

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Louis Branch a prisoner at HMP North Sea Camp on 22 September 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.

Mr Louis Branch died on 22 September 2018 from heroin and cocaine toxicity while a prisoner at HMP North Sea Camp. He was 32 years old. I offer my condolences to Mr Branch's family and friends.

Mr Branch arrived in custody with a long history of substance misuse. While in prison, he successfully completed drug treatment programmes and was noted by prison staff to be progressing well. However, during a four-day release on temporary licence, Mr Branch and an old friend went to a hotel for the night of 21 September and took heroin and cocaine and drank alcohol. Mr Branch was found dead in the hotel room the following morning.

I am satisfied that the care and treatment Mr Branch received for his substance misuse at North Sea Camp was equivalent to that which he could have expected to receive in the community. I make no recommendations.

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

October 2019

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Summary

Events

1. On 6 April 2016, Mr Louis Branch was sentenced to six years for robbery. He was sent to HMP Bedford. On 22 April, Mr Branch was transferred to HMP Wayland. This was not his first time in prison.
2. Mr Branch had a long history of cocaine, crack cocaine, heroin, ecstasy and cannabis misuse. While in prison, he successfully completed a number of drug treatment programmes and was noted by prison staff to be progressing well.
3. On 18 October 2017, Mr Branch was transferred to HMP North Sea Camp, an open prison that offers prisoners the opportunity to apply for release on temporary licence (ROTL) to enable them to prepare for release, maintain family ties or to undertake employment. Mr Branch successfully completed a number of day releases and in August 2018, he successfully completed a two-day resettlement overnight release (ROR), staying overnight at his aunt's house.
4. On 20 September, Mr Branch was granted ROR for four days to spend time with his family. Mr Branch reported to his probation officer as required and then went to his aunt's house where he was required to stay overnight until he returned to prison.
5. On 21 September, Mr Branch met an old friend and they booked themselves into a hotel, in contravention of his licence conditions. During the evening, they took heroin and cocaine and drank alcohol.
6. The next morning, Mr Branch's friend found him unresponsive. He telephoned for an emergency ambulance and attempted CPR (cardiopulmonary resuscitation) but was unsuccessful. A paramedic arrived and confirmed that Mr Branch had died.
7. The post-mortem report concluded that Mr Branch died from heroin and cocaine toxicity.

Findings

8. The clinical reviewer is satisfied that Mr Branch received a good level of input from healthcare staff, drug treatment services and the mental health in-reach team while at Wayland and North Sea Camp.
9. While in prison he successfully completed drug detoxification treatment and provided a number of negative mandatory drug tests. Following his successful detoxification treatment, he was supported by the prison's substance misuse team. There was good evidence of care planning aimed at helping Mr Branch overcome his substance misuse issues.
10. We are satisfied that the care Mr Branch received in relation to his substance misuse was equivalent to that which he could have expected to receive in the community.

11. Mr Branch's licence conditions said that he should remain at his aunt's home address. The conditions of his licence were fully explained to him and he signed his licence to confirm that he understood them. After Mr Branch's death, his aunt told prison staff that she was not fully aware of his licence conditions and that it was not made clear to her that he could not stay anywhere else overnight.
12. We are satisfied that a full risk assessment for ROR was completed in accordance with the ROTL Framework Policy 2019, and that there was no requirement on probation staff to share Mr Branch's licence conditions with his family. Mr Branch was an adult and the obligation was on him to abide by his licence conditions, not for his family to ensure that he did. We are also satisfied that Mr Branch died because he used drugs and not because he stayed in a hotel rather than at his aunt's house.

Recommendations

13. We make no recommendations

The Investigation Process

14. The investigator issued notices to staff and prisoners at HMP North Sea Camp informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
15. The investigator obtained copies of relevant extracts from Mr Branch's prison and medical records.
16. NHS England commissioned an independent clinical reviewer to review Mr Branch's clinical care at the prison.
17. We informed HM Coroner for Lincolnshire, Boston and Spalding of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
18. We wrote to Mr Branch's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter.
19. Our investigation was suspended between 25 September 2018 and 21 January 2019 while we waited for confirmation of the cause of death and toxicology reports. The completion of this report was delayed as a result.
20. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP North Sea Camp

21. HMP North Sea Camp is an open (Category D) prison near Boston in Lincolnshire, holding approximately 400 men. Accommodation is provided in five residential units. There are also 66 beds in four detached houses, known as the Jubilee Units, which are used for long-term prisoners living independently.
22. Nottinghamshire Healthcare NHS Foundation Trust provide healthcare services at the prison.

