

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Martin Brown, a prisoner at HMP Lancaster Farms, on 10 December 2018

**A report by the Prisons and Probation Ombudsman**

## Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

## Our Values

We are:

**Impartial:** *we do not take sides*

**Respectful:** *we are considerate and courteous*

**Inclusive:** *we value diversity*

**Dedicated:** *we are determined and focused*

**Fair:** *we are honest and act with integrity*



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

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 Martin Brown died on 10 December 2018 at HMP Lancaster Farms after collapsing in his cell. The cause of his death is unknown. He was 50 years old. I offer my condolences to Mr Brown's family and friends.

I am satisfied that Mr Brown received a good level of clinical care at Lancaster Farms, equivalent to that which he could have expected to receive in the community.

Mr Brown was managed under HMPPS safer custody procedures (known as ACCT) on a number of occasions, including the five days leading up to his death. I am satisfied that, overall, the ACCT process was well-managed and that there is nothing to suggest that Mr Brown's death was self-inflicted.

I am concerned that when Mr Brown became unwell, an ambulance was not called immediately after a medical emergency code was called. The control room should not wait for healthcare staff to confirm whether an ambulance is needed.

I am also concerned that when Mr Brown's condition deteriorated, communication between healthcare staff and the control room was unclear, and as a result it was a further 20 minutes before an emergency ambulance was requested. I cannot say whether the lengthy delay affected the outcome for Mr Brown, but in a medical emergency situation every minute may count.

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**

**March 2020**

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# Summary

## Events

1. On 27 January 2015, Mr Martin Brown received a seven-year extended sentence for arson (a four-year custodial sentence and three years on licence). On 23 May 2017, he was released on licence. On 30 May 2018, Mr Brown was recalled to HMP Preston for breaching his licence conditions. On 13 August, Mr Brown was transferred to HMP Lancaster Farms.
2. Mr Brown had epilepsy, for which he took appropriate medication. He said that he had also been diagnosed with Parkinson's disease. However, a consultant neurologist diagnosed Mr Brown with 'essential tremors' (a common movement disorder), which he thought was made worse by his epilepsy medication. Mr Brown also had a history of alcohol dependency.
3. Mr Brown's behaviour was volatile and he had aggressive verbal outbursts. He also self-harmed at times. He had significant engagement with mental health services while at Lancaster Farms.
4. On 5 December, Mr Brown was placed on suicide and self-harm prevention measures (known as ACCT) after being found tying a ligature. On 8 December, he was found with a ligature round his neck and a plastic bag over his head. He was not injured.
5. On 10 December, Mr Brown was locked in his cell after lunch. He was tearful and said that he was not happy. About five minutes later, at 12.20pm, Mr Brown pressed his cell bell and an officer went to his cell immediately. Mr Brown was screaming in pain and holding his chest. The officer called a code blue medical emergency over his radio. Control room staff did not call an emergency ambulance.
6. Two nurses responded and when they arrived at Mr Brown's cell, he was on the floor, was pale and clammy, but alert. Mr Brown's clinical observations were normal and at 12.25pm, the nurses told the control room that an ambulance would not be needed.
7. The nurses stayed with Mr Brown and continued to monitor him. At 12.50pm, the nurses decided that due to Mr Brown's lack of improvement and continued symptoms of a grey colour, clammy skin and chest pain, he should be "assessed" by a paramedic. The control room called an ambulance immediately, but informed the ambulance service that a blue light (emergency) ambulance was not needed.
8. At 1.10pm, the control room updated the ambulance service, informing them that Mr Brown's condition had worsened. The ambulance service informed the prison control room staff that based on the earlier call, an ambulance had not yet been dispatched.
9. At about 1.15pm, Mr Brown's condition deteriorated further, and the nurses started cardiopulmonary resuscitation (CPR). The control room staff updated

the ambulance service again and told them that Mr Brown had now gone into cardiac arrest. An ambulance arrived at the prison at approximately 1.20pm.

