

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr John Wakefield a prisoner at HMP Lowdham Grange on 15 November 2018

A report by the Prisons and Probation Ombudsman

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 John Wakefield died on 15 November 2018 at HMP Lowdham Grange of drug toxicity. Mr Wakefield was 43 years old. I offer my condolences to Wakefield's family and friends.

Post-mortem toxicology tests showed that Mr Wakefield had used psychoactive substances (PS) and cocaine before his death. He had a history of substance misuse but he told staff at Lowdham Grange that he was no longer using drugs and he declined to receive advice and support from the prison's substance misuse team. He tested positive for a psychoactive substance (PS) on only one occasion (March 2018).

I am satisfied that Mr Wakefield knew how to access substance misuse services in the prison but that he decided he did not need them. I am also satisfied that Mr Wakefield's care in relation to substance misuse was equivalent to what he could expect to receive in the community.

I am concerned that when Mr Wakefield was found unresponsive in his cell, the officer did not use an emergency medical code to alert others to the emergency. I am also concerned that an officer may not have carried out appropriate checks during the early morning roll check.

I am satisfied that these deficiencies did not contribute to Mr Wakefield's death as it appears he had been dead for some while when he was found. I am, however, disappointed to have to repeat recommendations on these points that I made in a previous report in September 2018. The prison must now address these concerns effectively.

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

Sue McAllister, CB
Prisons and Probation Ombudsman

September 2019

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Summary

Events

1. In February 2015, Mr Wakefield was recalled to prison and sentenced to ten years imprisonment for armed robbery.
2. When he arrived at HMP Lowdham Grange in May 2015, Mr Wakefield said that, although he had used drugs in the past, he did not do so any longer, and he declined the services of the substance misuse team.
3. During 2015 and 2016 Mr Wakefield was prescribed pain relief medication (which continued until his death) and received physiotherapy for back pain, which he found helpful. There were no notable entries in his records during 2017, and no concerns about his behaviour.
4. In January 2018, Mr Wakefield sought medical help for a shoulder injury and back pain. He was referred to a pain management clinic.
5. In March, staff recorded that Mr Wakefield was slurring his words. He tested positive for psychoactive substances (PS).
6. Mr Wakefield became a wing 'buddy' in May 2018, a trusted position, and there were no further recorded incidents of concern about his behaviour.
7. In October 2018, Mr Wakefield was seen in the prison's in-house pain clinic. The doctor refused to prescribe additional pain relief medication as she thought Mr Wakefield was displaying drug-seeking behaviour.
8. On 15 November, when an officer unlocked his cell at 7.40am, Mr Wakefield was found slumped against his cell door. An ambulance was called without delay. A specialist key was used to allow the cell to be opened to allow staff access.
9. When the cell was opened, medical staff entered immediately. They found that Mr Wakefield was very cold, with signs of rigor mortis and significant pooling of blood in his body. This suggested that he had been dead for some time. They therefore did not attempt to resuscitate him. A prison doctor pronounced Mr Wakefield dead at 8.40am.
10. An asthma inhaler that had been adapted to inhale illicit substances was found in the cell.
11. The post-mortem found that the direct cause of Mr Wakefield's death was drug toxicity (psychoactive substances). An enlarged heart was a potential contributory factor.

Findings

12. Mr Wakefield had used PS and cocaine before his death. We cannot say whether he had been a regular user of illicit drugs at Lowdham Grange, but we are satisfied that he knew how to access help with substance misuse if he had wanted it.

13. We found deficiencies in the procedures at Lowdham Grange for checking on the welfare of prisoners when completing roll checks and about the use of appropriate medical codes when discovering an emergency situation. We made recommendations to the prison on these issues in September 2018 and are disappointed to have found similar concerns in this investigation.
14. We are satisfied that these deficiencies did not contribute to Mr Wakefield's death as it appears he had been dead some time when he was found, but they could be crucial in other cases.