HM Inspectorate of Prisons

23. The most recent inspection of HMP North Sea Camp was conducted in July 2017. Inspectors reported that the 12 recommendations they had made about the resettlement process at the prison in 2014, had been either fully or partially, achieved. They considered that during their inspection in 2017, the resettlement process at the prison was of a good standard.
24. The inspectors also noted that the relationship between staff and prisoners was a respectful one which encouraged prisoners to progress towards resettlement and eventual release from custody.

Independent Monitoring Board

25. 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 February 2018, the IMB noted the good work of the resettlement unit who were involved in the organising of resettlement day release (RDR) and overnight home visits.

Previous deaths at HMP North Sea Camp

26. Mr Branch was the fifth prisoner to die at North Sea Camp since September 2015. There have been two further deaths since Mr Branch's death, which are under investigation. All the other prisoners died from natural causes. There are no similarities with those deaths.

Key Events

27. On 6 April 2016, Mr Louis Branch was sentenced to six years in prison for robbery. He was sent to HMP Bedford. On 22 April, Mr Branch was transferred to HMP Wayland.
28. Mr Branch had a long history of cocaine, crack cocaine, heroin, ecstasy and cannabis misuse, dating back to his early teens. He had previously been diagnosed with depression and was prescribed mirtazapine (an antidepressant). Mr Branch was referred to the prison's mental health inreach team (MHIRT) and integrated drug treatment services (IDTS). He was noted as being a smoker, but refused smoking cessation advice.
29. While at Wayland, Mr Branch successfully completed a drug detoxification programme, and a rehabilitation for addicted prisoners course (RAPT). Mr Branch had little further significant contact with healthcare staff while at Wayland.
30. On 19 May 2017, Mr Branch was transferred to HMP Hollesley Bay, an open prison. He became eligible for consideration for release on temporary licence (ROTL, short-term release from prison prior to eventual release to enable prisoners to maintain family ties or help them to find employment) but he decided not to make an application.

HMP North Sea Camp

31. On 18 October 2017, Mr Branch was transferred to HMP North Sea Camp for his own safety. During his reception healthscreen, healthcare staff noted his history of substance misuse and that he had successfully completed some drug treatment programmes.
32. The following day, Mr Branch spoke with a nurse from the prison's mental health inreach team (MHIRT). He told the nurse that he had handed himself into the police for his offence to get help with his addiction problems. He said that his issues with drug misuse and anxiety were due to his parents separating when he was young and that both his parents had now died. Mr Branch also said that following their deaths, his substance misuse had increased. The nurse noted Mr Branch's prescription for mirtazapine and planned to review him regularly.
33. On 28 December, Mr Branch was granted special purpose leave to attend his paternal grandfather's funeral, accompanied by one officer.
34. On 11 January 2018, he successfully completed resettlement day release (RDR) to Boston, accompanied by a prison officer.
35. On 12 February, Mr Branch was granted special purpose leave to attend the funeral of his maternal grandfather, accompanied by one officer.
36. On 14 February 2018, he told a nurse that he was feeling extremely low in mood due to the recent death of his grandparents, who he had been close with since his parents had died. The nurse continued to review Mr Branch regularly, offering him support.
37. On 23 February, Mr Branch decided to accept smoking cessation advice.

