

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frank Austin, a prisoner at HMP Wayland, on 12 September 2019

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 Frank Austin was found dead in his cell at HMP Wayland on 12 September 2019. The cause of his death is unascertained. Mr Austin was 38 years old. I offer my condolences to Mr Austin's family and friends.

Mr Austin experienced seizures and the pathologist considered that Sudden Unexpected Death in Epilepsy (SUDEP) was a possibility. The clinical reviewer found that the standard of healthcare Mr Austin received at Wayland was equivalent to that which he could have expected to receive in the community.

The investigation found that there was a short delay in calling a medical emergency code and in entering Mr Austin's cell when he was found unresponsive. It made no difference in this case as Mr Austin was dead when found, but it is important that staff follow the correct medical emergency procedures and do not delay entering a prisoner's cell where their life may be at risk.

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 2020

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Summary

Events

1. On 19 March 2018, Mr Frank Austin was sentenced to seven years in prison for assault and drug possession. He was moved to HMP Wayland on 12 April.
2. Mr Austin suffered from seizures, and was prescribed appropriate medication. He was referred to hospital for investigations into his seizures, but he refused to attend some appointments. In February 2019, he underwent an MRI scan, but asked for the procedure to be stopped before it had finished. No brain abnormalities were found.
3. Between 8.30pm and 9.00pm on 11 September, while carrying out a roll check, an officer saw Mr Austin sitting on his chair, slumped over his desk. He heard Mr Austin snoring so took no further action.
4. Just before 5.30am on 12 September, during the morning roll check, the officer saw Mr Austin in the same position as the evening before. He switched on the cell light and called to Mr Austin but got no response. He contacted two other officers on the wing and asked them to come to Mr Austin's cell to check on him.
5. The two officers arrived at the cell. They were also unable to get a response from Mr Austin. They contacted the Night Orderly Officer to get permission to enter the cell and then went in. Mr Austin was cold and not breathing. An officer called a medical emergency code but they did not try to resuscitate Mr Austin as they thought he was dead. Paramedics confirmed Mr Austin's death at 5.47am.
6. The post-mortem examination was unable to establish Mr Austin's cause of death. The pathologist considered that Sudden Unexpected Death in Epilepsy (SUDEP) could be a possibility.

Findings

7. The clinical reviewer was satisfied that the standard of Mr Austin's healthcare at Wayland was equivalent to that which he could have received to receive in the community.
8. We consider that the officer who found Mr Austin unresponsive at around 5.30am, should have called a medical emergency code rather than contacting his colleagues. Once three officers were at the cell, we consider that they should have entered the cell straightaway without asking for the Night Orderly Officer's permission.
9. We accept that the delays were minimal and made no difference to the outcome as Mr Austin was already dead, but it is important that staff follow the correct medical emergency procedures when they find a prisoner unresponsive and do not delay entering the cell where a prisoner's life may be at risk.

Recommendations

- The Governor should ensure that staff follow the correct medical emergency procedures, as set out in PSI 03/2013 and in Wayland's local protocol, including that they:
 - use the appropriate medical emergency code when they find a prisoner unresponsive; and
 - enter a cell immediately when necessary to preserve life, where it is safe to do so.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Wayland informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
11. The investigator visited Wayland on 19 September 2019. She obtained copies of relevant extracts from Mr Austin's prison and medical records.
12. NHS England commissioned an independent clinical reviewer to review Mr Austin's clinical care at the prison. They jointly interviewed six members of staff at Wayland on 5 November.
13. We informed HM Coroner for Greater Norfolk of the investigation. The coroner gave us the results of the post-mortem examination and we have sent the coroner a copy of this report.
14. One of the Ombudsman's family liaison officers contacted Mr Austin's next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She raised no issues.
15. Mr Austin's family received a copy of the initial report. They did not raise any further issues, or comment on the factual accuracy of the report.

Background Information

HMP Wayland

16. HMP Wayland is a medium security training prison in rural Norfolk, near Thetford. The prison holds just under 1,000 convicted adult male prisoners. Care UK provides healthcare services. There are no nurses on duty at night.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Wayland was in June 2017. Inspectors reported that following the eight deaths in custody since the previous inspection, a healthcare action plan had been put in place and the majority of recommendations had been satisfactorily implemented.
18. Inspectors found that new prisoners had an initial health screen which identified important health issues, and appropriate referrals were made.

Independent Monitoring Board

19. 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 May 2018, the Board noted that the time to see a GP had risen from four to 15 days. Did Not Attend (DNA) rates had improved slightly from 26% to 19%.

Previous deaths at HMP Wayland

20. Mr Austin was the third prisoner to die at Wayland since September 2017. Of the previous deaths, one was from natural causes and one was self-inflicted. We have previously made a recommendation about ensuring that staff enter a prisoner's cell immediately in a life-threatening situation.

Key Events

21. On 19 February 2018, Mr Frank Austin was remanded in custody, charged with assault, drug possession and driving offences, and sent to HMP Norwich.

