2015. Of the previous deaths, nine were due to natural causes and three prisoners took their own lives. Four prisoners have died at Lewes since, three from natural causes and one took his own life. We have previously made recommendations about the management of long-term health conditions and calling ambulances promptly.

Parole Board

24. The Parole Board for England and Wales is an independent public body. Its role is to make risk assessments about prisoners to decide whether they can safely be released into the community once they have served the minimum imposed by the courts.

Key Events

25. On 21 June 2011, Mr Martin Haines was convicted of arson and sent to HMP Lewes. He was subsequently given an imprisonment for public protection (IPP) sentence with a minimum tariff of 2 years and 332 days. (Offenders sentenced to an IPP are set a minimum term (tariff) which they must spend in prison. After they have completed their tariff they can apply to the Parole Board for release. Mr Haines would have been eligible for release from 22 June 2014.)

26. Mr Haines had a history of alcohol problems and received withdrawal support from the prison's substance misuse team. He also had several cardiovascular risk factors, including smoking and being overweight.

27. On 12 July, a prison GP reviewed Mr Haines' blood test results and noted that a test to check average blood sugar level over recent months (Hba1c) was 45 mmol/mol (normal being 20-42 mmol/mol). He requested a repeat blood test in six months but there is no record this took place.

28. On 3 July 2013, Mr Haines claimed to have taken an overdose of sertraline (an antidepressant medication) and prison staff started suicide and self harm prevention procedures (known as ACCT). Mr Haines denied taking the medication to end his life and told staff that he just wanted to improve his mood. Staff closed the ACCT on 11 July.

29. On 21 August, a consultant psychiatrist saw Mr Haines for a review and he reported struggling with not having a release date. He said that he felt low and that anxiety stopped him from attending groups to address offending behaviour. She stopped sertraline and prescribed mirtazapine (a different type of antidepressant). The psychiatrist saw Mr Haines for a review on 22 October and noted that he still refused to attend groups. She increased Mr Haines' mirtazapine and suggested psychological intervention to address his social anxiety.

30. On 31 December, a prison GP reviewed Mr Haines' blood test results and noted that he had a high Hba1c level (60 mmol/mol). She suggested that healthcare staff consider offering Mr Haines further lifestyle advice and taking therapeutic action. However, there is no record that either of these took place.

31. From 14 July 2014 to 24 March 2015, Mr Haines attended nine out of 17 cognitive behavioural therapy (CBT) sessions aimed to address anxiety. Records show that despite engaging relatively well, Mr Haines failed to complete the course and chose not to participate in further treatment. There is no record that he reported any thoughts of suicide or self harm during this period.

32. Over the next 14 months, Mr Haines spent a considerable amount of time out of his cell and kept busy by working in the prison's first night centre. He did not have much contact with healthcare staff, although he did continue to report ongoing anxiety. Staff recorded that Mr Haines was suitable for in possession medication on several occasions, but there is no record that they monitored his blood sugar levels or that they considered offering him smoking cessation advice.

33. On 30 June 2016, Mr Haines told a prison GP that he felt mirtazapine was not working and that he would like to try venlafaxine (another antidepressant). The GP recorded that Mr Haines suffered from long-term anxiety and prescribed venaflaxine (150mg), although there is no record that he considered a follow-up review or blood pressure monitoring. Later the same day, a nurse recorded that Mr Haines had received 28 days of medication in-possession.

34. On 1 December, a prison GP increased Mr Haines' venaflaxine to 225mg. There is no record that he saw Mr Haines in person, documented a reason for the dose increase or considered a follow-up review.

35. On 22 December, a member of staff from the public protection case work section of Her Majesty's Prison and Probation Service (HMPPS) requested an update on Mr Haines' progress prior to a parole hearing. On 17 January 2017, a prison based probation officer noted that Mr Haines was adamant he would not engage in group work and that he was not prepared to transfer to any establishment other than a Category C prison. The probation officer subsequently explored a transfer to HMP Thameside, but Mr Haines did not meet the criteria.

36. On 19 January 2017, Mr Haines received a letter from the Parole Board stating that they had considered his case and recommended that he remain in closed conditions. The reasons listed included an unwillingness to take responsibility for his actions, a lack of insight, difficulties in relationships and alcohol misuse.

37. Over the next three months, prison staff explored the possibility of moving Mr Haines to a suitable training prison to help him progress through his sentence. They identified HMP Swaleside's psychologically informed planned environment unit (PIPE – a specifically designed environment where staff have additional psychological training to recognise the importance and quality of relationships and interactions) as an option and arranged for an assessment. Staff had regular contact with Mr Haines and made several entries in his electronic case record indicating that he complied with the regime, was respectful and mixed well with other prisoners.