38. On 7 March, a nurse reviewed Mr Branch after he injured himself playing football. Mr Branch told her he had been under the care of the orthopaedic department at Ipswich Hospital for damage to his knee ligaments from a car accident nine years ago. Following her review, she referred Mr Branch to a GP for review. The same day, a prison GP reviewed Mr Branch. He noted that Mr Branch had had scan on his knee while at Wayland, but there had been no follow up appointments since his arrival at North Sea Camp. The GP referred Mr Branch to hospital for further review.
39. On 13 March, Mr Branch was authorised to have two unaccompanied half-day RDRs to Boston per month. The purpose of the RDRs was to enable Mr Branch to find employment for his eventual release from prison, and to maintain contact with his family. One of the conditions of his RDR licence was drug and alcohol testing on his return to prison. Mr Branch successfully completed a number of unaccompanied RDR visits to Boston.
40. On 1 May, Mr Branch failed a routine mandatory drug test (MDT), testing positive for codeine. He was placed on a disciplinary charge. At the disciplinary hearing Mr Branch told staff that he had been given drugs without his knowledge by a prisoner who had been bullying him for the previous four months. The hearing was suspended while prison staff investigated his allegations of bullying. While the investigation was ongoing, Mr Branch's planned RDRs were suspended.
41. Because of the positive MDT result, Mr Branch was seen by the prison's drug treatment team, Addaction, the same day. Mr Branch told an Addaction key worker that he had not used any illicit substances for the previous two years and had successfully completed a drug treatment course while in prison.
42. On 6 June, after an investigation by prison staff, Mr Branch's claims of bullying were upheld. The disciplinary charge was dismissed, and his RDRs were reinstated.
43. On 15 August, Mr Branch applied for a two-day temporary release on licence (ROTL, like RDR but for an extended period) to enable him to visit his aunt and uncle in Essex. Prior to his release, Mr Branch was given a set of licence conditions which he had to comply with. He read and signed the conditions to confirm that he understood them. His licence conditions said that he must maintain contact with his probation officer while in the community, and visit her office in person on at least one occasion. He must also live solely at his aunt's house. Mr Branch complied with his licence conditions and on his return to North Sea Camp on 17 August, he provided a negative MDT test.
44. Mr Branch made another application for ROTL from 20 to 24 September. His application was approved and the conditions of his release stayed the same. Prison staff explained the conditions of the licence to Mr Branch, and again, he signed them to confirm that he understood and that he would comply with the conditions of his licence.
45. On 13 September, prison staff carried out routine monitoring of telephone calls. They noted that Mr Branch had telephoned his friend to plan to meet him while on ROTL. His friend also offered Mr Branch work while he was on ROTL.

Events of 20 to 22 September 2018

46. On 20 September, Mr Branch left North Sea Camp and travelled to his aunt's house in Essex. On the way there, he visited West Essex Probation Office to meet with his probation officer, as part of his licence conditions. However, she was not available and he met with another probation officer instead. He noted that Mr Branch interacted well and did not appear to be under the influence of any substances.
47. The next day, Mr Branch's friend visited him at his aunt's house. In his statement to the police he said that Mr Branch had drugs and drug paraphernalia with him and they left together in his car and drove to a quiet layby where they took a combination of heroin and cocaine. The original plan had been to go back to his partner's house for a meal but this was abandoned after he had an argument with his partner. They then booked a hotel room for the night where they continued to use heroin and cocaine and to drink alcohol. His friend said that Mr Branch was still awake when he went to sleep.
48. At 7.00am on 22 September, Mr Branch's friend tried to wake him. He said as he did so, he heard Mr Branch make a 'strange' noise. He felt for a pulse and noted that Mr Branch felt cold and clammy to the touch. He telephoned for an emergency ambulance. While waiting for it to arrive, the emergency services operator gave him advice and he started CPR.
49. At 7:56am, a paramedic arrived and took over CPR. While he was doing so, Mr Branch's friend flushed the illicit drugs down the toilet and hid the drugs paraphernalia under the bed.
50. At 8.20am, the paramedic confirmed that Mr Branch had died.
51. Shortly afterwards, police arrived and carried out a search of the hotel room. They found used syringes, citric acid (used to dissolve heroin to make it easier to inject) and a quantity of heroin. They also noted that a plastic bag had been placed over the smoke alarm detector. Mr Branch's friend told the police that he and Mr Branch had arranged to meet and take drugs together while he was on ROTL from North Sea Camp. He also told them they had taken drugs together from an early age.
52. Police officers visited Mr Branch's aunt, his next of kin, to inform her of Mr Branch's death. The police also informed North Sea Camp at 1.18pm.

Contact with Mr Branch's family

53. On 23 September, an officer was appointed to act as the prison's family liaison officer (FLO). At 12.15pm, he telephoned Mr Branch's aunt but there was no answer.
54. The FLO telephoned Mr Branch's aunt again at 4.15pm. He offered support to the family and told Mr Branch's aunt that he would visit her at her home address to answer any questions she might have.
55. On 25 September, the FLO and Deputy Governor visited Mr Branch's aunt. She told them she was concerned that Mr Branch's licence conditions were not made

clear to her. She said that no one from the probation service had visited them prior to Mr Branch's release, they had had a brief telephone call from a probation officer, but she was not told that Mr Branch should not have stayed away from their address overnight.

56. Following his visit, the FLO telephoned Mr Branch's aunt on a number of occasions offering them support.
57. On 2 October, a memorial service was held at the prison. As Mr Branch's family were unable to attend, the FLO photocopied the book of remembrance and gave it to his aunt at his funeral.
58. Mr Branch's funeral was held on 18 October 2018. The prison offered a financial contribution towards the cost of the funeral in line with national guidance.

Support for prisoners and staff

59. After Mr Branch's death, the Head of Residence and Safety offered support to any staff affected by his death. The staff care team also offered support.
60. The prison posted notices informing other prisoners of Mr Branch'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 Branch' death.