10. Nursing staff and paramedics continued with CPR, but Mr Brown did not respond. At 2.00pm, it was confirmed that Mr Brown had died.
11. The post-mortem was unable to establish the cause of Mr Brown's death.

## Findings

### ACCT

12. Mr Brown was managed under ACCT procedures on a number of occasions and was on an ACCT at the time of his death.
13. There is nothing to suggest that Mr Brown's death was self-inflicted and the investigation found that, overall, the ACCT process was well-managed, with a multi-disciplinary approach to Mr Brown's care.
14. However, we found that ACCT observations – which should be carried out at unpredictable intervals - were completed on the hour or half-hour during the night. In addition, a case review was not documented correctly on 7 December, and there were no updates or follow-ups to the issues identified as part of Mr Brown's care plan, despite new tasks being added.

### Emergency response

15. When an officer called an emergency code blue over his radio at 12.20pm, on 10 December, control room staff did not call an ambulance immediately, contrary to national guidance.
16. When nursing staff arrived at the scene around 12.25pm, they assessed Mr Brown, and based on their initial observations, they felt that an ambulance was not needed at that stage and updated the control room. The clinical reviewer considers that this was a reasonable decision.
17. At 12.50pm, the nurses requested a paramedic be called to "assess" Mr Brown because his condition had not improved. It is not clear what they meant by this but it did not convey any sense of urgency and the control room told the ambulance service that it was not an emergency. This meant that an ambulance was not dispatched.
18. In total, 55 minutes elapsed between the calling of the code blue and control room staff requesting an emergency ambulance. We are concerned that there was such a long delay in calling an ambulance for Mr Brown, and that when the nurses asked the control room to call for a paramedic, their instructions were unclear. It is impossible to say if this delay impacted on the outcome for Mr Brown, however any delay in a medical emergency can be critical.

### Clinical Care

19. We are satisfied that the level of clinical care Mr Brown received while at Lancaster Farms was equivalent to that which he could have expected to receive in the community.

20. Mr Brown's epilepsy was appropriately managed with medication. Although he told staff that he had Parkinson's disease, a specialist diagnosed him with essential tremors, which appeared to be a side effect of his epilepsy medication. A plan was put in place to prescribe medication to manage the tremors, but Mr Brown died before it could be dispensed.
21. Mr Brown had significant engagement with mental health services at Lancaster Farms, which was timely and appropriate.

## Recommendations

- The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:
  - ACCT case reviews are held and documented in the correct format, using the appropriate documentation;
  - the documentation provides staff with a clear understanding of the required frequency when conducting ACCT observations;
  - observations are carried out at unpredictable intervals and within the prescribed timeframe.
- The Governor and Head of Healthcare should ensure that staff are aware of their responsibilities in a medical emergency and should not delay requesting an ambulance for prisoners who appear critically unwell.
- The Governor should ensure that the control room requests an emergency ambulance as soon as a medical emergency code is called.
- The Governor and Head of Healthcare should ensure that information communicated during a medical emergency between healthcare staff and the control room, and between the control room and the ambulance service, is clear and concise to enable the ambulance service to prioritise the call correctly.

## The Investigation Process

22. The investigator issued notices to staff and prisoners at HMP Lancaster Farms informing them of the investigation and asking anyone with relevant information to contact her. One prisoner responded.
23. The investigator obtained copies of relevant extracts from Mr Brown's prison and medical records.
24. The investigator interviewed five members of staff at Lancaster Farms on 11 February 2019.
25. NHS England commissioned a clinical reviewer to review Mr Brown's clinical care at the prison.
26. We informed HM Coroner for Preston and West Lancashire of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
27. We wrote to Mr Brown's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not respond to our letter initially. She later contacted us and asked for a copy of our report.
28. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out one factual inaccuracy and this report has been amended accordingly.
29. The initial report was sent to Mr Brown's next of kin. She did not identify any factual inaccuracies.

