Prisons & Probation Ombudsman
Independent Investigations

# Independent investigation into the death of Mr Derek Lowe, a prisoner at HMP Holme House, on 23 July 2019

**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 Derek Lowe was found dead in his cell at HMP Holme House on 23 July 2019. His cause of death is unknown. Mr Lowe was 46 years old. I offer my condolences to his family and friends.

The clinical reviewer found that, overall, Mr Lowe's care at Holme House was equivalent to that he could have expected to receive in the community.

I am concerned that staff delayed calling an ambulance after a medical emergency code was called when Mr Lowe was found unresponsive. It made no difference in this case as Mr Lowe was dead when found, but it is important that staff follow the correct medical emergency procedures. I am also concerned that staff attempted to resuscitate Mr Lowe when he was clearly dead. We have raised both these issues with Holme House before.

The investigation found that the prison's liaison with Mr Lowe's family was of an exceptionally high standard, and I would like to commend the staff concerned.

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** **December 2020**

## Contents

# Summary

## Events

1. On 1 February 2019, Mr Derek Lowe was remanded in custody charged with grievous bodily harm. He was moved to HMP Holme House on 9 April.

2. A nurse completed Mr Lowe's reception screen when he arrived at Holme House. The nurse noted no physical issues but a history of anxiety, depression and substance misuse. The nurse referred him to the substance misuse and mental health teams. Mr Lowe engaged with the substance misuse team but not the mental health team.

3. On 18 April, Mr Lowe was taken to hospital after collapsing and hitting his head. He was discharged from hospital the same day. He admitted he had taken 'Spice' (PS – psychoactive substances) and was closely monitored by prison healthcare staff.

4. On 23 July, at around 5.05am, an Operational Support Grade (OSG) found Mr Lowe unresponsive in his cell. He called a medical emergency code and staff attended. They went into the cell and started cardiopulmonary resuscitation (CPR).

5. Staff in the control room called an ambulance five minutes after the medical emergency code was called. Paramedics arrived at the prison at 5.35am. They assessed that Mr Lowe was dead. They pronounced his death at 5.46am.

6. The post-mortem examination was unable to ascertain the cause of Mr Lowe's death. Toxicology tests showed that Mr Lowe had therapeutic levels of drugs in his system that did not contribute to his death.

## Findings

7. The clinical reviewer found that, overall, Mr Lowe's care was equivalent to that he could have expected to receive in the community. However, she found that Mr Lowe's secondary health screen was scheduled to take place on 3 May, over three weeks after he had arrived, when it should have been within seven days.

8. The OSG called the appropriate medical emergency code when he found Mr Lowe, but staff in the control room did not call an ambulance immediately as they should have done. Although this did not affect the outcome for Mr Lowe because he was dead when found, it is important that staff follow the correct medical emergency procedures.

9. The family liaison officers faced significant challenges when it came to tracing, and informing, Mr Lowe's family of his death. They showed an impressive commitment to that challenge and provided the family with a great deal of support. We commend their actions.

## Recommendations

- The Head of Healthcare should ensure that all prisoners are offered a secondary health screen within seven days of their arrival at the prison in line with NICE Guidance 57.
- The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called, and that information about the prisoner's condition is given to control room staff so that they can pass on relevant information to the emergency services.
- The Governor should ensure that:
    - the prison's medical emergency response protocol is reviewed and agreed with the local ambulance trust; and
    - the protocol covers what initial clinical information is required before despatching an ambulance and the need for urgency in emergency situations.
- The Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.
- The Governor should ensure that this report is shared with the FLOs so they are aware of the Ombudsman's findings.

## The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Holme House informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

11. The investigator obtained copies of relevant extracts from Mr Lowe's prison and medical records.

12. NHS England commissioned a clinical reviewer to review Mr Lowe's clinical care at the prison. The investigator and clinical reviewer conducted joint and individual interviews over August and September 2019.

