Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martley Matthew, a prisoner at HMP Leicester, on 24 June 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 Martley Matthew died on 24 June 2019 from the effects of psychoactive substances (PS) at HMP Leicester. He was 62 years old. I offer my condolences to Mr Matthew's family and friends.

I am concerned that Mr Matthew was able to obtain PS at Leicester. The prison will need to strengthen its approach to reduce the availability of illicit drugs, in line with the Prison Service's *Prison Drugs Strategy*.

Staff did not follow the correct medical emergency procedures when they discovered Mr Matthew unresponsive in his cell. It made no difference in this case as Mr Matthew was dead when found, but any delays in responding to medical emergencies in future could be critical.

Louise Richards
Assistant Ombudsman **March 2020**

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Summary

Events

1. On 26 January 2018, Mr Martley Matthew was sentenced to 17 years in prison for grievous bodily harm and sent to HMP Leicester. He was moved to HMP Dovegate in August but was returned to Leicester on 21 January 2019.

2. While he was at Leicester in 2018, Mr Matthew was reported to have been under the influence of psychoactive substances (PS) on two occasions. When he returned to Leicester in January 2019, he told the reception nurse that he had used illicit substances in the last three months. A substance misuse worker spoke to him, but he said he had no drug or alcohol issues and refused to engage.

3. Mr Matthew displayed some concerning behaviour over the next few months, including associating with a known drug trafficker and suspicious behaviour during a visit. There are no records that he was seen under the influence of illicit substances. His key worker regularly met with him and raised no concerns.

4. On 23 June, during the evening roll check, an officer saw Mr Matthew sitting on his chair watching television. She said she saw him look up. The following morning, the same officer did the morning roll check and Mr Matthew was still in his chair, but his arms were down by his side and his head was tilted back. She banged on the cell door but got no response and could not see if he was breathing.

5. The officer called out to other officers for help, and two attended. One radioed for the Night Orderly Officer, who arrived quickly. He opened the cell and he and the officers went in. They could not find a pulse and said Mr Matthew was cold. The Night Orderly Officer called for a nurse and asked the control room to call an ambulance. The nurse gave Mr Matthew oxygen and started cardiopulmonary resuscitation (CPR). When ambulance paramedics arrived, they assessed that Mr Matthew was dead. They pronounced his death at 6.16am.

Findings

6. The clinical reviewer was satisfied that the care Mr Matthew received at Leicester was equivalent to that he could have expected to receive in the community.

7. We are concerned that drugs appear to be readily available at Leicester. The prison needs to identify and address the key weaknesses in reducing the supply of drugs.

8. There were issues with the prison's emergency response. Staff delayed entering Mr Matthew's cell and did not call a medical emergency code when they found him unresponsive. Although it made no difference in this case because Mr Matthew was dead when found, it is important that staff follow the correct medical emergency procedures so that appropriate treatment is given as quickly as possible.

9. Staff attempted to resuscitate Mr Matthew when he was clearly dead, which is against resuscitation guidelines.

Recommendations

- The Governor should identify and address the key weaknesses in reducing the supply of drugs at Leicester and revise the drug strategy in light of the findings.
- The Governor should ensure that staff are reminded of the national and local policies on entering cells during medical emergencies.
- The Governor should ensure that all staff are aware of and use the appropriate emergency code when they discover an apparent medical emergency.
- The Governor should ensure the clocks in the control room and the gate are accurate.
- The Governor and Head of Healthcare should ensure that staff do not attempt to resuscitate a prisoner where it would be futile, in accordance with European Resuscitation Council Guidelines.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Leicester 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 Matthew's prison and medical records and interviewed staff in August 2019.

12. NHS England commissioned a clinical reviewer to review Mr Matthew's clinical care at the prison.

13. We informed HM Coroner for Leicester City and South District of the investigation. The coroner gave us a copy of the post-mortem report. We have sent the coroner a copy of this report.

14. One of the Ombudsman's family liaison officers contacted Mr Matthew'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 raise any specific issues.

15. Mr Matthew's next of kin received a copy of the initial report. She did not raise any further issues, or comment on the factual accuracy of the report.

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

Background Information

HMP Leicester

17. HMP Leicester is a local prison that holds 350 men. The prison serves the courts of Leicestershire, Derbyshire, Northamptonshire and Nottinghamshire. Leicestershire Partnership NHS Trust provides healthcare services at the prison.

HM Inspectorate of Prisons

18. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Leicester in January 2018. Inspectors found significant improvement across many areas since their last inspection in 2015. Inspectors reported that staff were far more visible, and the relationships observed were more confident, friendly and supportive. HMIP congratulated the Governor and staff at the prison for the progress made.