Post-mortem report

61. The post-mortem report gave Mr Branch's cause of death as heroin and cocaine toxicity.

Information received after Mr Branch's death

62. The Head of Residence and Safety spoke to Mr Branch's roommate on 1 October. He told her that he and Mr Branch had made a pact that they would work hard together in the gym and stay away from drugs on their release from prison. He said that Mr Branch was adamant that he would not use drugs when he was released and said that he and his family were planning to move to Yorkshire where he could make a fresh start. However, he said that Mr Branch was 'weak to temptation' and had told him that he had planned to meet up with his friend, who he described as 'a crack friend', and that he knew he would end up using drugs with him when they got together. Mr Branch had suggested that he could use drugs on day one or two of his temporary release, then get them out of his system and not test positive when he returned to North Sea Camp.

Findings

Clinical care and substance misuse

63. The clinical reviewer considered that Mr Branch received a good level of input from healthcare, drug treatment services and the mental health in-reach team while at Wayland and at North Sea Camp. The clinical reviewer is satisfied that the clinical care Mr Branch received while at North Sea Camp was equivalent to that which he could have expected to receive in the community. We agree.
64. Mr Branch arrived at North Sea Camp with a long history of substance misuse. While in prison, he successfully completed drug detoxification treatment and provided a number of negative mandatory drug tests. Following his successful detoxification treatment, he was well supported by the prison's substance misuse team.
65. When Mr Branch failed a routine MDT on 1 May, his allegations that he had been given codeine without his knowledge by a prisoner who had been bullying him were appropriately investigated and upheld and he received immediate support from the prison's drug treatment service.
66. The clinical reviewer found that on the occasions Mr Branch did have cause to be reviewed by healthcare, MHIRT or Addaction staff, they responded promptly and appropriately. There was good evidence of care planning aimed at helping him to overcome his substance misuse issues.

Resettlement overnight release and informing the family of licence conditions

67. The Release on Temporary Licence Policy Framework 2019, says that the purpose of resettlement overnight release (ROR) is to allow offenders to spend time at their release address re-establishing links with family and the local community. Offenders can also use these temporary absences to facilitate interviews for work, training or accommodation.
68. We are satisfied that the prison ensured that Mr Branch completed accompanied and then unaccompanied day releases successfully before he was considered for resettlement overnight release (ROR). He then successfully completed a two-day ROR before being granted a four-day release.
69. Mr Branch's aunt said she was concerned that Mr Branch's licence conditions were not made clear to her and that no one from the probation service had visited her before Mr Branch's release on 20 September. She said that they had had a brief telephone call from a probation officer, but she was not told that Mr Branch should not have stayed away from their address overnight.
70. Mr Branch's Offender Manager told the investigator that the expectation is that the prisoner is fully aware of the licence conditions before he is released from custody. As the prisoner is over 18, he is expected to take responsibility for his own actions and probation staff are not therefore required to inform anyone other than the offender of their licence conditions. The licence conditions are then reiterated to the prisoner on release.

71. Mr Branch's Offender Manager said that in Mr Branch's case, this was his second ROR, as he had previously successfully completed a two-day ROR from 15 to 17 August at his aunt's home. She said that a full risk assessment had been completed before the first ROR, and that this had included a home visit and meetings with Mr Branch's aunt and uncle.
72. Before the second release, she telephoned Mr Branch's aunt to ask if she was happy for him to stay there again and Mr Branch's aunt mentioned that she had decorated his bedroom for him to stay there.
73. Mr Branch's Offender Manager also said that Mr Branch should have informed his aunt of the conditions of his licence. He knew that by staying out overnight that he would have been in breach of his licence conditions, and might not be granted further ROTL as a result.
74. We are satisfied that a full risk assessment for ROR was completed in accordance with the ROTL Policy Framework 2019, and that there was no requirement on probation staff to tell Mr Branch's aunt what his licence conditions were.
75. Although we recognise that the circumstances of Mr Branch's death are distressing for Mr Branch's aunt, it is very unlikely that the outcome would have been any different for Mr Branch even if she had known his licence conditions. Mr Branch died because he had used heroin and cocaine and not because he did not stay at his aunt's house. There is a high risk of death from drug overdose in the first month after release from prison; the first few days after release is the peak period. This may be due to changes in individual tolerance for opiates, which can decrease in a matter of days after a period of abstinence, and the risk of overdose is particularly acute when the prisoner has undertaken a detoxification programme in prison.
76. We make no recommendations.

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