38. On 7 April, a consultant psychologist and a supervising officer (SO) from Swaleside saw Mr Haines for an assessment. However, Mr Haines told them that he was not interested in the service they had to offer and that he planned to see if he could move to HMP Coldingly. The psychologist told Mr Haines she would take him off the referral list as the service was voluntary, but that she would reconsider a transfer should he change his mind. On 27 April, Mr Haines told a prison based probation officer that he was not willing to engage in any programmes. She urged him to reconsider.

39. On 13 July, prison staff noticed that Mr Haines' breath smelt of alcohol and he admitted to consuming hooch (prison brewed alcohol). Staff submitted an intelligence report.

40. On 10 October, a prison GP saw Mr Haines for a review and he reported a sore toe. She conducted an examination, diagnosed an infected ulcer and prescribed flucloxacillin (an antibiotic). On 25 October, a nurse noticed that Mr Haines' toe remained inflamed and a prison GP prescribed a further course of flucloxacillin.

41. On 10 November, a prison GP reviewed Mr Haines' blood test results and noted that his Hba1c was high (66 mmol/mol). The next day, the GP saw Mr Haines for a review and diagnosed type 2 diabetes. He prescribed metformin (a medication that lowers blood sugar levels), but there is no record of a formal care plan or an in-possession medication review.

42. On 24 November, a prison based probation officer stopped Mr Haines on the wing and asked him if he would reconsider attending any programmes. Mr Haines told him that he had diabetes and an ulcer and implied that he would not live very long. He said that he had no interest in getting out and would rather die in prison.

43. On 27 November, a nurse saw Mr Haines to review his sore foot and noted that he had high blood pressure (162/92 mmHg – the target for people with diabetes being below 140/80 mmHg). There is no record that further action was taken.

44. On 19 December, a prison GP noted that Mr Haines had reported ongoing foot pain to staff and prescribed amitriptyline (an antidepressant that can also be used to treat nerve pain). There is no record that she saw Mr Haines in person or that she considered the risks associated with taking amitriptyline in conjunction with venlafaxine. The following day, a different GP reviewed Mr Haines' blood test results and noted that he had a high cholesterol level (7.2 mmol/l – normal being below 5 mmol/l). There is no record that staff told Mr Haines about the result or reviewed his blood pressure.

45. On 11 January 2018, a nurse saw Mr Haines to check his blood sugar level and recorded a high blood pressure reading (157/88 mmHg). On 10 February, a different nurse examined Mr Haines' foot and noted that his blood pressure remained high (145/95mmHg). Although there is no evidence that staff considered taking further action, records show that Mr Haines failed to attend several appointments.

Events on Sunday 18 March

46. At around 8.50am, an officer looked through the observation hatch on Mr Haines' cell and unlocked the door. He said he saw one of Mr Haines' feet by the toilet and carried on unlocking the rest of the landing. The officer told the investigator that he did not call out to Mr Haines or feel a need to check on him, as it looked like he was using the toilet.

47. At around 9.10am, a prisoner knocked on the window of the wing office and told two officers that Mr Haines was unresponsive on the floor of his cell. Both officers made their way to the cell and when they arrived, one of them went inside. The officer saw Mr Haines lying on the floor on his right side with his knees bent up toward his chest. He checked his vital signs and found that he was very cold to touch. The other officer remained outside the cell and, at 9.16am, called an emergency medical code blue (which indicates that a prisoner is unconscious or has breathing problems).

48. In the meantime, a third officer arrived and tried to help the officer in the cell move Mr Haines, but his body was too stiff. One of the officers attempted to start cardiopulmonary resuscitation (CPR) but the stiffness of Mr Haines' body meant

that he was unable to continue. Within minutes, two nurses arrived. One of them examined Mr Haines and decided not to start CPR as rigor mortis was present and he was clearly dead.

Contact with Mr Haines' family

49. At 11.05am, the prison appointed a SO as family liaison officer (FLO) and an officer as her deputy. At 2.30pm, they both arrived at the address of Mr Haines' named next of kin in Eastbourne, East Sussex. The FLO broke the news of Mr Haines' death, but the individual did not wish to have any involvement.

50. On 4 April, after making multiple attempts to identify an alternative next of kin, the FLO obtained permission to search Mr Haines' cell. However, she was not able to identify a next of kin. The prison subsequently arranged and paid for Mr Haines' funeral, which took place on 16 May.

