Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Andrew Clewes, a prisoner at HMP Swaleside, on 3 November 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 Andrew Clewes died at HMP Swaleside on 3 November 2019, as a result of the misuse of psychoactive substances (PS). He was 33 years old. I offer my condolences to Mr Clewes' family and friends.

Mr Clewes' clinical care was equivalent to that he could have expected to receive in the community. Unfortunately, despite support to address his substance misuse, he continued to use alcohol and drugs. The investigation found that operational staff did not report this to the substance misuse service and Mr Clewes did not have meetings with his key worker, which might have provided additional support, due to a delay in implementing the key worker scheme.

I am satisfied that staff acted quickly when they found Mr Clewes unresponsive. However, I am concerned that a defibrillator taken to the emergency was defective, an issue that we raised with Swaleside following another investigation earlier this year. Although this is unlikely to have affected the outcome for Mr Clewes, the Governor and head of healthcare need to address this issue urgently.

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 **April 2021**

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Summary

Events

1. Mr Andrew Clewes was remanded to HMP Birmingham in November 2016, charged with grievous bodily harm. He was later convicted and sentenced to 12 years imprisonment. After moving to two other prisons, Mr Clewes was transferred to HMP Swaleside on 7 September 2018.

2. Mr Clewes had used drugs in the community and continued to do so in prison. Staff also found alcohol in his cell several times. Mr Clewes received support from the substance misuse service, but he was not entirely open about his use. In March 2019, he was found smoking drugs and in July, correspondence addressed to him tested positive for tramadol and psychoactive substances (PS).

3. At 4.23pm on 3 November, a prison officer found Mr Clewes unresponsive in his cell. Attempts by staff and paramedics to resuscitate him were unsuccessful and his death was confirmed at 5.10pm.

4. The post-mortem found that he died as a result of the misuse of PS.

Findings

5. The clinical reviewer is satisfied that Mr Clewes' clinical care was equivalent to that he could have expected in the community. The prison GP followed up Mr Clewes' complaints of chest pains, but he died before they could be fully investigated.

6. Swaleside has a comprehensive and up to date substance misuse strategy to help reduce the availability and demand for drugs. Managers actively addressed spikes in PS use.

7. There were strong links between the prison and the substance misuse service, including clear mechanisms for information sharing. Unfortunately, prison staff failed to comply with the requirement to notify the substance misuse service that Mr Clewes had been found with alcohol and under the influence of drugs. This meant that his caseworker had to accept, at face value, his assertion that he no longer needed support.

8. In his first few months at Swaleside, Mr Clewes' substance misuse caseworker failed to carry out reviews at the agreed six-week intervals. Once it came to light, the service took prompt action to resolve this.

9. Although a prison officer had been allocated as Mr Clewes' key worker, there is no evidence of any meetings, or management compliance checks.

10. The first defibrillator taken to the emergency could not be used as the seals were damaged. We have previously raised the issue of a faulty defibrillator being taken to an emergency.

Recommendations

- The Governor should ensure that all prisoners suspected of substance misuse are promptly reported to the substance misuse service.
- The Governor of Swaleside should ensure that staff have meaningful interaction with the prisoners in their care, and that the key worker scheme promotes early and regular contact with prisoners.
- The Governor must take urgent action to ensure that defibrillators are regularly checked and pads are replaced before their expiry date, so that they are always in good working order.

The Investigation Process

11. The initial investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. One prisoner responded.

12. The initial investigator visited Swaleside on 12 November 2019. He obtained copies of relevant extracts from Mr Clewes' prison and medical records.

13. A second investigator took over the investigation at the end of November.

14. NHS England commissioned an independent clinical reviewer to review Mr Clewes' clinical care at the prison. The second investigator and the clinical reviewer jointly interviewed two members of staff and a prisoner at Swaleside on 9 January 2020. The second investigator later interviewed another staff member by telephone and obtained additional information from managers responsible for security, drug strategy and the substance misuse service.

15. Our investigation was suspended while waiting for the cause of death and final clinical review. This has delayed the initial report.

16. We informed HM Coroner for Mid Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

17. One of the Ombudsman's family liaison officers explained the investigation to Mr Clewes' next of kin, his grandmother and partner, and asked if they had any matters they wanted the investigation to consider. Another family member later engaged solicitors who contacted the PPO family liaison officer. Mr Clewes' family said that he had mentioned chest pain and asked whether this had been investigated by healthcare staff.