19. However, inspectors were concerned at the ready availability of PS. Over half of respondents to an HMIP survey said that illicit drugs were easy to obtain at Leicester. This continued to affect the stability of the prison but there were some good initiatives to raise awareness of PS among prisoners and staff. The average random mandatory drug testing positive rate was 18.8%, far higher than the target. A drug supply reduction strategy was in place, and some good work was being done to address demand, but efforts to reduce the supply of drugs were not effective enough.

20. Inspectors reported that healthcare services had improved, although clinical records did not always contain a mental health care plan or report regular nursing reviews.

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 ending 31 January 2019, the IMB reported that the introduction of a Rapiscan (used to detect drugs impregnated in paper) in May 2018 had had a major impact on drug use. There had been an impressive reduction during 2018 of supply and use of PS, with far fewer instances of prisoners being seen under the influence (an average of 17 a month in June to December 2018 compared to an average of 31 a month in January to May). Unauthorised items, including drugs, continued to enter the prison by being thrown over the perimeter wall, although a significant number had been intercepted. An enthusiastic and vigilant team in visits, assisted by CCTV and dogs, had detected a significant number of passes.

Previous deaths at HMP Leicester

22. Mr Matthew was the fifth prisoner to die at HMP Leicester since June 2017. All the previous deaths were self-inflicted. There are no similarities with Mr Matthew's case.

Psychoactive Substances

23. 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.

24. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at that time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

25. HMPPS now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

26. On 26 January 2018, Mr Martley Matthew was sentenced to 17 years in prison for grievous bodily harm and sent to HMP Leicester (where he had been on remand). He was moved to HMP Dovegate in August 2018 but returned to Leicester on 21 January 2019. He had a history of using psychoactive substances (PS) in prison (he was reported to have been under the influence of PS twice during his initial period in custody at Leicester).

27. On 21 January 2019, a nurse completed Mr Matthew's reception health screen at Leicester. He told her that he had used illicit drugs within the past three months and had no history of mental health problems. She referred him to a GP because of his history of hypertension (high blood pressure).

28. A healthcare professional from the substance misuse team also saw Mr Matthew on 21 January. Mr Matthew told her he had no drug or alcohol issues and refused to work with the Integrated Drug Treatment Service (IDTS). She recorded that Mr Matthew declined to even sign a refusal form saying, 'I never sign anything'. Nonetheless, she gave Mr Matthew harm minimisation advice on alcohol and illicit drugs (including PS).

29. On 29 January, a member of staff submitted an intelligence report saying that Mr Matthew had been seen constantly looking around for staff during a visit. His visitor looked as though she was going to pass something to him but was not seen doing so.

30. On 18 April, a member of staff submitted an intelligence report saying that Mr Matthew had been associating with a known drug trafficker.

31. On 26 April, a psychiatrist from Arnold Lodge (a secure psychiatric unit) carried out a mental health assessment on Mr Matthew at the request of his solicitor. Mr Matthew was pleasant and polite throughout and the psychiatrist concluded that he did not have a mental illness.

32. On 15 May, a member of staff submitted an intelligence report saying that Mr Matthew had been seen standing outside a cell containing several prisoners and as staff walked past, he moved his body in front of the door to block the view into the cell.

33. Mr Matthew's had an allocated key worker. Key workers should get to know the prisoners they are responsible for, act as a first point of contact for any problems, help with resettlement issues, have regular meaningful conversations with them and make regular entries in prisoners' records about their progress.

34. The key worker's first entry as Mr Mathew's key worker was made on 11 February 2019. He made regular entries about his interactions with Mr Mathew and there were none that raised concerns. He last saw Mr Matthew on 19 June 2019 (five days before his death) and recorded that he seemed happy, was attending his computer classes and did not raise any concerns when asked. He told Mr Matthew he was going to be on nights on another unit for two weeks, and so would not see him, but if anything urgent arose Mr Matthew should ask another officer to email him.

Events of 23 and 24 June 2019

35. On 23 June, at approximately 8.10pm, Officer A started the evening roll check (count of prisoners). She said that Mr Matthew was in his cell, sitting on a chair in front of his television. He was looking downwards towards the floor and then he looked up at his television screen.

36. On 24 June, at approximately 5.52am, Officer A began the morning roll check. When she got to Mr Matthew's cell, she saw he was sitting on his chair as before, but his head was back, and his arms were down by his side. She could not see if his eyes were open or closed.