# Background Information

## HMP Lancaster Farms

30. HMP Lancaster Farms is a modern, medium security resettlement prison with accommodation for 560 adult male prisoners. Healthcare is provided by Spectrum. Healthcare staff work from 7.30am to 7.30pm, Monday to Thursday, 7.30am to 6.00pm on Friday and 8.00am to 5.30pm at weekends.

## HM Inspectorate of Prisons

31. The last inspection of HMP Lancaster Farms was conducted in 2018. Inspectors reported that Lancaster Farms was a competent prison, led by a capable management team and generally confident staff. Working relationships between the prison and the healthcare provider, Spectrum, were good, as were business and governance monitoring systems.
32. Prisoners said they were generally satisfied with healthcare, although a minority were dissatisfied with pain management. The prisoners' forum, patients' forum and surveys were used effectively to consult service users. Prisoners with long-term conditions were managed by a GP or senior nurse, and were registered on SystemOne and had care plans. Nurse-led clinics for long-term conditions were scheduled regularly and plans were underway to offer prisoners help to manage their long-term conditions. Mental health services, provided by Tees, Esk and Wear Valleys NHS Foundation Trust were good.

## Independent Monitoring Board

33. 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 January 2018, the IMB reported that, overall, Lancaster Farms was a well-managed prison and generally provided a safe environment for prisoners. The Board noted that ACCT procedures were adhered to and the needs of vulnerable prisoners were carefully considered.

## Previous deaths at HMP Lancaster Farms

34. Mr Brown was the third prisoner to die of natural causes at Lancaster Farms since 2014. There are no similarities with those deaths.

## Assessment, Care in Custody and Teamwork (ACCT)

35. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide or self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be carried out at irregular intervals to prevent the prisoner anticipating when they will occur. Regular multidisciplinary review meetings involving the prisoner should be held.

36. As part of the process, a caremap (a plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the caremap have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011, *Management of prisons at risk of harm to self, to others and from others (Safer Custody)*.

## Key Events

37. On 27 January 2015, Mr Martin Brown received a seven-year extended sentence for arson (a four-year custodial sentence and three years on licence). On 23 May 2017, he was released on licence.
38. On 30 May 2018, Mr Brown was recalled to HMP Preston for breaching his licence conditions. On 13 August, he was transferred to HMP Lancaster Farms.
39. Mr Brown had epilepsy, for which he took appropriate medication. He told staff at his reception screen that he had been diagnosed with Parkinson's disease, but healthcare found no documented evidence of the diagnosis in Mr Brown's medical records. Mr Brown also had a history of alcohol dependency.
40. Mr Brown's behaviour was volatile and he had aggressive verbal outbursts. He had significant engagement with mental health services while at Lancaster Farms. Staff and the prison's mental health team supported him on numerous occasions by placing him on suicide and self-harm procedures known as ACCT because he was either self-harming and/or low in mood.
41. On 6 September, Mr Brown was moved to the wellbeing unit. The wellbeing unit was a more supportive environment for Mr Brown and he was enrolled on the Drug and Alcohol Rehabilitation Programme to help prepare him for his release. On 19 November, Mr Brown began the Gateway programme (a substance misuse counselling programme).
42. On 22 November, Mr Brown saw a consultant neurologist because he believed that he had Parkinson's disease. The neurologist diagnosed 'essential tremors', a common movement disorder, and suggested the tremors were made worse by Mr Brown's epilepsy medication. The neurologist wrote to the prison GP and said that a prescription of propranolol would help control the tremors. A prison GP reviewed the letter from the neurologist on the day Mr Brown died (10 December), so Mr Brown did not receive the medication prior to his death.
43. From 3 to 5 December, Mr Brown's behaviour was poor. He received warnings from staff because his behaviour was not appropriate for the wellbeing unit.
44. On 5 December, Mr Brown collected his evening meal. He threw it all over the landing, while shouting and swearing at staff and prisoners, before returning to his cell. As a result, he was told that he had been given his last warning and would be moved off the wellbeing unit the following morning.
45. Around an hour later, at about 6.30pm, an officer went to check on Mr Brown. When she looked into the cell, she saw Mr Brown holding a ligature made of string and standing on the pipes. When she challenged him, he said that he was feeling down and confused. Mr Brown was not injured and did not need to see a nurse. She calmed Mr Brown down and told him that she would be opening an ACCT document. Mr Brown was observed every half an hour, until a full assessment could be completed.
46. On 6 December, Mr Brown attended a suitability meeting with a wing manager and the Spectrum drug and alcohol services recovery team. They considered

