Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Wilkins a prisoner at HMP Sudbury on 5 February 2016

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141

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 Lee Wilkins died on 5 February 2016 at HMP Sudbury. A post-mortem could not determine the cause of Mr Wilkins' death. He was 50 years old. I offer my condolences to Mr Wilkins' family and friends.

The post-mortem was inconclusive but considered that Mr Wilkins could have died from a combination of a mild head injury, epilepsy and use of illicit drugs. Mr Wilkins told healthcare staff that he suffered with seizures but he had not been formally diagnosed with epilepsy. I agree with the clinical reviewer that healthcare staff appropriately referred Mr Wilkins to a neurologist and prescribed appropriate medication to treat any seizures. Overall, I agree with the clinical reviewer that Mr Wilkins' death was neither predictable nor preventable.

Sudbury is taking steps to reduce the supply of drugs into the prison. However, they could do more to improve staff training on drug awareness and the process around substance misuse referrals.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **September 2017**

Contents

Summary

Events

1. On 22 May 2015, after spending two months on remand, Mr Lee Wilkins was sentenced to three years and six months imprisonment for drug offences. He spent time at HMP Hewell and HMP Featherstone before being transferred to HMP Sudbury on 10 December 2015.

2. Upon arrival at Hewell, Mr Wilkins told healthcare staff that he had suffered from fits years before but had not been diagnosed with epilepsy and was a drug user. A prison GP prescribed carbamazepine (traditionally used to treat seizures) to stabilise his mood, methadone and other withdrawal medication.

3. While at Featherstone, Mr Wilkins told a prison GP that he had suffered recent seizures. The GP ordered blood tests but the results were normal so he did not take any further action.

4. On 10 December, after arriving at Sudbury, Mr Wilkins told a nurse that he had taken new psychoactive substances (NPS) once but did not like them. The nurse referred him to the substance misuse service, who monitored him.

5. On 22 December, a GP reviewed Mr Wilkins and noted that the clinical reason for prescribing carbamazepine was unclear. The GP continued the prescription with a view to a gradual reduction. During the review, Mr Wilkins said he saw a neurologist at Featherstone, although this was not recorded in his medical record.

6. On 7 January 2016, a prison GP decided to stop Mr Wilkins' carbamazepine prescription, though they would restart it if he had another fit. Mr Wilkins continued to receive methadone, on a reducing dosage.

7. On 28 January, Mr Wilkins told a prison GP that he was suffering from nocturnal wandering, hitting objects and talking to people who were not there. The GP considered that Mr Wilkins was at risk of epileptic fits so restarted the carbamazepine prescription and referred him for a neurology review.

8. On 30 January, an officer recorded in Mr Wilkins' prison record that other prisoners had alleged that he was using 'Mamba' (a type of NPS). The officer passed this information to the healthcare unit but did not refer him to the substance misuse service.

9. At approximately 12.05am on 5 February, an operational support grade (OSG) officer performed a roll check and noticed that Mr Wilkins did not respond to noise or a light being shone in his face. The OSG called for assistance from a Senior Officer (SO), who found that Mr Wilkins was not breathing. The SO called a code blue emergency (which indicates that a prisoner is unconscious or not breathing) and started cardiopulmonary resuscitation. A control room operator immediately called an ambulance. Paramedics arrived at 12.23am but they were unable to resuscitate Mr Wilkins and declared that he had died at 12.30am.

Findings

10. The consultant pathologist could not ascertain the cause of death, but considered that Mr Wilkins could have died from a combination of an epileptic seizure, a mild head injury and use of illicit drugs (specifically NPS). Our investigation has not uncovered any evidence that Mr Wilkins suffered a head injury in the days before his death. In relation to the epileptic seizures, the clinical reviewer was satisfied that a prison GP had referred Mr Wilkins to a neurologist and prescribed Mr Wilkins a low dose of carbamazepine to treat seizures. Overall, we agree with the clinical reviewer that Mr Wilkins' death was neither predictable nor preventable.

11. While we are satisfied that Sudbury continues to take steps to reduce the supply of drugs into the prison, including the recent upgrading of CCTV cameras, we consider that staff require appropriate training on drug awareness and when it is appropriate to contact the substance misuse team about prisoners suspected of or known to be using drugs.