37. Officer A knocked on Mr Matthew's door, but he did not move. She could not see if his chest was moving. At around 5.53am, she called down to Officer B, who was on the landing below, and told her that she did not think Mr Matthew was breathing.

38. Officer B went to Mr Matthew's cell and looked through the observation panel. She could not see Mr Matthew breathing either. Another officer had also heard Officer A's shout and arrived at the cell. He shouted to Mr Matthew and banged on the cell door and then radioed for the Night Orderly Officer (Oscar 1) to attend.

39. The Night Orderly Officer, (a Custodial Manager (CM)), arrived around 90 seconds later and opened the cell. Officer B checked Mr Matthew's neck for a pulse but could not find one. She said that Mr Matthew was cold. Another officer was also unable to find a pulse.

40. At 5.57am, the CM contacted the healthcare emergency responder and asked him to attend. The nurse asked him if the incident was a code blue and the CM said it was a 'medical emergency'. The CM said that as soon as he spoke to the nurse, he asked the control room to call an ambulance. (The control room log says the ambulance was called at 6.02am, though the ambulance service records show the call was received at 6.04am.)

41. The nurse arrived at 6.02am and he and the CM lifted Mr Matthew off his chair and laid him on the floor. The nurse cleared Mr Matthew's airway and supplied him with oxygen. He also inserted a Guedel airway and applied a defibrillator to Mr Matthew (which advised 'no shock'). He started cardiopulmonary resuscitation (CPR).

42. The ambulance arrived at the prison at around 6.10am and paramedics arrived at the cell a few minutes later. Paramedics considered that Mr Matthew showed signs that he was already dead, including rigor mortis, and, at 6.16am, recorded that he had died. (The prison's CCTV shows that paramedics did not arrive at the scene until 6.18am. There is clearly a discrepancy between the prison and the ambulance service's timings.)

Contact with Mr Matthew's family

43. On 24 June, the prison appointed a family liaison officer. She visited Mr Matthew's named next of kin with an officer and a Governor to break the news of Mr Matthew's death.

44. Mr Matthew's funeral was held on 30 August. The prison paid for it, in line with national policy.

Support for prisoners and staff

45. On 24 June, a prison manager held a hot debrief and staff were offered support.

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

Post-mortem report

47. Toxicology tests showed that Mr Matthew had taken PS before he died. The pathologist found no evidence of any traumatic or natural disease that could have been responsible for Mr Matthew's death. The post-mortem report concluded that Mr Matthew died from the adverse effects of synthetic cannabinoids (PS).

Findings

Clinical care

Substance misuse management

48. Mr Matthew had a history of using PS in prison. When Mr Matthew arrived at Leicester in January 2019, he told the reception nurse that he had taken illicit substances within the last three months. However, he refused to work with the prison's Integrated Drug Treatment Service when a member of the substance misuse team spoke to him. Despite this, she gave Mr Matthew minimisation advice about alcohol and illicit drugs (including PS). The clinical reviewer was satisfied that Leicester took appropriate steps to try to help Mr Matthew with his substance misuse issues.

Mental health

49. The clinical reviewer did not have any concerns about Leicester's approach to Mr Matthew's mental health care. Despite refusing to work with substance misuse services, Mr Matthew did not display any signs that he lacked capacity to make that decision.

50. A mental health assessment in April 2019, as requested by Mr Matthew's solicitor, was carried out and did not reveal any mental illness. The clinical reviewer was satisfied that substance misuse and mental health care was equivalent to that Mr Matthew could have expected to receive in the community.

Drugs strategy and sharing intelligence

51. Staff submitted several intelligence reports about Mr Matthew's potentially suspicious behaviour relating to drugs at Leicester. He and a visitor had constantly checked the whereabouts of staff during a visit, he was associating with a known trafficker and seemingly deliberately obscured an officer's view of another prisoner's cell.

52. The investigator asked the Head of Security if Mr Matthew had ever been subject to drug tests or cell searches. He said that he had not as there was nothing conclusive in the intelligence reports and, during his last period at Leicester, Mr Matthew had never appeared to be under the influence of drugs.

53. The Head of Reducing Reoffending and Induction provided a copy of Leicester's drug strategy dated May 2019. She said it was going to be updated, but this would not be happening immediately. The current strategy (which was in place when Mr Matthew died) addresses reducing demand, restricting supply and building recovery. It aims to do so by effective use of CCTV, detection dogs, strategic searches, gathering and sharing intelligence, employing technology, testing, and providing support and rehabilitation options.

