Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Steven Ward, a prisoner at HMP Lowdham Grange, on 26 May 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 Steven Ward died on 26 May 2019 at HMP Lowdham Grange from drug toxicity. He was 34 years old. I offer my condolences to Mr Ward's family and friends.

Mr Ward had a history of trafficking and supplying psychoactive substances (PS) in prison, but he had no history of using it himself and did not appear under the influence of drugs during his time at Lowdham Grange. A close friend of his was unaware that Mr Ward used PS and was very surprised that he had done so.

My investigation found that the key worker scheme did not work as it should have done in this case. We also raised two concerns about the emergency response, although neither affected the outcome for Mr Ward, and it would have been difficult for the prison to have predicted or prevented his death.

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 **February 2020**

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Summary

Events

1. Mr Steven Ward had a history of substance misuse, violence and drug related offending. On 26 April 2018, Mr Ward was sentenced to 15 years for robbery. On 4 April 2019, he was transferred to HMP Lowdham Grange. Mr Ward told a nurse at an initial health assessment that he had no issues with alcohol or drugs and was not on any medication.

2. On 24 April, Mr Ward met his Offender Supervisor and appeared keen to address his offending behaviour. On 30 April, he told a key worker that he felt safe and had no issues at Lowdham Grange. He said he had good contact with family and friends and was not in any debt.

3. At about 2.08am on 26 May, officers found Mr Ward unresponsive on the floor of his cell. The prison night nurse, officers and paramedics gave him cardio-pulmonary resuscitation, but Mr Ward was pronounced dead at 2.52am.

4. The post-mortem report gave Mr Ward's cause of death as drug toxicity.

5. Mr Ward's co-defendant and friend said that Mr Ward was in a "good place" at Lowdham Grange and appeared happy and motivated. He said he was unaware, and surprised, that Mr Ward had used PS.

Findings

6. Mr Ward had a history of trafficking and supplying drugs in prison but no history of using psychoactive substances (PS). He was not found under the influence of PS at Lowdham Grange or suspected of involvement with it. We found it would have been difficult for the prison to have predicted or prevented his death.

7. Mr Ward only saw a key worker once in over seven weeks and there were very few entries from wing staff on his electronic case notes. We cannot say whether closer involvement with a key worker would have revealed Mr Ward's PS use, but it is clear the key worker scheme did not work as it should have done in his case.

8. An emergency code was not used to effectively communicate the nature of the emergency when Mr Ward was found unresponsive. We also consider that there were sufficient officers present to have entered his cell sooner. It is unlikely that either of these factors would have changed the outcome for Mr Ward, who appears to have been dead when he was found.

9. Despite it being very likely that Mr Ward was dead when prison staff attempted to resuscitate him, he was not in rigor mortis and the clinical reviewer concluded that the decision to resuscitate was reasonable in the circumstances.

Recommendations

- The Governor should ensure that the prison meets the standards of staff-prisoner involvement expected in the key worker scheme, including that all

interactions are recorded on electronic case notes (NOMIS) and managers quality check the entries.

- The Governor should ensure that all staff are made aware of, and understand, their responsibilities during medical emergencies including that:
    - Night staff enter cells as quickly as possible in a life-threatening situation.
    - Night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.

The Investigation Process

10. The investigator issued notices to staff and prisoners at HMP Lowdham Grange 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 Ward's prison and medical records and records from the East Midlands Ambulance Service.

12. NHS England commissioned a clinical reviewer to review Mr Ward's clinical care at the prison. The investigator and clinical reviewer interviewed four members of staff at Lowdham Grange on 3 July 2019. The clinical reviewer spoke to a nurse by telephone who was not available for interview. The investigator also spoke to one prisoner.

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

14. One of our family liaison officers wrote to Mr Ward's mother and partner, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The investigator spoke to Mr Ward's mother and sister. They both had a number of questions about the emergency response and resuscitation which we have answered in this report and by telephone.

Background Information

HMP Lowdham Grange

15. HMP Lowdham Grange is a category B training prison which holds up to 888 sentenced adult men. It is operated under contract by SERCO. Healthcare and substance misuse services are provided by Nottinghamshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons

16. HM Inspectorate of Prisons (HMIP) carried out an unannounced inspection of Lowdham Grange in August 2018. Inspectors found that nearly half the prisoners said that it was easy to get illegal drugs. Supply reduction work had improved and the use of specialist equipment to scan mail was good. The safer custody and healthcare teams effectively supported prisoners found under the influence of psychoactive substances (PS). Work to prevent staff corruption was well developed and had led to the dismissal of five staff.