Recommendations

- The Director should ensure that:
 - all prison staff are made aware of and understand PSI 03/2013, Medical Emergency Response and their responsibilities during medical emergencies: and
 - staff are provided with guidance on identifying and correctly communicating the nature of a medical emergency in line with the local Medical Emergency Response Code protocol.
- The Director should ensure that:
 - the local policy on roll checks is reviewed and updated; and
 - staff properly check on prisoners' wellbeing during roll checks.
- The Director should ensure that the key drug issues at Lowdham Grange are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Lowdham Grange informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
16. The investigator obtained copies of relevant extracts from Mr Wakefield's prison and medical records.
17. The investigator interviewed eight members of staff at HMP Lowdham Grange on 18 and 19 March.
18. NHS England commissioned a clinical reviewer to review Mr Wakefield's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator.
19. We informed HM Coroner for Nottinghamshire of the investigation. He gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
20. The investigator contacted Mr Wakefield's mother and partner to explain the investigation and to ask whether they had any matters they wanted the investigation to consider.
21. Mr Wakefield's partner asked when Mr Wakefield had last been seen, what checks were made on him during the night, what was expected of staff when they were completing roll checks and whether Mr Wakefield's bed was made when he was found.
22. Mr Wakefield's mother was concerned about how her son had access to illicit drugs in the prison and why he could not press his emergency cell bell in the night.
23. We have addressed their questions in this report.
24. 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.
25. Mr Wakefield's mother and partner received a copy of the initial report. The solicitor representing Mr Wakefield's partner wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

Background Information

HMP Lowdham Grange

26. HMP Lowdham Grange is a medium secure prison, managed by Serco, which holds around 888 men, many of whom are serving life or indeterminate sentences. Nottinghamshire Healthcare NHS Foundation Trust provides general healthcare, which includes 24-hour nursing cover.

HM Inspectorate of Prisons

27. The most recent inspection of HMP Lowdham Grange was carried out in August 2018. Inspectors reported that the safer custody and healthcare teams supported prisoners who had been under the influence of substances effectively, which constituted good practice. They found that levels of violence were high, most violence was linked to drugs and half the prisoners they spoke to said it was easy to get illicit drugs.
28. Supply reduction work had improved, however, and significantly fewer prisoners had tested positive for drugs over the previous six months than during the same period in 2017. The use of specialist equipment to scan mail for illicit substances was good, but the practice of destroying prisoners' mail without photocopying it was excessive. Work to prevent staff corruption was well developed with some commendable outcomes.

Independent Monitoring Board

29. 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 most recently published annual report for the year ending January 2018 (published in June 2018), the Board noted that the use of psychoactive substances remained high and caused unpredictable and, at times, violent behaviour. The Board found low staffing levels made management of prisoners difficult and the use of inexperienced staff contributed to challenging atmospheres on some wings.

Previous deaths at HMP Lowdham Grange

30. Mr Wakefield was the eighth prisoner to die at Lowdham Grange since October 2015. Of the previous deaths, three took their own lives, one died from natural causes, and three were drug-related. There has been one further self-inflicted death since Mr Wakefield died.
31. In September 2018 we made recommendations to Lowdham Grange about communicating medical emergencies correctly and completing proper roll checks.

Psychoactive Substances (PS)

32. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of

disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

33. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
34. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of PS are included in the testing process.

Key Events

35. In 2015, Mr Wakefield was recalled to prison and sentenced to ten years imprisonment for robbery. He was transferred to HMP Lowdham Grange on 28 May 2015.
36. During his reception assessment, Mr Wakefield told a nurse that although he had used drugs in the past, he had been 'clean' for eight years. (This was not correct as Mr Wakefield had tested positive for cocaine and opiates when he was admitted to HMP Wandsworth in 2014. At that time, Mr Wakefield said he was using crack cocaine, with occasional heroin use.) He also reported that he suffered with back pain.
37. In June 2015, a nurse met Mr Wakefield for a substance misuse assessment and offered him help to maintain his abstinence. He declined help, saying he had done lots of courses in the past and did not feel he needed any help. The nurse told him how he could access substance misuse services in future if he needed to.
38. In October 2015, a nurse prescribed Mr Wakefield pain relief for his back. In July 2016, Mr Wakefield began physiotherapy and was taught exercises, but he said that these did not help with his back pain. A Physiotherapist contacted a prison GP for further pain relief. In July 2016, a prison GP prescribed gabapentin (used for nerve pain) for Mr Wakefield without seeing him. Mr Wakefield continued to take gabapentin for the rest of his life. He completed his physiotherapy in September 2016 and said that his back pain was better.
39. On 24 January 2018, a nurse referred Mr Wakefield for a medication review after he reported that he was in a great deal of pain due to a shoulder injury. (This did not take place.)
40. On 2 March, Mr Wakefield was seen by officers to be slurring his words and was unsteady on his feet. He was given a drugs test which tested positive for PS. This information was recorded in the wing PS log but was not passed to the substance misuse team.
41. On 12 May, Mr Wakefield was given the position of 'wing buddy'. This is a trusted position used to offer advice to other prisoners in need. Staff did not record any entries about Mr Wakefield between May and 20 October when he was noted to be angry that a microwave had been removed from his wing.
42. On 3 October, Mr Wakefield was seen by a prison GP in the prison's in-house pain clinic for his pain management until 3 October 2018. She completed a comprehensive history but did not complete a physical examination. The prison GP refused to prescribe additional pain relief medication as she concluded that he was showing drug-seeking behaviour. Mr Wakefield was unhappy with the examination and angrily walked out of the clinic.