54. We are concerned that, despite Leicester's drug strategy, drugs appear to be readily available at the prison. We make the following recommendation:

The Governor should identify and address the key weaknesses in reducing the supply of drugs at Leicester and revise the drug strategy in light of the findings.

Emergency Response

Delay in entering cell

55. Prison Service Instruction (PSI) 24/2011, which sets out the procedures for management and security in prisons at night, says that under normal circumstances prisoners' cells can only be opened on the authority of the Night Orderly Officer and with at least two members of 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 the 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. The prison's local policy reflects this guidance.

56. On 24 June, just before 6.00am, Officer A started her roll check. When she reached Mr Matthew's cell, he was sitting in a chair with his arms by his side and his head tilted back. Mr Matthew did not respond to her knocking on his door and she called colleagues for assistance (she did not use her radio). Two other officers attended, and one officer radioed for the Night Orderly Officer to attend. The CM (the Orderly Officer) arrived in less than 90 seconds and immediately went into the cell.

57. The investigator asked the three officers why they had not entered the cell when they had failed to get a response from Mr Matthew, and something appeared to be wrong. Officer B said Officer A had asked her whether they should go in, but she thought there should be three people present whatever the circumstances. Officer A told the investigator that at the time she thought that three staff should be in attendance (and include the Night Orderly Officer) before entering a locked cell during night state. She said that since then, an instruction had been circulated that said if it was an emergency, and it was safe to do so, an officer could enter the cell alone. A third officer told the investigator that he did not recall a discussion about going into the cell because they were waiting for the CM to arrive, but he said that if it was an emergency, and it was safe to do so, an officer could enter a cell alone.

58. We consider that as three officers were present, and Mr Matthew was not responding, they should have gone into the cell without waiting for the CM. We are also concerned that Officers A and B appeared to be unaware of the prison's policy that an officer could enter a cell alone where there was a potential threat to life and it was safe to do so. We note that the delay in entering the cell made no difference in this case as Mr Matthew was dead when discovered, but nevertheless it is important that staff know that they can enter a cell in an emergency situation. We make the following recommendation:

The Governor should ensure that staff are reminded of the national and local policies on entering cells during medical emergencies.

Delay in calling medical emergency code

59. 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. Leicester's local policy says that a code red should be called where there is serious loss of blood, scalds or a suspected fracture and a code blue for difficulty breathing and unconsciousness. Calling a code tells healthcare staff to attend the scene with necessary equipment immediately and staff in the communications room to call an ambulance immediately.

60. None of the three officers who attended Mr Matthew's cell called a code blue even though they could not get a response from him and it was not clear if he was breathing. None of the officers completely understood the code system, including the officer who was in the control room – they all thought that a code red was considered less serious than a code blue and most of them thought healthcare would need to authorise calling an ambulance for a code red. (The CM was fully aware how the code system worked but said he had not called one when he went into the cell because it was very apparent that Mr Matthew was dead – hence he asked for healthcare to attend first.)

61. We note that Mr Matthew was dead when found and that the delay in calling a medical emergency code made no difference. However, in future medical emergencies, a delay of only a few minutes may be critical so it is important that staff follow the correct medical emergency procedures. We make the following recommendation:

    The Governor should ensure that all staff are aware of and use the appropriate emergency code when they discover an apparent medical emergency.

62. The investigator spoke to the officer who had been in the control room that night. He said that he had telephoned for an ambulance as soon as he was asked to (at 6.02am). The CM said that he had asked the control room to call for an ambulance straight after asking healthcare to attend (which according to the control room log was 5.57am). It is not possible to say which account is correct.

63. The ambulance service's log shows that the call was received at 6.04am, whereas the officer's control room log records the time as 6.02am. We make the following recommendation:

    The Governor should ensure the clocks in the control room and the gate are accurate.

Inappropriate resuscitation attempt

64. In September 2016, Professor Sir Bruce Keogh, National Medical Director at NHS England, wrote to Heads of Healthcare for prisons and Immigration Removal Centres introducing new guidance to support staff on when not to perform cardiopulmonary resuscitation (CPR). This guidance was designed to address the issue of inappropriate resuscitation following a sudden death in a prison and was taken from the European Resuscitation Council Guidelines 2015

which state, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”.

65. Ambulance paramedics recorded there were obvious signs of death when they assessed Mr Matthew, including the presence of rigor mortis. This indicated that he had been dead for some time.

66. Staff should not carry out CPR where it would be futile. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

The Governor and Head of Healthcare should ensure that staff do not attempt to resuscitate a prisoner where it would be futile, accordance with European Resuscitation Council Guidelines.

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