that Mr Brown had been given multiple behaviour warnings. He was told that he was being removed from the Gateway programme because it was felt that it was too much pressure for him. However, he would be able to continue working with his Spectrum recovery keyworker, with an aim to re-join the programme at the end of January 2019. The wing manager said that he would have a 'full mental breakdown' and would 'leave the wing in a box'.

47. On the afternoon on 6 December, a prison manager completed an ACCT assessment with Mr Brown. Mr Brown talked about his previous self-harm and said that he was currently feeling low in mood, had no control and no support. Mr Brown said that when he had been found with the ligature the previous day, he had wanted to die, but now just felt confused. Mr Brown spoke positively about the future, what he would like to do and how his family were a support.
48. Following the assessment, Mr Brown had an ACCT review chaired by a Custodial Manager (CM) and attended by a prison chaplain and a member of the integrated mental health team. The review recorded that Mr Brown was visibly upset and tearful and said he had been enjoying the Gateway programme, but had now been removed. Mr Brown admitted to throwing his dinner and shouting, but said that it was out of frustration at his Parkinson's disease. Mr Brown said that he was unsure how long he would stay in custody, as he had been told by his probation officer that he would be put forward for release if he completed the Gateway course. Mr Brown told the review that he had not been informed about his recall or what was happening about his release.
49. When asked about thoughts of self-harm, Mr Brown said that the only way he would leave the wing would be 'in a box'. When asked directly by the CM whether he wanted to be dead, Mr Brown said, 'No, not really'. The review concluded that Mr Brown presented as a raised risk of further self-harm, but reduced the observations from twice per hour to once.
50. Three actions were added to the ACCT caremap, including finding out about Mr Brown's recall status, asking the charity Shelter to work with Mr Brown to assist with accommodation on release, and referring him to substance misuse services.
51. On 7 December, Mr Brown was taken to the segregation unit for a disciplinary hearing because he had been placed on report for throwing his food. While in the unit, Mr Brown said that he was going to kill himself as he was not getting the right support. Staff informed the staff on the wing about Mr Brown's comments.
52. On his return to the wing, a CM from the prison's safer custody team saw Mr Brown for an ACCT review. The review was also attended by a nurse and a member of the chaplaincy team. The CM recorded that the issues that Mr Brown had raised while in segregation were still present, and that he said again that he would leave the wellbeing wing 'in a box'. He told Mr Brown that he would remain on the wing over the weekend, and a further review would take place after the weekend, and would be attended by substance misuse staff. Mr Brown's observations remained at hourly.

53. At 12.55pm, an officer completed a routine check on Mr Brown and observed him tying a towel round the bars of his window. The officer informed the duty manager and Mr Brown's observations were increased to two per hour until a review was completed. There is no evidence that a further review took place on 7 December, but an entry in the ongoing record indicates that at 2.15pm, a review was completed and observations returned to hourly.
54. On 8 December, the substance misuse team reviewed Mr Brown. They talked to him about deselection from the Gateway programme and reassured him that he would be able to re-apply if he could address his behavioural issues.
55. At 11.15am that morning, a prisoner found Mr Brown with a ligature round his neck and a plastic bag over his head. The prisoner alerted staff who called a code blue medical emergency and helped Mr Brown. He did not have any injuries and did not need medical help. A CM carried out an ACCT review and recorded that, because of his tremors, Mr Brown needed social care help with meals and completing paperwork to help with his outbursts of frustration. Observations were increased to every 30 minutes. The CM also added two new actions to the caremap, about disability assistance and Mr Brown not sleeping.