Events of 14/15 November 2018

43. On 14 November, an officer locked Mr Wakefield's cell for the evening and completed the roll check at 7.45pm. At around 2.00am on 15 November, an officer completed a welfare check at Mr Wakefield's cell. This involved looking into the cell and checking for signs of life. The officer said in a statement that he could remember looking into Mr Wakefield's cell but did not notice anything untoward.
44. On 15 November, at 6.45am, an officer completed the early morning roll check and looked into Mr Wakefield's cell. He told the investigator that as part of this process he would check for signs of breathing, using a torch to see into the cell when it was dark. CCTV shows that the officer looked through the observation panel of Mr Wakefield's cell and then closed the flap. This took one or two seconds. The officer told the investigator that he could not recall looking into Mr Wakefield's cell specifically but if he had, and had seen anything untoward, he would have used his radio to raise the alarm.
45. At 7.15am, an officer began his shift on Mr Wakefield's wing. The officer told the investigator that he went to unlock Mr Wakefield's cell at around 7.40am so that Mr Wakefield could collect his medication. He said that he could not open the door. The officer said he knew that the door was stiff, as Mr Wakefield had installed a seal around the frame to prevent draughts. The officer gave the door a hard push and realised that Mr Wakefield was lying half propped up against the door and the door frame. He saw Mr Wakefield's head drop to the floor. He told the investigator he knew something was wrong so used his radio to ask healthcare staff to attend urgently. As a result of this message, the control room called a code blue emergency over the radio at 7.44am and an ambulance was called. (A code blue call indicates that a prisoner is unconscious, not breathing or is having breathing difficulties.) The officer said he tried to lift Mr Wakefield's head but was unable to do so because he could not open the door properly. He said that Mr Wakefield felt very cold to the touch.
46. A second officer could see that the officer was having trouble opening Mr Wakefield's door and went to help him. The second officer told the investigator that she also tried to lift Mr Wakefield's head so that they could enter the cell, but could not do so because Mr Wakefield's body was blocking it. The second officer then left the cell to collect an anti-barricade key (which allows the cell door to be opened outwards). She asked for assistance from the Assistant Director on her way.
47. When the second officer returned with the key, staff worked quickly to unlock the door. The Assistant Director told the investigator that care was taken to ensure that Mr Wakefield did not fall backwards when the door was opened. Two nurses arrived at the cell while the door was being opened and prepared their medical equipment.
48. Both nurses told the investigator that when they entered the cell they could see that Mr Wakefield was not breathing, had widespread lividity (purple staining caused by the pooling of blood in the body which occurs after death) and no circulation. A nurse said that Mr Wakefield's right arm felt stiff, which indicated that rigor mortis had set in. Both nurses agreed that Mr Wakefield had died and

resuscitation was not appropriate. The ambulance was stood down and prison GP pronounced Mr Wakefield dead at 8.40am.

49. After his death, an asthma inhaler that had been converted to allow the inhalation of illicit drugs was found in Mr Wakefield's cell.
50. The investigator asked staff about the state of Mr Wakefield's cell when they entered. All said that it looked tidy, although most could not remember what his bed looked like specifically. The Assistant Director said it looked as though the bed was made and had not been slept in.