18. Mr Clewes' family and legal representative received a copy of the initial report. They made no comments.

19. The initial report was shared with HM Prison and Probation Service. They provided additional information about two of the issues and asked for the related recommendations to be recast.

Background Information

HMP Swaleside

20. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. Minster Medical Group provides GP cover on weekdays on Monday to Friday, and Medway on Call Care provides an out of hours GP service. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

21. The most recent inspection of HMP Swaleside was in December 2018. Inspectors reported that illicit drugs, including PS, were a serious problem and the high rate (25%) of positive mandatory drug tests suggested widespread use. They found that the security and substance misuse departments worked well together and a good strategy was underway to address the drug problem. Although there had been some success, it was too soon to measure its effectiveness.

22. The Inspectorate conducted a review of progress in September/October 2019, to assess progress against 12 of the 50 recommendations in the inspection report. Inspectors found there had been good progress in reducing the use of illicit drugs and the percentage of prisoners failing random drug tests had fallen.

Independent Monitoring Board

23. 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 April 2019, the IMB reported that that the apparent easy acquisition of drugs, including PS, had caused problems, such as violence and debt and had led to some prisoners choosing to stay in their cells. The introduction of the Rapiscan screening machine and a dedicated search team had significantly reduced the amount of drugs.

Previous deaths at HMP Swaleside

24. Mr Clewes was the 13th prisoner to die at Swaleside since November 2017. Of the previous deaths, one was self-inflicted, nine were due to natural causes, one was due to the effects of a cell fire, and one (on the same day as Mr Clewes' death) is thought to have been drug-related (although the cause of death is still awaited). There have been two further deaths from natural causes.

25. We have previously made recommendations about documenting interventions and ensuring defibrillators are kept in good working order.

Psychoactive Substances (PS)

26. 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.

27. The effects of PS are unpredictable and prisoners do not know what exactly they are using. In the course of our investigations we see numerous examples of apparently fit young men dying as a result of the effects of PS.

Key Events

28. On 2 November 2016, Mr Andrew Clewes was remanded to HMP Birmingham, charged with grievous bodily harm. It was not his first time in prison. On 4 April, Mr Clewes was convicted and sentenced to 12 years in prison. On 3 May, he was given a concurrent sentence for driving while unfit through drugs.

29. Mr Clewes later transferred to HMP Altcourse and HMP Dovegate, where he told staff that he had used cocaine and cannabis in the community. He was found under the influence of drugs several times in prison and a large number of security intelligence reports suggested links to possession of weapons and mobile phones, drug dealing and violence, as both a perpetrator and victim. His cell was identified as a place where other prisoners took drugs. Staff issued warnings and took action under the prison's Incentives and Earned Privileges (IEP) scheme (the process for incentivising and managing behaviour).

Transfer to HMP Swaleside

30. On 7 September 2018, Mr Clewes was moved to HMP Swaleside. Dovegate's mental health team informed Swaleside that Mr Clewes had an outstanding secondary mental health referral.

31. On 21 September, Mr Clewes had an induction with Forward Trust, the substance misuse service, followed by an assessment on 26 September. He told his caseworker that he had no current issues around drug and alcohol use. Care plans were created and objectives were set to help Mr Clewes stay drug-free and increase his awareness of the effects of PS and other illicit substances. He was also given several in-cell workbooks, including one on PS (which he completed over the next seven months). Reviews were expected at six-weekly intervals.

32. At an assessment with a mental health nurse on 2 October, Mr Clewes' main concerns were the distance from his children and sleeplessness. He was discharged from the mental health team that day and he subsequently declined a move to C wing (where there was access to mental health daycare).

33. In October and December, mandatory drug tests (MDTs) taken by Mr Clewes were negative.

34. During a cell search on 10 December, staff found a distilling kit and hooch (illicitly brewed alcohol) in Mr Clewes' cell. He was downgraded to the 'basic' regime level of the IEP scheme.

35. On 28 December, Mr Clewes reported longstanding chest pains to a prison GP. Although the GP felt that the symptoms were anxiety-related and not suggestive of heart problems, he requested tests and later referred Mr Clewes to the Rapid Access Pain Clinic and a cardiologist. Mr Clewes refused anxiety medication and died three weeks before a planned hospital appointment.