HMP Norwich

22. When Mr Austin arrived at Norwich, his reception health screen identified that he had a long history of substance misuse, anxiety and depression, back pain, reduced mobility and non-epileptic seizures (seizures with no formal diagnosis of epilepsy) following a head injury in 2003. Mr Austin was prescribed pregabalin (used to treat epilepsy, nerve pain and anxiety), duloxetine (antidepressant) and clonazepam (used to prevent and control seizures). He was also put on a methadone (opiate substitute) programme.
23. A nurse saw Mr Austin on 21 February. She referred him to the prison's mental health team and arranged a GP appointment to discuss his back pain (which he did not attend, nor a subsequent appointment on 26 February).
24. An entry in Mr Austin's medical record on 4 March, noted that staff suspected he had attempted to conceal one of his medications (possibly clonazepam) under his top lip. He was asked to swallow the tablet and warned that a repeat of this could result in his medication being withdrawn.
25. On 19 March, Mr Austin attended court by videolink and was sentenced to seven years in prison. Staff noticed he seemed to be under the influence of an illicit substance, although he denied this and said it was the effects of clonazepam.
26. A physiotherapist saw Mr Austin on 22 March to discuss his back pain. Mr Austin said he had a degenerative disc in his spine and had been in pain for the past ten years. He was referred to the remedial gym and noted as unfit to work. A prison GP saw Mr Austin less than a week later. Mr Austin appeared sedated and his speech was slurred, and the prison GP reduced his prescription for clonazepam. They discussed Mr Austin's back pain and he said he was waiting for a walking stick (which he was given). The prison GP referred Mr Austin to hospital.
27. Mr Austin tested positive for cocaine and opiates on 29 March. A prison GP from the Integrated Drug Strategy System (IDTS) team, assessed Mr Austin as suitable to begin methadone reduction and recovery. Another test on 6 April showed negative results for everything apart from methadone.

HMP Wayland

28. Mr Austin was moved to HMP Wayland on 12 April 2018. Over the next few months, Mr Austin engaged with healthcare staff for his mental health, back pain and seizures. He continued to be prescribed methadone.
29. In March, May and June, the prison detected illicit substances in letters addressed to Mr Austin. On 11 June, he refused to attend a neurology appointment at the hospital. In July, an intelligence report said that Mr Austin and another prisoner were regularly using psychoactive substances (PS) and heroin.

30. On 4 July, a prison GP met with Mr Austin. Mr Austin spoke about his chronic back pain and asked to see a pain specialist. Mr Austin said he wanted to discontinue methadone, which they agreed to review. However, Mr Austin did not attend appointments scheduled for 6 and 9 July.
31. Mr Austin attended an appointment with the GP on 11 July, noted as an urgent review. Mr Austin had declined his methadone and said he no longer wished to take it. Mr Austin said he understood the consequences of immediate withdrawal and began a symptomatic detoxification. He also asked to move to a drug-free wing in the prison.
32. Mr Austin did not attend a neurology appointment on 18 July, as he was unhappy about handcuffs being used. A prison GP discussed his history of seizures and they agreed a re-referral to hospital. He requested a prescription for dihydrocodeine (an opioid used to treat moderate pain). She refused, but offered a small dose of codeine.
33. On the same day, a nurse met with Mr Austin and they discussed his discharge from the mental health team. Mr Austin agreed to this, although said he had noticed some fluctuation in his mood, which he attributed to methadone withdrawal. Mr Austin completed his methadone detoxification on 8 August. He continued to experience sporadic pain, particularly from his knee.
34. Mr Austin refused to attend another neurology appointment on 19 November.
35. During January and February 2019, Mr Austin's prescription for pregabalin was reduced, and another neurology appointment was scheduled for September. He remained on his other medication. On 27 February, Mr Austin had a MRI scan, but only part of the scan was completed before Mr Austin asked for it to be stopped. It showed no abnormalities.
36. A drug worker met with Mr Austin on 9 January. Mr Austin told her he had been using Subutex (an opioid used to treat severe pain, which is widely abused in prison) due to boredom. By the end of January, Mr Austin told Ms High that he had stopped using Subutex and felt better for it. He met with another drug worker on 8 April. He said that he had started using PS and wanted some support with this. She met with Mr Austin again on 29 April, where they discussed some external pressures that were worrying him. Mr Austin said he could stop taking illicit drugs when he chose to, and had done so. He said he felt more positive after talking to her.
37. The drug worker met with Mr Austin on 5 August, he told her he was keen to address his drug use and they discussed a number of different coping strategies.
38. On 10 September, she met with Mr Austin again. Part of their discussion was about his illicit drug use. He said he had made progress as, rather than using daily, he used "here and there". Mr Austin said he knew where to find Ms High should he need her, and she arranged another appointment for the week of 14 September.