Contact with Mr Wakefield's family

51. A member of staff was appointed as family liaison officer (FLO) shortly after Mr Wakefield died. She and the Director left the establishment on the morning of Mr Wakefield's death to break the news to his mother at her home address. They also attempted to visit Mr Wakefield's partner at home but she no longer lived at the address the prison had on file. In the meantime, Mr Wakefield's partner heard of his death through social media and as a result the Director spoke with her over the phone.
52. The FLO supported the family and helped with arranging the funeral which took place on 17 December 2018. The prison contributed to the cost of the funeral in line with national policy.

Support for prisoners and staff

53. After Mr Wakefield's death, the Assistant Director 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.
54. The prison posted notices informing other prisoners of Mr Wakefield'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 Wakefield's death.

Post-mortem report

55. The post-mortem report found the cause of Mr Wakefield's death to be drug toxicity (synthetic cannabinoid), with underlying left ventricular hypertrophy (an enlarged heart). There was a small amount of cocaine in his blood indicating recent use, but not sufficient to cause his death.
56. The pathologist commented that he regarded the direct cause of Mr Wakefield's death to be drug toxicity. He considered that the enlarged heart may have been a contributory factor.

Findings

Emergency response

57. PSI 03/2013, Medical Emergency Response Codes, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring that staff take the relevant equipment to the incident and that there are no delays in providing medical assistance to prisoners or in calling an ambulance.
58. When an officer found Mr Wakefield slumped against the door in his cell, he used his radio to call for healthcare to respond urgently, instead of calling a code blue medical emergency. The officer told the investigator that he understood the emergency call signs to use but panicked when faced with the situation.
59. In September 2018 we made a recommendation to the prison about the use of medical emergency codes when staff discover an emergency situation. Although the control room called an ambulance immediately in Mr Wakefield's case, we are concerned that not using the appropriate emergency code may result in a delay in calling an ambulance in future cases. We repeat our earlier recommendation:

The Director should ensure that:

- **all prison staff are made aware of and understand PSI 03/2013, Medical Emergency Response and their responsibilities during medical emergencies and**
 - **staff are provided with guidance on identifying and correctly communicating the nature of a medical emergency in line with the local Medical Emergency Response Code protocol.**
60. Once Mr Wakefield's cell door had been opened and nurses were able to reach him, they agreed that he had died and that attempts to resuscitate him would be futile and undignified. The clinical reviewer is satisfied that the decision to not attempt resuscitation was the correct one.

Checks on prisoners

61. We cannot say when Mr Wakefield died. Rigor mortis and lividity were already present when Mr Wakefield was found at 7.40am. As rigor mortis normally sets in within two to four hours of death, it seems likely that Mr Wakefield had been dead for some time.
62. Although the Assistant Director thought Mr Wakefield's bed had not been slept in, this does not give a specific time of death as prisoners often sit up late watching television. The toxicology tests also show that Mr Wakefield had used PS the night before he died. He may have sat up late and intended to go to bed after doing this.
63. We cannot say why Mr Wakefield did not press his alarm bell before he died. We can only speculate that he may have collapsed suddenly or that the PS may have left him immobile or unconscious (which can be typical effects of PS).

64. Lowdham Grange operates a policy of checking prisoners once during the night. Mr Wakefield was checked at around 2.00am by an officer who said he saw nothing untoward when he looked into the cell.
65. An officer completed the roll check at 6.45am. He told the investigator that he also saw nothing untoward when he looked through the observation flap. However, CCTV shows that the officer only looked into Mr Wakefield's cell very briefly, and the cell would have been in darkness at the time as sunrise was not until 7.18am that day. As rigor mortis was present when Mr Wakefield was found at 7.40am, it is possible that he was already dead when the roll check took place. If so, he would have been lying by the door when the officer conducted the roll check at 6.45am, and the officer would have seen that Mr Wakefield was not in bed if he had conducted a thorough check.
66. If Mr Wakefield was already dead at 6.45am, it would not have made any difference if he had been discovered during the roll check. However, conducting thorough roll checks could make the difference between life and death in other cases. We made a recommendation about this to Lowdham Grange in September 2018 following a previous investigation, and we repeat that recommendation.