13. We informed HM Coroner for Teesside of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Lowe's family to explain the investigation and to ask if they had any matters they wanted the investigation to consider. Mr Lowe's daughter wanted to know if Mr Lowe was in a single or a shared cell. This has been covered in our report.

15. Mr Lowe's family received a copy of the initial report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

16. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out a factual inaccuracy and this report has been amended accordingly.

# Background Information

## HMP Holme House

17. HMP Holme House is a medium security prison which holds around 1,200 convicted men. Health services at the prison are delivered by several different providers. The prison has an inpatient unit and nurses are on duty 24 hours a day.

## HM Inspectorate of Prisons

18. The most recent inspection of HMP Holme House was in February and March 2020, but the inspection report has not yet been published.

19. The previous inspection was in July 2017. Inspectors were concerned that drugs were readily available. Nearly 11% of mandatory drugs tests were positive, and this figure rose to 36% when psychoactive substances (PS) were included. Nearly 60% of prisoners said it was easy to get drugs in the prison, with a quarter claiming they had developed a drug problem at the prison. Despite these statistics the prison did not have an integrated or effective supply reduction strategy in place.

20. Inspectors reported that the healthcare interactions that they observed between staff and prisoners were very good, but they noted that chronic staff shortages in the primary care nursing team had affected service delivery. In their survey, only 22% of prisoners said that the quality of health services was good. Many prisoners complained about long waiting times and inspectors found that prisoners were waiting up to five weeks for routine doctor and nurse practitioner appointments. However, they found that patients with urgent needs were seen quickly.

## Independent Monitoring Board

21. 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 December 2018, the IMB reported that the prison had seen steady and significant improvements in stability and performance. This had been achieved against a backdrop of tight staffing resources. It did not consider that healthcare services were equivalent to those in the community, citing very long GP appointment waiting lists and constant nurse shortages.

## Previous deaths at HMP Holme House

22. Mr Lowe was the 12th prisoner at Holme House to die since July 2017. Of the previous deaths, eight were from natural causes, one was self-inflicted, and two were drug-related. We have previously made recommendations about delays in control room staff calling ambulances in medical emergencies and staff attempting resuscitation inappropriately where the prisoner is already dead.

23. There have been eight deaths since Mr Lowe's, six were from natural causes and two were self-inflicted. Most of these are still being investigated, but in an investigation into a death that occurred in October 2019, we again made a

recommendation about the need to call an ambulance promptly in a medical emergency.

# Key Events

24. On 1 February 2019, Mr Derek Lowe was remanded in custody charged with grievous bodily harm and sent to HMP Durham. He was moved to HMP Holme House on 9 April.

25. A nurse carried out Mr Lowe's reception health screen when he arrived at Holme House. The nurse noted no significant physical concerns but a history of depression and anxiety and substance misuse. Mr Lowe was already on a methadone detoxification programme. The nurse referred Mr Lowe to the substance misuse team and the mental health team.

26. On 10 April, Mr Lowe was reviewed by a member of the mental health team. She referred him to the 'Rethink' service as he had talked about past trauma and anxiety and depression. (Mr Lowe either failed to attend appointments or walked out of them.)

27. Mr Lowe was initially located on the DART (Drug and Alcohol Recovery Team) induction wing. His methadone therapy continued, and DART staff regularly reviewed it.

28. On 18 April, Mr Lowe was admitted to hospital after being found unresponsive in his cell with a head injury. He was taken to hospital and discharged later that day. He later admitted he had taken 'Spice' (PS – psychoactive substances). Staff observed him hourly throughout the night and continued observing him every one to two hours until 21 April. He occasionally complained of a headache or a 'spinning head' during that time, and nurses gave him paracetamol.