Recommendations

- The Governor at HMP Sudbury should ensure that staff receive appropriate training on drug awareness, including new psychoactive substances, to allow them to more appropriately support prisoners suspected of or who have admitted using drugs.
- The Governor at HMP Sudbury should ensure that staff pass on information about drug use, or refer prisoners suspected of or who have admitting using drugs, to the substance misuse team promptly.

The Investigation Process

12. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

13. The investigator obtained copies of relevant extracts from Mr Wilkins' prison and medical records.

14. The investigator interviewed three members of staff at Sudbury on 8 March 2016.

15. Another investigator interviewed five members of staff at Sudbury on 2 May 2017.

16. NHS England commissioned a clinical reviewer to review Mr Wilkins' clinical care at the prison.

17. We informed HM Coroner for Derby and South Derbyshire of the investigation. Our investigation was suspended for over a year until we received the post-mortem and toxicology reports from the coroner. We regret the consequent delay in issuing this report. We have sent the coroner a copy of this report.

18. One of the Ombudsman's family liaison officers contacted Mr Wilkins' ex-partner to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She did not raise any concerns.

19. 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.

20. Mr Wilkins' ex-partner was informed the initial report was available, but did not wish to receive a copy or make any comment.

Background Information

HMP Sudbury

21. HMP Sudbury is an open prison that houses over 550 adult men. A number of prisoners are released each day on licence to help with their resettlement. Derbyshire Health United provided healthcare services during the day on weekdays and in the mornings at weekends, though no healthcare staff are on duty at night. There are specialist clinics to treat substance misuse. In April 2016, Care UK was awarded the contract.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Sudbury was in April 2017, though the report has yet to be published. The most recently published inspection was in November 2013. Inspectors reported that very low staffing levels created feelings of insecurity for the prisoners and the relationship between staff and prisoners was poor. Prisoners were unhappy about healthcare provision, which inspectors considered was partly due to more restrictive prescribing practices. Overall, inspectors considered that health services had improved but staffing shortages had had an adverse impact on service delivery.

23. Despite a well-constructed strategic approach to reducing drug supplies, illicit substance use remained a significant problem. Random mandatory drug testing positive rates were low, but undetectable new psychoactive substances were a serious problem. Prisoners who tested positive for prescribed medication were routinely put on hold for release on temporary licence, even when the medication was part of their treatment.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB reported that Sudbury was a well run prison providing a positive environment for most prisoners even though it was an old building with a limited budget and low staff numbers. Healthcare was described as patchy with some long waiting lists and the use of agency staff compromising provision.

Previous deaths at HMP Sudbury

25. Mr Wilkins was the second person to die at Sudbury since January 2015. There have been three subsequent deaths. Three of the deaths at Sudbury, including Mr Wilkins, have involved the use of new psychoactive substances (NPS). We have made previous recommendations about how staff should respond if prisoners appear to be under the influence of NPS, though they were made after Mr Wilkins' death.

New psychoactive substances

26. New psychoactive substances, previously known as 'legal highs' are an increasing 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 NPS 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 and self-harm.

27. In July 2015, we published a Learning Lessons Bulletin about the use of 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 NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

28. Since September 2016, 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. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

29. On 26 March 2015, Mr Lee Wilkins was remanded to HMP Hewell on suspicion of drug offences. On 22 May, he was convicted and sentenced to three years and six months imprisonment. He spent time at Hewell and HMP Featherstone, before being transferred to HMP Sudbury on 10 December 2015.

30. Upon arrival at Hewell, Mr Wilkins told healthcare staff that he had a history of angina and drug use. He confirmed that he had suffered from fits four or five years before but that he had not been diagnosed with epilepsy. Healthcare staff referred Mr Wilkins to the substance misuse service and prescribed him a daily 40ml dose of methadone and other withdrawal medication.

31. On 12 May, Mr Wilkins told a locum prison GP that he was struggling with being in prison so the GP prescribed carbamazepine (traditionally used to treat seizures) and sertraline (used to treat depression) to stabilise his mood and to treat his depression.

32. On 11 June, a nurse planned a weekly 1ml reduction in Mr Wilkins' dose of methadone. However, the dosage did not change because he transferred to Featherstone the following day.