Support for prisoners and staff

51. After Mr Haines' death, a prison manger debriefed the 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.

52. The prison posted notices informing other prisoners of Mr Haines' 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 Haines' death.

Post-mortem report

53. A post-mortem examination found that Mr Haines died of cardiac arrest, caused by coronary artery artherosclerosis (hardening and narrowing of the arteries supplying the heart). High levels of Mr Haines' prescribed medication were found in his blood, at concentrations above the therapeutic range but below fatal levels, and alcohol was also detected at four times the driving limit. In addition, unabsorbed venlafaxine was found in Mr Haines' stomach. The post-mortem report listed the high levels of medication and alcohol, and Mr Haines' type 2 diabetes as contributory factors in his death.

54. The report concluded that the most likely cause of Mr Haines' cardiac arrest was an abnormal heart beat resulting from the effects of venlafaxine and amitriptyline at levels above their usual therapeutic ranges, and alcohol, in the presence of major, but undiagnosed coronary artery atherosclerosis. It added that deliberate or accidental overdose ought to be considered.

Events after Mr Haines' death

55. On 20 March, a prisoner told staff that he spoke to Mr Haines before his death and asked him if he would like to fill in a smoke free survey. The prisoner said that Mr Haines responded by saying "no" and that it "wasn't part of his plan".

56. On 4 April, while looking for next of kin details in Mr Haines' cell, the FLO found a note that appears to have been written in November 2017. In the note, Mr Haines stated that he could not take any more of his sentence and that he blamed the offender management unit for him remaining in prison three years

and five months after his minimum term expired. He wrote that he was assessed as high risk due to concerns he would start drinking again, but that it was not an issue because he had drunk alcohol every week since he had been in prison.

57. On 30 April, officers clearing Mr Haines' cell found another, more recent note. In this note, Mr Haines appeared to refer to the prison's plan to go smoke free. He said that he had been smoking for 51 years and that he was nearly four years over his minimum term (this would have been 22 June). He said that smoking was the only thing he had left in his life and that the only answer was "topping himself".

Findings

Assessment of Mr Haines' risk of suicide and self-harm

58. PSI 64/2011 on safer custody requires all staff who have contact with prisoners to be aware of the risk factors and triggers that might increase prisoners' risk of suicide and self harm, and to take appropriate action. Any prisoner identified as at risk of suicide or self-harm must be managed under ACCT procedures.

59. Mr Haines was last monitored under ACCT procedures in July 2013, when he took an overdose of his prescribed medication. Other than this, records show that he had a good relationship with prison staff, engaged well with other prisoners and never reported any thoughts of self-harm or suicide. There is no record that healthcare staff reviewed Mr Haines' medication in-possession risk assessment since June 2016, but we are satisfied that there was no evidence to indicate he presented a risk of overdose or that he would have benefited from a review.

60. On 22 June 2018, Mr Haines would have been four years over his minimum term. There was at least one occasion where he reported feeling low about not having an end date to his sentence, but he refused to participate in any group work sessions to address his behaviour due to anxiety. We are satisfied that staff appropriately referred Mr Haines for mental health intervention and that they actively encouraged him to progress by exploring prison moves and various group work programmes.

61. It was apparent from one of the notes he left, that Mr Haines was fearful about having to give up smoking when the prison became smoke free. In a statement, the prison's smoke free project lead said that, in January 2018, all prisoners were told that the prison would be going smoke free on 30 April. He said that the support offered to prisoners took several forms including, smoking cessation clinics on the wings and information on vapes (electronic cigarettes) and loans to purchase them.

62. No one who saw Mr Haines in the weeks before his death had reason to consider that he was at risk. He did not report any thoughts of suicide or self-harm to staff and there is no evidence he disclosed his concerns about the prison's plan to go smoke free to staff. We are therefore satisfied that there was no reason for staff to consider ACCT monitoring in the weeks leading to his death. We do not consider that staff could reasonably have predicted his actions.

Illicitly brewed alcohol

63. The post-mortem found that Mr Haines' blood alcohol limit was four times the driving limit. He had a significant history of alcohol misuse and had engaged with the prison substance misuse team for support with withdrawal. Other than one incident in July 2017, when Mr Haines told staff that he had drunk hooch, there is no evidence to suggest he had access to hooch on a regular basis. However, we are concerned that in the first note staff found in his cell, Mr Haines said that he had drunk hooch every week since he had been in prison.

64. At interview, a security intelligence analyst told us that when intelligence is received about alcohol, the standard procedure would be to arrange a cell search. However, he said that searches and other interventions, such as a referral to the prison's substance misuse team, only tend to take place when there are multiple strands of evidence. We are satisfied that staff took appropriate action by submitting an intelligence report and that there was little evidence to indicate additional intervention was required.