29. Mr Lowe refused to attend his secondary health screen scheduled for 3 May.

30. On 8 July, a mental health nurse saw Mr Lowe. Mr Lowe told him he had numbness in his arms and legs, constant pain, hot and cold flushes and he was not sleeping well. He said these symptoms were partially relieved when he took his next methadone dose. He said that he had been promised a GP appointment so that he could be prescribed gabapentin for pain in his wrist caused by an old injury. (Gabapentin is a prescription-only medicine used to treat epilepsy and neuropathic pain, but it can also be used to enhance the euphoric effects of other drugs, such as opiates, and is highly tradeable in prison.) The nurse recorded that he told Mr Lowe that a GP would need to decide if gabapentin was appropriate.

31. On 16 July, a prison GP saw Mr Lowe. She recorded that she had conditionally agreed to prescribe gabapentin for the pains he reported and mirtazapine (an antidepressant). Mr Lowe was not to have his medication 'in possession'. She also sent the mental health team a task requesting that they review Mr Lowe as he had told her he had been hearing voices.

32. On 16 July, a DART nurse also saw Mr Lowe. She gave him advice about 'harm minimisation' and he told her he no longer used illicit drugs on top of his methadone. (Mr Lowe had previously told her he had taken quetiapine (an antipsychotic) which was not a drug prescribed to him.) Mr Lowe said he felt stable on the current methadone dose and was sleeping much better.

## Events of 22 July

33. On the evening of 22 July, Mr Lowe spent time in another prisoner's cell. He had received a letter from his solicitor and asked the prisoner to read it to him. The letter was about a witness in Mr Lowe's impending court case. The prisoner said Mr Lowe did not seem to be under the influence of anything and was in good spirits. He estimated that Mr Lowe returned to his cell just before they were locked in their cells for the night, at about 7.00pm.

34. An officer locked Mr Lowe in his single cell at around 7.00pm, and shortly after, at 7.15pm, carried out the evening roll check on his wing. She said that Mr Lowe was on his bed watching television and he gave her a 'thumbs up' sign.

35. Between 8.00pm and 8.30pm, a nurse gave Mr Lowe his evening medication (gabapentin). She was also accompanied by three officers. Mr Lowe engaged appropriately and did not cause the staff any concerns. He showed them that he had swallowed his medication. This was the last time any staff saw Mr Lowe alive.

## Emergency response on 23 July

36. At 5.05am on 23 July, an Operational Support Grade (OSG) started the morning roll count on B Wing. When he reached Mr Lowe's cell, he opened the observation panel and saw Mr Lowe on his front, on the floor with his head and the top half of his body under the bed. He noticed blood close to Mr Lowe and on the seat of his trousers.

37. The OSG kicked the cell door a few times but did not get a response. He radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) at 5.15am. At 5.20am, an OSG in the control room called an ambulance.

38. Staff responded to the code blue and arrived at Mr Lowe's cell.

39. A Custodial Manager (CM) opened the cell door and went in with a nurse. The nurse asked for a defibrillator. An officer went to fetch the defibrillator from the Senior Officer's office (she estimated the round trip took three to four minutes). On the way, she radioed for a Healthcare Assistant (HCA) to attend.

40. Staff moved Mr Lowe so that they could administer cardiopulmonary resuscitation (CPR). Mr Lowe had a deep wound on the right of his forehead and his skin was mottled.

41. The HCA arrived and put an oxygen mask on Mr Lowe and applied pressure to his head wound. Staff carried out CPR on rotation. An airway could not be inserted because Mr Lowe's jaw was stiff.

42. Paramedics arrived at the prison at 5.35am. They assessed that Mr Lowe had rigor mortis (stiffening of the body that occurs after death). Mr Lowe was pronounced dead at 5.46am.

## Contact with Mr Lowe's family

43. On 23 July, the prison appointed two officers as the family liaison officers (FLOs). Mr Lowe had not listed a next of kin, but the FLOs identified that he had a partner. They visited her address later that day where they broke the news. The FLOs made further enquiries and were able to contact other family members including Mr Lowe's daughter and his father. They maintained contact with Mr Lowe's family, offering support and information.