17. Wing staff made limited entries on electronic case notes (NOMIS) and these were rarely quality checked by managers.

Independent Monitoring Board

18. 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 2019, the IMB reported that the use of PS by prisoners was common and presented challenges for staff ranging from catatonic to extremely violent prisoners. They reported that prison staff had taken proactive action and had successfully reduced the supply of drugs during the year.

Previous deaths at HMP Lowdham Grange

19. Mr Ward was the seventh prisoner to die at Lowdham Grange since May 2017. In our investigation into the death of a man in December 2017, we found that he was too easily able to obtain drugs. In investigations into the deaths of two men in October 2018 and May 2019, we found that they had used PS but there was no evidence that staff had referred them to substance misuse services. In our investigation into the death of a man in November 2018, we found that he received appropriate care for his PS misuse.

Psychoactive Substances (PS)

20. 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.

21. 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.

22. HM Prison and Probation Service (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.

Keyworker Scheme

23. The purpose of the key worker scheme is to prioritise development of staff-prisoner relationships and give each prisoner a point of contact who will meet them regularly to help and support them. Requirements of the scheme include:

- All prison officers who work on a residential unit will be allocated a maximum of 6 prisoners who they are expected to see, individually, for an average of 45 minutes a week.
- All prisoners in closed prisons will be allocated a key worker, including those on remand.
- Key workers will record meetings, discussions and any progress that has been made on NOMIS in a detailed manner. These notes will be regularly checked as part of on-going quality assurance, so it is important that they are sufficient.

Key Events

24. Mr Steven Ward had a history of substance misuse, violence and drug related offending. He had been in prison before, and his security record showed evidence of involvement in the prison drug culture. On 10 June 2016, Mr Ward was released on licence from HMP Ranby. On 30 August 2017, he was arrested for armed robbery. His licence was revoked, and he was recalled to prison. On 26 April 2018, Mr Ward was sentenced to 15 years in prison for robbery. Prison intelligence reports in September 2018, December 2018 and February 2019 showed that Mr Ward was suspected of receiving PS from visitors and in the mail. Mr Ward did not fail any mandatory drug tests in prison and was not found under the influence of drugs in prison. (There are no entries in Mr Ward's medical records about substance misuse after 2014 when he attended a psycho-social course in HMP Ranby.)

25. On 4 April 2019, Mr Ward was transferred to HMP Lowdham Grange. He told a nurse at an initial health assessment that he had no issues with alcohol or drugs and was not on any medication. He said that he was waiting for hormone treatment in hospital for enlarged breasts. She referred Mr Ward to the GP to follow up his outstanding hospital appointment and to the dentist because he complained of toothache. The clinical reviewer concluded that Mr Ward received appropriate intervention for both these issues at Lowdham Grange.

26. A member of the prison chaplaincy team spoke briefly to Mr Ward on 5 April and recorded that he appeared to be settling in well. The next entry on Mr Ward's prison record is on 24 April, when Mr Ward met his Offender Supervisor. Mr Ward said that he suffered from anxiety and depression but did not take medication because he did not like how it made him feel. Mr Mason referred Mr Ward to the mental health team. Mr Ward said he smoked cannabis daily in the community but declined the offer of a referral to the substance misuse team. Mr Ward said that he was keen to undertake available offending behaviour courses at Lowdham Grange.

27. On 30 April, an officer met Mr Ward for a keyworker session because his nominated keyworker was on leave. She explained the frequency and length of sessions, their purpose and the boundaries of confidentiality. She said that Mr Ward was very relaxed, and he said he felt safe and had no issues in Lowdham Grange. He was waiting to see the dentist and had applied for a number of jobs in the prison. He said that he had good contact with family and friends and was not in any debt. She noted that Mr Ward's regular keyworker needed to prepare a progression plan for him. Mr Ward did not see his keyworker before he died.

28. On 13 May, the Offender Supervisor visited Mr Ward to give him the result of his annual recategorisation review. Mr Ward was not on the wing, so he left the review under his cell door.

25/26 May 2019

29. CCTV footage showed Mr Ward playing pool during afternoon social time with other prisoners. Mr Ward appeared well and in good spirits. At about 5.45pm, staff locked him in his cell for the night. Mr Ward's co-defendant and friend said that he spoke to Mr Ward at about 9.00pm via his window. Mr Ward was

watching boxing on television and was in good form. Mr Ward said he would "shout" him again at 11.00pm but he did not. Cell bell records showed Mr Ward did not press his emergency cell bell after night-time lock up.