Events of 11/12 September

39. On 11 September, an officer was carrying out routine roll checks on D Wing. He checked Mr Austin between 8.30pm and 9.00pm. He saw Mr Austin was in an unnatural position, sitting on a chair, slumped over his desk with his head lying on it, with his left hand pointing down towards the cell door. The officer Whiting was concerned so opened the inundation port in the cell door (a hole which a hose can be inserted in if there is a fire), and could hear Mr Austin snoring.
40. At approximately 5.28am on 12 September, during the morning roll check, an officer noticed that Mr Austin was in the same position as the evening before. The officer put on the cell light and called Mr Austin, but got no response. He contacted two other officers who were on the wing, and asked them to come to Mr Austin's cell to check on him. They arrived quickly. An officer tried to get a response from Mr Austin from outside the door, but Mr Austin did not respond. The officer contacted the Night Orderly Officer for permission to enter the cell, and then went in with an officer. They saw Mr Austin was holding a television remote control and a vape battery in his other hand and another part of the vape, with white powder in it, was on the desk.
41. An officer tried to rouse Mr Austin, while the other officer noted Mr Austin's skin appeared grey and he felt cold. He checked whether Mr Austin was breathing by holding his hand and then a mirror to his mouth, and found that he was not. At 5.31am, an officer radioed a code blue call (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties). An operational support grade (OSG), immediately requested an ambulance.
42. Two officers tried to move Mr Austin, but he felt stiff and cold and an officer thought that rigor mortis had set in. Staff did not, therefore, try to resuscitate him.
43. Paramedics arrived at Mr Austin's cell at 5.47am, and confirmed that Mr Austin had died.

Contact with Mr Austin's family

44. Two managers visited Mr Austin's next of kin at her home at 10.30am, to break the news of her son's death.
45. The prison contributed to Mr Austin's funeral in line with national guidance.

Support for prisoners and staff

46. After Mr Austin's death, the Governor 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.
47. The prison posted notices informing other prisoners of Mr Austin'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 Austin's death.

Post-mortem report

48. The post-mortem examination was unable to establish a definite cause of death and the post-mortem report concluded that the cause of Mr Austin's death is unascertained.
49. The pathologist found that examination of the lungs showed marked congestion, suggesting terminal acute heart failure, but the heart was structurally normal. The pathologist considered that Sudden Unexpected Death in Epilepsy (SUDEP) was a possibility. Toxicology tests showed only therapeutic levels of prescribed medication. The pathologist said there was nothing to suggest that Mr Austin's death was due to anything other than natural causes.

Findings

Clinical care

50. The clinical reviewer noted that Mr Austin accessed a range of primary and secondary healthcare services at Wayland, his pain relief was regularly reviewed and he attended several appointments with a doctor to discuss pain management. Mr Austin was referred to spinal surgeons and attended three physiotherapy sessions at Wayland.
51. Mr Austin was also referred to the neurology department at the hospital for an MRI scan and an EEG (which can identify abnormalities in the brain wave activity, associated with seizures). Mr Austin refused to attend two neurology appointments and terminated the MRI scan before it was complete. The available images showed no abnormalities.
52. The clinical reviewer concluded that all aspects of Mr Austin's healthcare at Wayland were of a good standard and equivalent to the care he could have expected to receive in the community.

Emergency response

53. Prison Service Instruction (PSI) 03/2013, *Medical Emergency Response Codes*, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for Governors to have a protocol on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It says that if a medical emergency code is called over the radio, an ambulance must be called immediately.
54. Wayland's Medical Response Codes and Emergency Ambulance Protocol, NTS 5/2017, issued on 2 May 2017, says that staff should call a code blue where they find a prisoner who is unconscious or having breathing difficulties, and a code red for severe blood loss or burns. An ambulance should be called immediately when a code blue or red is called.
55. PSI 24/2011, *Management and Security of Nights*, says that while permission must normally be obtained from the Night Orderly Officer to enter a cell during night state, the preservation of life takes priority and there is no need to obtain permission where life is at risk and where it is safe to enter the cell.
56. We consider that there was an unnecessary delay in calling the code blue and in entering Mr Austin's cell. When an officer saw Mr Austin slumped over his desk and he failed to respond to the light being switched on or the officer's calls, the officer should have called a code blue, without calling other officers for their opinion.
57. We accept that the situation was not entirely clear at that stage and that the officer may not have considered it safe to enter the cell on his own. However, once officers arrived, we can see no reason why they did not enter the cell. We accept that the delay was minimal and it made no difference in Mr Austin's case as he was dead when found, but it is important that staff respond to medical

emergencies without delay as minutes may be critical in some situations. We make the following recommendation:

The Governor should ensure that staff follow the correct medical emergency procedures, as set out in PSI 03/2013 and in Wayland's local protocol, including that they:

- **use the appropriate medical emergency code when they find a prisoner unresponsive; and**
- **enter a cell immediately when necessary to preserve life, where it is safe to do so.**

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