36. Mr Clewes wrote to Forward Trust's central office to complain about the quality of the in-cell packs and to ask for a change of caseworker. The Trust's Head of Governance and Quality Assurance replied on 13 March 2019 and Swaleside's service manager checked Mr Clewes' records the same day. He spoke to Mr

Clewes' caseworker about the lack of contact since October 2018 and arranged a meeting on 19 March. At that meeting, Mr Clewes said he had stopped using drugs, but he agreed to complete more workbooks.

37. The next day, 20 March, Mr Clewes was caught in a workshop, smoking drugs with another prisoner. Staff placed him on disciplinary charges for this incident and the previous possession of hooch, but they were later dismissed due to procedural problems. During March and April, Mr Clewes was found with hooch three times and his period on the basic regime was extended.

38. Mr Clewes had his final meeting with his substance misuse caseworker on 1 May. He had completed all the workbooks and it was agreed that he needed no further structured support at that time. His care plans were closed.

39. On 19 and 22 July, staff confiscated two birthday cards and a letter addressed to Mr Clewes which had tested positive for tramadol and PS. Mr Clewes made a formal complaint and staff explained why they had been withheld.

40. Forward Trust wrote to Mr Clewes on 4 October, to invite him to a six-month review. They said that if he did not need support at that time, he could apply for an appointment at any time. There is no evidence that he responded.

Events of 3 November

41. At 4.23pm on 3 November, an officer went to deliver Mr Clewes' evening meal. She looked through the observation hatch and saw him on the floor towards the back of his cell, face down with his knee to his chest. The officer radioed a code blue (which indicates that a prisoner is unresponsive or has breathing difficulties) and the control room requested an ambulance. Another officer and supervising officer joined the officer at Mr Clewes' cell and they began cardiopulmonary resuscitation. The prison's paramedic and a nurse also went to the cell.

42. The first defibrillator brought to the incident could not be used, as the seals had already been opened. Staff brought another defibrillator two or three minutes later.

43. The ambulance arrived at the prison at 4.34pm. The paramedics reached the cell two minutes later and took over the resuscitation attempt. It was unsuccessful and the paramedics confirmed Mr Clewes' death at 5.10pm.

Information given after Mr Clewes' death

44. The police searched Mr Clewes' cell and found a makeshift electric plug made from matchsticks and exposed copper wires. On a table next to the wall socket, there was also the empty tube from a pen. (The items found are typically used to make a spark and smoke illicit drugs.)

45. Mr Clewes' friend told the investigator that Mr Clewes had sometimes used PS as an escape in a controlled way with only mild effects. He would not "go off his head" but remained functional, on his feet and able to hold a conversation. When he expressed concerns, Mr Clewes had assured him that his drug use was under control. He said that staff knew that Mr Clewes used PS.

46. Mr Clewes' friend said that at around 2.00pm on the day of his death, Mr Clewes showed slight signs of PS use, but he had previously seen him more affected. He seemed normal by the time they were locked up again around 4.00pm and Mr Clewes' friend was not worried about him. Another prisoner, who used to smoke PS with Mr Clewes, had told Mr Clewes' friend that Mr Clewes had none left when they were locked in their cells that afternoon.

Contact with Mr Clewes' family

47. The prison's family liaison officer (FLO) and an officer broke the news of Mr Clewes' death to his partner, at her home. They offered condolences and provided information and support. Mr Clewes' partner said that she would inform other members of the family, including Mr Clewes' father and grandmother. The FLO kept in touch with Mr Clewes' family over the following weeks, liaising on their behalf with the Coroner and the funeral director.

48. The FLO and the deputy governor attended Mr Clewes' funeral, which was held on 9 December. In line with national policy, the prison contributed to the funeral expenses.

Support for prisoners and staff

49. After Mr Clewes' 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.

50. The prison posted notices informing other prisoners of Mr Clewes' 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 Clewes' death.

Post-mortem report

51. The post-mortem report concluded that the cause of Mr Clewes' death was misuse of psychoactive substances.

52. The pathologist noted that use of PS was likely to have resulted in "significant cardiac complications, comprising palpitations and hypertension which would cause acute cardiac failure and cardiac arrest".

Findings

Drug Strategy at HMP Swaleside

53. Swaleside has a detailed Drug, Alcohol and Substance Misuse Strategy which was updated in the latter half of 2019. The last HMIP inspection in December 2018 noted considerable problems, but a follow-up review in October 2019 found that new strategic measures had successfully reduced drug use and supply.