#### **Events of 10 December**

56. On 10 December, about 10.15am, Mr Brown telephoned his offender manager. He said that his Parkinson's disease was flaring up and he felt in a "battle with his mind and body". He said that he was struggling to feed himself, needed a carer, and was being bullied by another prisoner. He also said his antidepressants were being reduced and that he had attempted to hang himself twice in the last week. The offender manager shared this information with his offender supervisor at the prison, who said she would go to see him on 13 December, when she was next on the wing, to offer support.
57. At 11.00am, Mr Brown attended an ACCT review chaired by a CM. Mr Brown was described as unsettled, angry and giving short answers to questions. Mr Brown said that he was being bullied on the wing, but when asked, he would not consider a move off the wing to help resolve the issue. He said his mental and physical health were causing him concern, and that he "did not wish to be here anymore". When asked to elaborate on what he meant, Mr Brown declined. Staff concluded that Mr Brown's risk of harm to himself remained raised and observations were set at every 30 minutes. There were no further actions added to the caremap, and no evidence that any further action was taken about Mr Brown's allegations of being bullied.
58. At 11.25am, Mr Brown told an officer that he had just spoken to his mother on the telephone and said goodbye to her as he felt mentally and physically unwell. She told the security department, who listened to Mr Brown's telephone call with his parents. He spoke to his father first and said that he would not harm himself and was trying to manipulate a trip to the hospital. He then spoke to his mother and told her he would harm himself, he had little support and did not want to move wings. A prison manager increased Mr Brown's observations to every 20 minutes, based on the information obtained from the telephone call.

59. At 11.50am, an officer observed Mr Brown sitting in his cell talking to another prisoner.
60. At 12.15pm, after lunch, Mr Brown was locked in his cell. He was tearful and said that he was not happy. About five minutes later, Mr Brown pressed his cell bell and an officer responded immediately. Mr Brown was screaming in pain and holding his chest. The officer radioed a code blue emergency (indicating a prisoner has breathing difficulties or is unconscious).
61. The communications log shows that a code blue was called at 12.20pm. However, there is no evidence that the control room called an emergency ambulance.
62. Two nurses responded. When they arrived at Mr Brown's cell, he was on the floor. One nurse noted that he was pale and clammy, and his level of consciousness was reduced. They found no evidence that he had had an epileptic seizure and they helped him to his bed where they gave him oxygen. His level of consciousness improved and he said he had severe back pain and denied having taken any illicit substances. The nurses decided it was not a medical emergency and, at 12.25pm, they told staff in the communications room that an ambulance was not needed.
63. A nurse continued to monitor Mr Brown's clinical observations, such as blood pressure, pulse and oxygen, which were within the normal range. At 12.43pm, the control room log noted that healthcare staff were still 'dealing with' Mr Brown in his cell.
64. The nurse knew that Mr Brown had epilepsy and thought he might be in a postictal state (a state of altered consciousness that may follow a seizure). At about 12.45pm she asked a prison GP to review Mr Brown, and told him Mr Brown was potentially postictal and that his observations were unremarkable. The GP advised the nurses to continue to "keep him safe and observe" and that he would review Mr Brown later.
65. Although Mr Brown's observations were within the normal range and he continued to talk to the nurses, he was becoming more pale and clammy. The nurse said that he needed to be "assessed" by a paramedic. This message was apparently passed to the control room by the Orderly Officer at 12.50pm.
66. The control room called an ambulance immediately. The recording of the 999 call shows that the ambulance service was told that Mr Brown was complaining of "severe chest pains", and was "clutching his chest" and "very clammy", and that the call was "not a blue light [ie an emergency] but he needs assessing by a paramedic".
67. Mr Brown's condition began to deteriorate rapidly from 12.50pm and he became unresponsive. At 1.10pm, the communications room updated the ambulance service that Mr Brown was deteriorating, but the ambulance service was unable to give an estimated time of arrival as an ambulance had not yet been allocated.
68. At about 1.15pm, Mr Brown went into full cardiac arrest and stopped breathing. A nurse began CPR and used an automatic defibrillator (which did not deliver a shock). Two more nurses arrived. One nurse helped with the resuscitation,

whilst the other went to fetch a prison GP, who attended and helped with the resuscitation.