44. Mr Lowe's funeral was held on 6 August and the FLOs and a prison manager attended. In line with national policy, the prison paid the funeral costs.

## Support for prisoners and staff

45. After Mr Lowe's death, a prison manager 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.

46. The prison posted notices informing other prisoners of Mr Lowe'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 Lowe's death.

## Post-mortem report

47. The post-mortem examination was unable to determine Mr Lowe's cause of death. Toxicological analysis of blood and urine samples showed the presence of Mr Lowe's prescribed medication, plus trazadone (an antidepressant) which he was not prescribed. All were at therapeutic levels and the pathologist considered that they had not contributed to Mr Lowe's death.

48. The post-mortem examination showed no injuries to account for death. Although there was a laceration to the right side of the forehead, this had not resulted in significant blood loss or a significant underlying brain injury. There was no pathological evidence to show that Mr Lowe had suffered a traumatic death.

49. The pathologist noted some narrowing of one of the arteries that supplies blood to the heart and some scarring of the heart itself, but less than typically seen in someone who has died from heart disease. The pathologist noted that Mr Lowe was said to have 'self-identified' as having diabetes and epilepsy. She found no evidence that Mr Lowe's death had resulted from diabetes. She noted that individuals with epilepsy may die suddenly and unexpectedly and that Sudden Death in Epilepsy (SUDEP) may be diagnosed where there is a documented history of epilepsy and no other obvious cause. However, as there was no documented history of epilepsy in Mr Lowe's case, the pathologist discounted this and concluded that the cause of Mr Lowe's death was unascertained.

# Findings

## Clinical care

50. The clinical reviewer was satisfied that, overall, the care Mr Lowe received at Holme House was equivalent to that he could have expected to receive in the community.

51. However, she found that his secondary health screen was not scheduled within the target timescale. The secondary health screen should be carried out within seven days of the reception health screen. Mr Lowe had his reception health screen on 9 April, but his secondary health screen was not scheduled to take place until 3 May. We make the following recommendation:

    **The Head of Healthcare should ensure that all prisoners are offered a secondary health screen within seven days of their arrival at the prison in line with NICE Guidance 57.**

## Emergency Response

*Entering the cell*

52. Prison Service Instruction (PSI) 24/2011, *Management and Security of Nights*, says that under normal circumstances prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two staff present. However, it goes on to say that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the Night Orderly Officer and an individual member of staff can enter the cell on their own. It says that any lone member of staff's decision to enter a cell, should be informed by a 'dynamic risk assessment' – informed by attempts to gain a response, what they can see through the observation panel and any other knowledge of the prisoner. Its provisions are mirrored in the local policy at Holme House.

53. An OSG was doing the morning roll check when he discovered Mr Lowe face down in his cell. He called a code blue immediately and did not go into the cell until more staff arrived.

54. The investigator asked the OSG if he had considered going into Mr Lowe's cell before assistance arrived. He said that he did not know anything about Mr Lowe, was not convinced he could overpower Mr Lowe if he had needed to and even though he could see blood he was not certain that the situation was life threatening, so he did not go in.

55. The investigator asked the OSG under what circumstances he might go into a cell alone. He was initially uncertain and said he would never go into a cell alone but then went on to say he thought he would if a prisoner had ligatured. He said he would not go in even if someone was bleeding profusely as they probably had a sharp implement they could use on him. The investigator asked the CM if he had been surprised that the OSG had not gone into Mr Lowe's cell, but he said

he did not know what factors the OSG had taken into account when risk assessing the situation, so he could not give an opinion.

56. We are content that in Mr Lowe's case, the OSG conducted a risk assessment and came to a reasonable conclusion that it may not be safe for him to enter the cell alone.

*Delay in calling ambulance*

57. PSI 03/2013 requires prisons to have a medical emergency response code protocol, which should ensure that an ambulance is called immediately when a medical emergency code is called. Holme House has such a protocol.