54. Our investigation found that monthly, multidisciplinary drug strategy meetings and the day to day actions taken to reduce drug supply and demand were well documented. Security intelligence on supply routes, drug dealing and staff corruption was collated, analysed and acted on. The prison now has a dedicated searching team, as well as 'ring-fenced' MDT staff. Performance targets had been met.

55. Over the course of the 2019/20, an average of 18.7% MDTs were positive. This had reduced from 25% at the time of the 2018 inspection. In addition to MDTs, there were suspicion tests, a frequent testing programme and risk assessment tests for prisoners in trusted positions. Prisoners suspected of drug dealing were moved to other locations to stem the flow of drugs, and those who posed a serious threat were moved to other prisons. Of the tests conducted between July and October 2019, only one was positive for PS. However, from November, there was a notable increase in the use of PS.

56. Mr Clewes and another prisoner both died on the same day at Swaleside from suspected drug use. Within two weeks the security department produced a detailed threat analysis to consider and address the apparent increase in the use of PS. Staff also spoke to known users of PS to emphasise the risks.

57. We are satisfied that Swaleside has a coherent drug strategy and that managers proactively address issues that arise.

Support for substance misuse

58. There appear to be strong and effective links between prison departments and Forward Trust. Forward Trust receives a copy of the prison's morning briefing sheet, so that they can contact all the prisoners whose drug use led to a medical emergency the previous day; they are routinely informed of men reported to be under the influence, or suspected of drug use; and the Trust's staff are now able to access medical records. A Forward Trust representative attends offender management and parole meetings, suicide and self-harm prevention case reviews, as well as constant watch and complex case reviews. Around 450 prisoners engage with the service, one to one or in groups. Men who do not want to stop using drugs are offered harm minimisation advice on the wing.

59. Mr Clewes willingly engaged with the substance misuse service and his complaint about the service was resolved.

60. The investigation found that although prison staff took punitive action after Mr Clewes' episodes of alcohol and drug misuse, there was no evidence in his records that they reported his drug use to Forward Trust. Sharing such

information would have provided the caseworker with a more balanced picture, given that Mr Clewes had been guarded about his continuing substance misuse. While we are satisfied that there are mechanisms in place for operational staff to report substance misuse, a lapse in reporting meant that Mr Clewes was not offered timely intervention. We make the following recommendation:

The Governor should ensure that all prisoners suspected of substance misuse are promptly reported to the substance misuse service.

Key worker meetings

61. All prisoners in closed prisons must have a key worker to engage with them, identify their needs and provide one to one support through their sentence. Key workers should document meetings in prisoners' electronic case notes and management checks should be made.

62. There is no record of a named key worker in the investigation documents, but the prison told the investigator that there was a named officer. There are no entries in Mr Clewes' case notes to indicate that they had met.

63. In response to the initial report, Swaleside said that staffing constraints had delayed implementation of the key worker scheme and staff did not have the time or resources to complete this role to the required standard. All staff on site had been trained by November 2019, and all wings had begun keywork. However, several risks were highlighted and there was a general lack of understanding among staff. In January 2020, the national team assisted staff across various disciplines to ensure an effective roll out, and official sign off. There was then a significant increase in keywork delivery, as well as an increase in Prison Offender Managers.

64. We cannot say whether key worker input would have helped Mr Clewes to remain drug-free, but the delay in implementation meant that he did not get the support expected from this process. We make the following recommendation:

The Governor of Swaleside should ensure that staff have meaningful interaction with the prisoners in their care, and that the key worker scheme promotes early and regular contact with prisoners.

Clinical care

65. Mr Clewes' family asked about the handling of his reported chest pains. The clinical reviewer found that his symptoms were appropriately investigated to explore the possibility of heart problems.

66. We agree with the clinical reviewer that Mr Clewes' clinical care was equivalent to that he could have expected to receive in the community.

Emergency response

67. Operational and healthcare staff responded quickly and followed the expected procedures when Mr Clewes was found. However, we are concerned that this is the second emergency at Swaleside in which we have found that a defibrillator was defective. It seems that insufficient preventative action was taken after the

previous death in July 2019 and the clinical reviewer noted that it is still not clear who is responsible for the checking equipment on residential wings.

68. Although the faulty defibrillator did not make a difference to the outcome for Mr Clewes, we repeat that potentially lifesaving emergency equipment must be properly maintained. We make the following recommendation:

The Governor must take urgent action to ensure that defibrillators are regularly checked and pads are replaced before their expiry date, so that they are always in good working order.

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