69. The communications room updated the ambulance service that Mr Brown had now gone into cardiac arrest. An ambulance arrived at the prison five minutes later. It took paramedics three minutes to get to Mr Brown.
70. The nurses and paramedics continued with CPR, but Mr Brown did not respond. At 2.00pm, it was confirmed that Mr Brown had died.

### **Contact with Mr Brown's family**

71. A prison chaplain was appointed as the prison's family liaison officer (FLO). The Governor and the chaplain visited Mr Brown's next of kin at her home. They told her Mr Brown had died and offered their condolences.
72. They then visited Mr Brown's parents and informed them that Mr Brown had died. They offered their condolences and explained what would happen next. A FLO was appointed for Mr Brown's parents.
73. The chaplain and Governor provided on-going support to Mr Brown's next of kin and parents.
74. Mr Brown's funeral was held on 28 December. The prison offered a financial contribution towards the funeral in line with national guidance.

### **Support for prisoners and staff**

75. After Mr Brown'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.
76. The prison posted notices informing other prisoners of Mr Brown'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 Brown's death.

### **Post-mortem report**

77. The post-mortem was unable to establish the cause of Mr Brown's death.
78. There was no evidence of drug or alcohol misuse, although the pathologist said that the use of PS could not be completely ruled as there are so many different types.
79. There was no evidence of any natural disease or injury that would have been the cause of Mr Brown's death and nothing to suggest that it was caused by epilepsy.

# Findings

## Management of the risk of suicide and self-harm

80. Prison Service Instruction (PSI) 64/2011, which covers safer custody, lists a number of risk factors and potential triggers for suicide and self-harm. These include previous self-harm and suicidal ideation, a history of mental health problems and recall to prison. These factors applied to Mr Brown. Staff acted appropriately in opening an ACCT document when Mr Brown was found with a ligature on 5 December.
81. All but one of the four case reviews were multidisciplinary, involving prison staff, nurses, chaplaincy and managers. Staff worked together to reduce Mr Brown's risk to himself. They were aware of his physical and mental health problems and demonstrated understanding, compassion and careful consideration in trying to help him in reducing his distress.
82. However, despite some positive work, the investigation has identified some failings in the operation of ACCT.

## *Caremap actions*

83. PSI 64/2011 says that caremap actions should be detailed and time-bound and aimed at reducing risk. They should reflect the prisoner's needs, level of risk, and the triggers of his distress. Mr Brown's ongoing issues were appropriately recorded, and plans to address these were added on the caremap at the initial case review. Further actions were added at case reviews. However, there is no evidence that any of the listed actions had been satisfactorily resolved and no indication of what was being done to address them was provided at the subsequent reviews. There was also no evidence of any actions taken in response to Mr Brown's claims that he was being bullied.
84. When Mr Brown was found tying a ligature on 7 December, the ongoing record refers to a review taking place. However, there is no case review documentation to support this, or to record what decisions were made.

## *Frequency of observations*

85. Mr Brown's observations were initially set at twice hourly and then fluctuated between irregular hourly, half-hourly and three per hour, as his risk was judged to have increased and decreased.
86. Observations were mostly carried out as prescribed, although those completed at night were not completed at unpredictable intervals, but were made either on the hour or half-hour. This was not in line with PSI 64/2011. In addition, the entry on the front of the ACCT folder, advising staff about the frequency of observations, is not as clear it should be.