30. Two Prison Custody Officers (PCO) were responsible for A, B, C and D wings that night. The investigator watched CCTV from B wing. There is no time on the footage, so timings have been taken from the control room log, time elapsed between events on CCTV, and ambulance records. PCO A checked Mr Ward during the night-time roll count at about 10.00pm. At 2.00am, PCO B and PCO A began a welfare check of every prisoner on their wings starting on D Wing.

31. PCO A said he checked Mr Ward's cell at about 2.08am and noticed that Mr Ward's bed and the floor next to it were empty. He looked immediately down and saw Mr Ward face down on the floor with his head towards the bed and his feet underneath the sink. He said that he tried to get a response from Mr Ward and called PCO B over to help him. Mr Ward's cell light was on and neither officer could see Mr Ward breathing. PCO B radioed the communications room that Mr Ward was unresponsive and asked for assistance. He did not use an emergency code.

32. PCO A said he did not want to go into the cell without other officers in case Mr Ward tried to escape. PCO C arrived just over three minutes later. He radioed for permission to enter Mr Ward's cell and a Custodial Operations Manager (COM) agreed they could if they felt safe to do so. PCO B broke the seal on his key pouch and all three officers entered Mr Ward's cell, four minutes after PCO A checked Mr Ward's cell. (At night, officers on wings do not carry cell keys on their key chains but have a key in a sealed pouch for use in an emergency.)

33. The officers checked Mr Ward for signs of life. They turned him over and noticed he had vomited. PCO A said Mr Ward looked dead, his arms and legs were cold, but his chest was still reasonably warm. PCO C said that Mr Ward looked blue and felt cold, but he did not see signs of rigor mortis.

34. Thirty seconds after the officers entered the cell, a nurse arrived with the emergency response bag, together with PCO D. The nurse checked for signs of life, radioed for an emergency ambulance and told the officers to start cardio-pulmonary resuscitation. He said Mr Ward was grey and his pupils were fixed and dilated.

35. PCO A began chest compressions while the nurse attached Mr Ward to the defibrillator. PCO A and PCO D took turns to do chest compressions while the nurse gave Mr Ward oxygen using a bag and mask. The nurse said that he was unable to insert an iGel airway (a larger airway with a superior seal for delivering oxygen to the lungs) because Mr Ward's mouth was too stiff but was able to insert a smaller one to keep his tongue from blocking his airway (a Guedel airway). The defibrillator did not advise giving Mr Ward an electric shock. CCTV showed a first responder and ambulance crew of two arrived on B wing about 19 minutes after the nurse first entered Mr Ward's cell.

36. The ambulance crew attached Mr Ward to their own equipment and moved him to the landing because there was more space. They gave Mr Ward adrenaline and tried to clear his airway with an electric suction machine. They also attached

a Lucas machine (a mechanical chest compression device). At about 2.49am, an air ambulance crew with a doctor arrived. The doctor gave Mr Ward more adrenaline and naloxone (used to block the effects of opioid overdose) but, at 2.52am, he confirmed that Mr Ward had died.

37. After Mr Ward's death, the co-defendant told the investigator that he was in a cell a couple of doors away from Mr Ward's. He was already in Lowdham Grange when Mr Ward arrived. He said that he did not know that Mr Ward had started using PS, but Mr Ward was an experienced prisoner and would have known where to get it. He thought Mr Ward was happier in Lowdham Grange than he had been at previous prisons and was surprised that he had taken drugs. He said Mr Ward had given up smoking and appeared keen on getting fit. Mr Ward had put on weight and seemed to be making progress.

Contact with Mr Ward's family

38. The Director and the prison family liaison officer drove to Mr Ward's parents' house at 8.00am the next morning and broke the news of Mr Ward's death. The prison contributed to the cost of the funeral in line with national guidance.

Support for prisoners and staff

39. There was no hot debrief immediately after Mr Ward's death, although all the staff interviewed that were involved in the emergency response said they had been well-supported by the prison. A cold debrief was held for all staff a few weeks after Mr Ward died.

40. The prison posted notices informing other prisoners of Mr Ward's death, and to offer support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Ward's death. Mr Ward's co-defendant said that he was told personally of Mr Ward's death and had received offers of support.