58. When the OSG failed to get a response from Mr Lowe, he called a code blue over his radio. The control room log says the code blue was called at 5.15am. It records the ambulance as being called at 5.20am. The investigator spoke to the OSG who was in the control room when the code blue was called. He said that he knew the emergency services operator would ask him questions about Mr Lowe that the OSG outside the cell door would not be able to answer (such as questions about Mr Lowe and whether he was breathing or not).

59. However, when there was no answer from the house block phone, the OSG telephoned for an ambulance anyway. He was surprised when they told him that as he did not know if Mr Lowe was breathing or not, they would have to allocate him an '18-minute response', something he had not heard before. When he got more information (at 5.27am), he telephoned emergency services back and they upgraded the request. Two ambulances arrived, the first at 5.35am.

60. The delay in calling an ambulance, and in passing on relevant information about Mr Lowe's condition to the ambulance service, did not affect the outcome for Mr Lowe as he was dead when found. However, it is important that the correct procedure is followed when a medical emergency code is called and that an ambulance is called straightaway. It is also important that basic information about the prisoner's condition is passed to the ambulance service so that they can prioritise the call effectively. We know that in an emergency situation a delay of a few minutes may be critical.

61. We have identified delays in control room staff calling for ambulances in previous investigations at Holme House. In response to a recommendation we made in April 2019, the prison said it would review the medical emergency code protocol and issue a reminder to staff. However, we have found the same issue again in this case. We make the following recommendation:

**The Governor should ensure that control room staff call an ambulance immediately when a medical emergency code is called, and that information about the prisoner's condition is given to control room staff so that they can pass on relevant information to the emergency services**.

60. It is also important that the local ambulance trust understands that the special circumstances in prisons mean that staff in the control room may not always have information about the prisoner or his condition. PSI 3/2013, *Medical Emergency Medical Codes*, says:

> "As the logistical and operational arrangements of each prison will differ, the terms of the medical emergency response protocols must be written and agreed in conjunction with the local healthcare commissioner at the prison and the local ambulance trust ... Regular reviews of the protocol should be built into the process and agreed with the local healthcare commissioner and ambulance trust."

61. We make the following recommendations:

**The Governor should ensure that:**

- **the prison's medical emergency response protocol is reviewed and agreed with the local ambulance trust; and**
- **the protocol covers what initial clinical information is required before despatching an ambulance and the need for urgency in emergency situations.**

*Inappropriate resuscitation attempt*

62. Mr Lowe presented with signs of rigor mortis and other indicators that he had already died when he was found on 23 July. Despite this, healthcare staff started CPR. European Resuscitation Council Guidelines for Resuscitation 2015, which were shared with prison managers in September 2016, say that "resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The examples given of when resuscitation will be futile include the presence of rigor mortis. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

63. We have raised this issue with Holme House before, following a previous investigation into a death there. The prison's action plan in response to our recommendation said: '*The Head of Healthcare will ensure that nursing staff are appropriately trained, that Hotel 2 responders have competency-based assessments that are completed and signed off by a senior nurse, and that Guidance from Resuscitation Council / BMA/ RCN (2016) is made available to all nursing staff.*' The Head of Healthcare undertook to complete this action by June 2019; Mr Lowe died in July 2019.

64. We make the following recommendation:

**The Head of Healthcare should ensure that staff are aware of the circumstances in which resuscitation is inappropriate.**

## Family Liaison

65. Mr Lowe had not listed anyone as his next of kin, and, when he died, the family liaison officers had to undertake extensive research to establish who should be informed and where they lived. Over time, it transpired Mr Lowe not only had a partner, but a daughter from a previous relationship and a father who was still alive. The FLOs went to considerable lengths to establish that key family members were traced, informed of Mr Lowe's death in person and that all were offered support for some time afterwards. We commend their actions and make the following recommendation:

**The Governor should ensure that this report is shared with the FLOs so they are aware of the Ombudsman's findings.**

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