87. We make the following recommendation:

**The Governor should ensure that staff manage prisoners at risk of suicide or self-harm in line with national guidelines, including in particular that:**

- **Case reviews are held and documented in the correct format, using the appropriate documentation.**
- **The documentation provides staff with a clear understanding of the required frequency when conducting ACCT observations.**
- **Observations are carried out at unpredictable intervals and within the prescribed timeframe.**

### Emergency response

88. PSI 03/2013 requires prisons to have a medical emergency response code protocol which should ensure that an ambulance is requested immediately when a medical emergency code is called. The PSI says that it must not be a requirement for a member of healthcare staff or a Duty Manager to attend the scene before an ambulance is called. It also says that if staff are in any doubt about the nature of the injury, they must call an ambulance as “it is better to act with caution and request an ambulance that can be cancelled if it is later assessed as not required”. The provisions of the PSI are mirrored in local policies at Lancaster Farms.

89. We are, therefore, concerned that when an officer called a code blue at 12.20pm on 10 December, control room staff did not call an ambulance immediately, contrary to national and local guidance.

90. When nursing staff arrived at the scene around 12.25pm, they assessed Mr Brown and considered that an ambulance was not needed at that stage and updated the control room. The clinical reviewer considers that the nurses’ decision was a reasonable one.

91. As Mr Brown’s condition deteriorated, the nurses requested at 12.50pm that he be “assessed” by a paramedic. The control room called an ambulance and passed the nurses’ request to the ambulance service, but informed the ambulance service that it was not an emergency. We consider that the nurses’ request for an “assessment” by a paramedic was unclear and confusing. They should have made it clear to the control room whether or not an emergency ambulance was required so that the ambulance service could prioritise appropriately. As Mr Brown was very clammy and had severe chest pain at this point, we consider that the nurses should have requested an emergency ambulance.

92. As a result of this lack of clarity, it was not until the control room called the ambulance service again at 1.10pm - 20 minutes later - to say that Mr Brown was “getting worse” that an ambulance was actually despatched.

93. In all, there was a delay of 55 minutes between the officer calling the code blue and an emergency ambulance being requested. (Once the ambulance was despatched, it arrived within five minutes.) We cannot say if this significant

delay affected the outcome for Mr Brown, but in a medical emergency every minute may count.

94. We make the following recommendations:

**The Governor and Head of Healthcare should ensure that staff are aware of their responsibilities in a medical emergency and should not delay requesting an ambulance for patients who appear critically unwell.**

**The Governor should ensure that the control room requests an emergency ambulance as soon as a medical emergency code is called.**

**The Governor and Head of Healthcare should ensure that information communicated during a medical emergency between healthcare staff and the control room, and between the control room and the ambulance service, is clear and concise to enable the ambulance service to prioritise the call correctly.**

### Clinical care

95. Mr Brown had epilepsy, which was appropriately managed with medication. Although he told staff he had Parkinson's disease, he had not been diagnosed with this condition and was appropriately referred to a consultant neurologist for review. The neurologist diagnosed 'essential tremors', which were probably caused by Mr Brown's epilepsy medication. Mr Brown died before he could take medication prescribed to help to control the tremors. He had no other significant physical health concerns.
96. Mr Brown had significant engagement with mental health services at Lancaster Farms, which was timely and appropriate.
97. Mr Brown had a significant history of alcohol misuse, which was linked to his offending behaviour. Before his recall to prison, Mr Brown was showing signs of alcohol dependency. Mr Brown engaged with the Drugs and Alcohol Rehabilitation Programme in prison to help prepare him for release. Mr Brown said he enjoyed the programme and the support it offered.
98. The pathologist found no evidence of drugs or alcohol in Mr Brown's system. There is no intelligence to suggest Mr Brown was involved in the use of illicit substances or alcohol while at Lancaster Farms. We are satisfied that Mr Brown received appropriate support for alcohol misuse while at Lancaster Farms.
99. We agree with the clinical reviewer that the clinical care Mr Brown received while at Lancaster Farms was equivalent to that which he could have expected to receive in the community.

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