Post-mortem report

41. The post-mortem report showed no physical cause for Mr Ward's death. Toxicology showed PS in Mr Ward's blood and urine. The pathologist concluded Mr Ward died from drug toxicity.

Findings

Identifying Mr Ward's drug use

42. Lowdham Grange has a comprehensive drug and alcohol strategy dated March 2019, which is reviewed and updated annually. The strategy sets out local objectives to prevent supply and reduce demand for illicit substances. There is also a local PS patient pathway which highlights that prisoners suspected of or found using PS can be referred to the substance misuse service by a variety of means, including through wing officers or after a disciplinary hearing.

43. Mr Ward had historic involvement of trafficking and supplying drugs in his previous prisons. He had no history of using PS in prison and his co-defendant said he was unaware of, and surprised by, his use of them before his death. In the absence of any history or evidence that Mr Ward used PS it is difficult to see how the prison could have predicted or prevented his death.

44. However, we note that Mr Ward only had one session with a key worker in over seven weeks at Lowdham Grange. We cannot say whether greater involvement with a keyworker would have revealed Mr Ward's PS use, but it is clear that the scheme did not work as it should have done in his case. HMIP noted in their last inspection in August 2018, that the key worker scheme was "promising but not embedded" and found that wing staff made limited entries on electronic case notes and evidence of management checks. We therefore recommend:

    The Governor should ensure that the prison meets the standards of staff-prisoner involvement expected in the key worker scheme, including that all interactions are recorded on electronic case notes and managers quality check the entries.

The Emergency Response

45. We have two concerns about the emergency response on 26 May. At night, officers have a key in a sealed pouch for use in an emergency. Prison Service Instruction (PSI) 24/2011, which covers management and security at nights, says that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then 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. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

46. PCOs A and B tried to get a response from Mr Ward for almost four minutes after they found him lying on the floor of his cell. They did not open the cell as they said they did not think it would be safe to do so before their colleagues arrived. PCO C, the third officer on scene, also tried to gain a response from Mr Ward and asked for the night orderly officer's permission before opening the cell. We recognise that it can be difficult for staff in such situations but, when there is a potentially life-threatening situation, it is essential to act quickly.

47. Neither PCOs A nor B could see Mr Ward breathing, despite the cell light being on, and he was lying in an unnatural position on the floor (which we have seen in other investigations into deaths from PS toxicity). In circumstances where there are two staff present and others have been summoned, we would normally expect prison staff to go into a cell as soon as possible in case there is a chance of saving someone's life. When three officers are present, we consider it should not be necessary to obtain permission before doing so other than in exceptional circumstances.

48. PSI 03/2013 requires governors to have a two-code medical emergency response system based on the instruction. As is usual, Lowdham Grange use code blue to indicate an emergency when a prisoner is unconscious, or having breathing difficulties, and code red when a prisoner is bleeding. Its provisions are mirrored in local policies at Lowdham Grange. Calling an emergency code should automatically trigger the control room to call an ambulance.

49. All the staff interviewed were aware of the two-code system, but no one used it in this case. As a result, there was a delay of over four minutes before an ambulance was called. Although earlier entry of the cell and use of an emergency code would almost certainly not have changed the outcome for Mr Ward, it is important that prison staff understand their roles in a medical emergency, as early intervention when someone is found unresponsive might save their life. We make the following recommendation:

The Director should ensure that all prison staff are made aware of and understand their responsibilities during medical emergencies, including that:

- **Night staff enter cells as quickly as possible in a life-threatening situation.**
- **Night staff use the appropriate medical emergency response code, by radio where possible, to effectively communicate the nature of the emergency.**

Resuscitation

50. European Resuscitation Council Guidelines for Resuscitation 2015 which were shared with prison managers in September 2016 say, "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile". The guidelines define examples of futility as including the presence of rigor mortis. The British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 on making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of an individual's situation. These decisions should never be dictated by 'blanket' policies. Trying to resuscitate someone who is clearly dead is distressing for staff and undignified for the deceased.

51. Mr Ward's family asked why the nurse instructed staff to attempt resuscitation even though the officers who found him believed he was dead. The nurse told the clinical reviewer that Mr Ward was grey, but he could see no signs of mottling

of the skin and Mr Ward was not in rigor mortis. He did not know how long Mr Ward had been collapsed and decided that resuscitation was worth a try. The clinical reviewer concluded that the nurse's decision was reasonable in the circumstances even though it was very likely that Mr Ward was already dead. We make no recommendation.

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