33. During an initial health assessment at Featherstone, Mr Wilkins told a nurse that he suffered from fits in his sleep. There was no record that the nurse took any action following the initial health assessment.

34. On 15 June, Mr Wilkins began receiving support from Featherstone's drug and alcohol recovery service. Three days later, a substance misuse support worker completed a triage assessment and identified that Mr Wilkins required support for his heroin addiction. She created a recovery plan, which involved regular support for Mr Wilkins, and encouraged him to engage with voluntary drug testing.

35. On 19 June, Mr Wilkins told a prison GP that he had suffered recent seizures. The GP ordered blood tests to find out whether an infection or other condition was causing the seizures. He reviewed the results on 13 July and found that they were normal. He did not take further action.

36. On 26 June, Mr Wilkins told a nurse that he felt he had experienced possible seizures at night. There was no record that she took any action following Mr Wilkins' statement.

37. On 15 July, a worker from the community mental health team saw Mr Wilkins to check on his mental health. Mr Wilkins told her that he had not used any illicit substances in prison but admitted to taking non-prescribed medication.

38. A week later, a healthcare assistant saw Mr Wilkins, who asked for an increase in his methadone dosage because he experienced withdrawal symptoms in the afternoon. She tested his urine, which was positive for methadone but negative for all other drugs. The following day, a prison GP increased Mr Wilkins' daily dose of methadone to 45ml.

39. On 10 December, Mr Wilkins was transferred to Sudbury. A nurse completed an initial health assessment and Mr Wilkins said that he had taken NPS once but did

not like it. Mr Wilkins confirmed that he had misused drugs in the past so she referred him to the substance misuse service. Mr Wilkins did not make any reference to suffering with fits or seizures during the assessment.

40. Two days later, a nurse reviewed Mr Wilkins, who confirmed that he suffered from fits at night. She referred Mr Wilkins to a prison GP.

41. On 16 December, Mr Wilkins saw his offender supervisor and said that he had not taken any illicit substances since February 2015.

42. On 22 December, a prison GP reviewed Mr Wilkins and noted that the clinical reason for prescribing carbamazepine was unclear. The GP decided to continue the prescription with a view to a gradual reduction. During the review, Mr Wilkins said that he had seen a neurologist when at Featherstone, though there was no record of this in his medical record and Featherstone deny referring him to a neurologist.

43. On 7 January 2016, a prison GP reviewed Mr Wilkins and decided to stop his carbamazepine prescription. He confirmed that if Mr Wilkins had another fit then the prescription would be restarted. During the review, Mr Wilkins confirmed that he wanted to reduce his methadone dosage because he wanted to be off it once he was released in December. As a result, the GP reduced his methadone prescription by 3ml a week.

44. A week later, a nurse reviewed Mr Wilkins as part of substance misuse monitoring. He said that he was feeling the effects of the methadone reduction so she gave him advice on how to cope.

45. On 27 January, Mr Wilkins gave a negative drug test for cocaine, cannabis, morphine, subutex and benzodiazepine.

46. On 28 January, a nurse recorded in Mr Wilkins' medical record that another prisoner had said that Mr Wilkins kept the wing awake during the night. The other prisoner said that Mr Wilkins had been shouting until there was "an almighty bang".

47. Later that day, a prison GP reviewed Mr Wilkins, who said that he was suffering from nocturnal wandering, hitting objects and talking to people who were not there. He considered that Mr Wilkins was at risk of epileptic fits so restarted his carbamazepine prescription and referred him for a neurology review.

48. The following day, Mr Wilkins saw a nurse and said that he had blacked out for three minutes though no one had witnessed this. Later that day, another nurse saw Mr Wilkins, who denied using any other drugs.

49. On 30 January, an officer recorded in Mr Wilkins' prison record that other prisoners had said that he was behaving oddly at night. She also recorded an allegation that Mr Wilkins was using 'Mamba' (a type of NPS). She passed on this information to the healthcare unit, who were aware that Mr Wilkins had been behaving oddly. An intelligence report was submitted to the prison's security department.

50. On 2 February, a prison GP reviewed Mr Wilkins but decided not to prescribe any further medication because he needed a neurology review. He noted there was evidence that Mr Wilkins had bitten his tongue.