65. The presence of alcohol in Mr Haines' blood and his reference to having access to hooch on a regular basis does, however, suggest weaknesses with the prison's substance misuse strategy. While we recognise that the prison's substance misuse policy is relatively detailed, the focus is on illicit drugs and there is nothing directly related to preventing the production and consumption of hooch. We make the following recommendation:

The Governor should review the prison's substance misuse strategy to ensure that it contains measures to reduce the availability and use of illicitly brewed alcohol.

Unlock procedures

66. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual says, "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.".

67. Additionally, Prison Service Instruction 75/2011 states that "there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock… Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.".

68. When interviewed, the officer who unlocked Mr Haines' cell told the investigator that he had a quick look in Mr Haines' cell to check he was present, but did not attempt to get a response from him as he thought he was using the toilet. CCTV shows the officer approach Mr Haines' cell and look through the observation hatch for a matter of seconds, before moving onto the next cell. The officer told us that, if he had he looked more thoroughly, it is likely that he would have noticed the position of Mr Haines' foot was that of someone lying on the floor and not sitting on the toilet.

69. While the failure to follow the correct unlock procedure did not affect the outcome for Mr Haines given it appears he had been dead for some time, it is important that staff identify if a prisoner's life is at risk at the earliest opportunity. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

70. Prison Service Instruction (PSI) 03/2013, Medical Response Codes, requires prisons to have a two code medical emergency response system. Lewes' local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and for healthcare staff to attend with the appropriate emergency equipment.

71. We are satisfied that the two officers responded quickly when a prisoner told them that Mr Haines was unresponsive and that one of them used the correct emergency code. Healthcare staff arrived promptly with the medical equipment and a nurse appropriately decided not to start CPR.

72. However, we are concerned that an ambulance was not called immediately. The control room log shows a code blue was radioed at 9.16am, but the ambulance log states they received a call at 9.22am. At interview, the operational support grade (OSG) in the control room told us that he was there on his own and that he had to ask a nurse to attend Mr Haines, as well as gather more information, before calling an ambulance. This is not in line with PSI 03/2013. When a code blue is called over the radio network this automatically notifies the staff who need to attend and control room staff should call an ambulance immediately.

73. While the immediate calling of an ambulance would not have changed the outcome for Mr Haines, in other emergency situations it could be crucial. We therefore make the following recommendation:

    The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called.

Clinical care

74. In July 2011, Mr Haines' blood test results identified higher blood sugar levels than would normally be expected. The clinical reviewer considered that he had pre-diabetes and therefore should have had an annual HbA1c blood test and cardiovascular risk assessment. Mr Haines did not have another HbA1c test until December 2013 and, despite blood sugar levels high enough for diabetes, this was not followed up. Even after Mr Haines was formally diagnosed with diabetes in November 2017, there is no record of a care plan or indication that healthcare staff acted on his high blood pressure readings. The Head of Healthcare told us that although the prison does run chronic disease clinics, these were stopped for a period due to staff shortages.

75. The clinical reviewer also considered that healthcare staff did not review or manage Mr Haines' venaflaxine in line with National Institute of Care Excellence (NICE) guidance on hypertension (high blood pressure). NICE guidelines say that blood pressure should be carefully checked at the start of treatment and regularly monitored throughout, particularly during a change of dose. However, there is no record of a care plan to ensure that Mr Haines' blood pressure remained under control or that healthcare staff reviewed his venaflaxine prescription. In addition, when amitriptyline was added in December 2017, a

face to face review did not take place. The post-mortem report states that venaflaxine and amitriptyline are cautioned in patients with cardiovascular disease and diabetes, but there is no record staff considered the associated risks.

76. Although Mr Haines did not have a formal diagnosis of heart disease, the clinical reviewer considered that the combination of smoking, obesity, high blood pressure, high cholesterol and diabetes in a man aged 60, would have put him at elevated risk. While regular reviews and assessments may not have prevented Mr Haines' death, healthcare staff need to ensure that prisoners presenting at risk of cardiovascular and diabetes are assessed and monitored appropriately. We therefore make the following recommendation:

The Head of Healthcare should ensure that:

- **healthcare staff know how to detect diabetes and hypertension;**
- **long-term conditions such as diabetes and hypertension are managed in line with National Institute of Care Excellence (NICE) guidelines; and**
- **reviews of repeat anti-depressant medication comply with NICE guidelines.**

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