The Director should ensure that:

- **the local policy on roll checks is reviewed and updated; and**
- **staff properly check on prisoners' wellbeing during roll checks.**

Substance misuse

67. Lowdham Grange has a comprehensive Drug and Alcohol Strategy dated March 2018-2019, which is reviewed and updated annually. The strategy sets out the objectives to prevent the supply of and reduce the demand for illicit substances. A drug supply reduction action plan is completed and reviewed each month and sets out the targets for cell searches, visitor and staff searching and the process for referring those found under the influence of illicit substances to substance misuse services.
68. At his reception medical assessment in 2015, Mr Wakefield said that he had used drugs in the past but no longer did so. He was assessed by a substance misuse worker but declined any further involvement with the substance misuse team.
69. In March 2018, Mr Wakefield tested positive for PS. Under the prison's protocol for following up on PS use, this should have resulted in Mr Wakefield being referred to the substance misuse team for advice and support, but this did not happen.
70. Although there were no other positive drugs tests, Mr Wakefield's personal officer, told the investigator that he suspected that Mr Wakefield had been using drugs on other occasions and that he associated with another prisoner who was also suspected of using drugs.
71. The toxicology report showed that Mr Wakefield had a small amount of cocaine in his bloodstream but this was not sufficient to cause his death. His cause of

death was PS toxicity and it is likely that this was inhaled through the modified asthma inhaler found in his cell.

72. The clinical reviewer considered that Mr Wakefield knew how to access substance misuse services in the prison but decided he did not need them. She was satisfied that Mr Wakefield's care in relation to substance misuse was equivalent to that he could expect to receive in the community.
73. We are concerned that Mr Wakefield was able to obtain drugs – PS and cocaine – with apparent ease at Lowdham Grange. Drug-taking is a serious problem across much of the prison estate. Individual prisons are for the most part doing their best to tackle the problem by developing their own local drug strategies. However, the PPO has called for national guidance to prisons from HMPPS providing evidence-based advice on what works, and we welcome the fact that such guidance has now been issued, together with a Prison Service strategy to reduce the supply of and demand for drugs in prisons.
74. In relation to reducing the supply of drugs, the Prison Service strategy says:
- “Every prison is different, and will benefit from tools to assess their specific security needs. We have worked with prisons to carry out Vulnerability Assessments in prisons to build a picture of the security risks and enable establishments to better target their resources to tackle them. This resource will continue to be offered across the estate. The Drug Diagnostic toolkit used for the prisons in the 10 Prisons Project has also proved to be useful in identifying key issues in different establishments and so we will share this for use across the whole estate, supporting prisons to identify where changes could have the greatest impact.”

We, therefore, recommend:

The Governor should ensure that the key drug issues at Lowdham Grange are identified and that the prison's local drugs strategy is revised to ensure that these key issues are being addressed.

Clinical care

75. Mr Wakefield had chronic back pain and received pain relief medication and physiotherapy for this condition. He nevertheless continued to use the gym regularly and the clinical reviewer commented that it appeared Mr Wakefield's back pain did not limit his activities most of the time.
76. Mr Wakefield was prescribed gabapentin (for pain relief) for his back without being seen by a doctor, and continued to receive this medication without review. He had a nine-month wait to be seen in the prison's in-house pain clinic and was unhappy with the decision of the doctor not to prescribe him additional pain relief. Although the issues Mr Wakefield had with his backpain were not directly related to his death, the clinical reviewer concludes that the failure to complete a medication review and the long wait to be seen in a pain clinic was not equivalent to the care Mr Wakefield could have expected to receive in the community. The clinical reviewer makes two recommendations about this that the Head of Healthcare will need to consider.

77. The post-mortem report found that Mr Wakefield had an enlarged left heart ventricle but no evidence of heart disease. The clinical reviewer commented that Mr Wakefield had a history of cocaine use in the community and cocaine is known to adversely affect heart function and can cause the enlargement of muscle mass in the left ventricle. The clinical reviewer said that that Mr Wakefield had regular blood pressure tests at Lowdham Grange which were within the normal range, and he did not complain of chest pain or shortness of breath. It would not therefore have been possible for the medical staff to have predicted his heart abnormality. The clinical reviewer concluded that in the absence of symptoms of heart failure, Mr Wakefield's enlarged heart was unlikely to have contributed to his death.

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