Events of 4 and 5 February 2017

51. At approximately 7.30pm on 4 February, two prisoners asked Mr Wilkins whether he wanted to go outside to smoke a cigarette. Mr Wilkins said no, as he was planning on going for a walk.

52. At approximately 10.30pm, another prisoner walked past Mr Wilkins' cell. The prisoner asked Mr Wilkins whether he was okay, and he responded with a thumbs up.

53. An hour later, the same prisoner checked on Mr Wilkins but thought that he was asleep because he was lying on his bed with the lights switched off.

54. At approximately 12.00am on 5 February, an operational support grade officer (OSG) started a roll check on Mr Wilkins' wing. Five minutes later, she arrived at Mr Wilkins' cell, looked though the flap on the cell door and noticed that Mr Wilkins was laid on top of his bedding with a wet patch on his trousers. She shone her torch onto Mr Wilkins' face and tapped it on the cell door but he did not respond. She was concerned about Mr Wilkins so used her radio to ask for immediate assistance from a Senior Officer (SO), the senior member of staff on duty that night. She did not call a code blue emergency (which indicates that a prisoner is unconscious or not breathing).

55. The SO arrived promptly and accompanied the OSG into Mr Wilkins' cell. He shook Mr Wilkins' shoulder and checked whether he was breathing. The SO found that he was not breathing so he called a code blue emergency. A member of staff in the gate house immediately called for an ambulance.

56. The SO started cardiopulmonary resuscitation (CPR) and gave Mr Wilkins rescue breaths. An officer responded to the code blue with the defibrillator and assisted with the CPR. The officer fitted the defibrillator, which did not shock Mr Wilkins and advised for CPR to continue.

57. Paramedics arrived at 12.23am but they were unable to resuscitate him and declared that he had died at 12.30am.

Contact with Mr Wilkins' family

58. On the morning of 5 February, the prison appointed an officer as a family liaison officer. At 9.20am that day, she travelled to the home address of Mr Wilkins' ex-partner, his nominated next of kin, to break the news of his death and to offer her condolences and support. A police officer accompanied her.

59. Later that day, Mr Wilkins' father contacted the officer and asked for details about how his son had died. She provided this information and offered her condolences.

60. The officer provided ongoing support to Mr Wilkins' next of kin, father and cousin until his funeral, which was held on 11 March. The prison contributed to the costs of the funeral in line with national instructions.

Support for prisoners and staff

61. After Mr Wilkins' death, the duty governor debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising and to offer support. The staff care team also offered support.

62. The prison posted notices informing other prisoners of Mr Wilkins' 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 Wilkins' death.

Post-mortem report

63. The post-mortem report concluded that the cause of Mr Wilkins' death could not be ascertained.

64. The consultant pathologist confirmed that there was evidence that Mr Wilkins had suffered a mild head injury and that his history of epilepsy placed him at risk of sudden unexpected death. The toxicology report also found that illicit drugs, in the form of synthetic cannabinoids (NPS), were present in his blood. As a result, the pathologist stated that the presence of these three factors could have combined to cause Mr Wilkins' death.

Findings

Clinical care

65. The consultant pathologist considered that Mr Wilkins could have died from a combination of an epileptic seizure, a mild head injury and use of illicit drugs (specifically NPS). Our investigation has not uncovered any evidence that Mr Wilkins suffered a head injury in the days before his death and the clinical reviewer considered that the presence of a subdural haematoma (where blood collects between the skull and the brain) was consistent with the effects of seizures.

66. A prison GP referred Mr Wilkins to a specialist on 28 January, after confirming that he had suffered with seizures in the past. National Institute for Health and Care Excellence (NICE) guidelines CG137 says that all adults suspected of suffering with seizures should be seen urgently by a specialist to ensure a precise diagnosis and to start treatment. As the average waiting time to see a neurologist at a local hospital was 38 days, the clinical reviewer was satisfied that there was insufficient time to appropriately diagnose Mr Wilkins because he died eight days after the referral. The clinical reviewer was also satisfied that healthcare staff had prescribed Mr Wilkins a low dose of carbamazepine used to treat seizures.

67. Overall, the clinical reviewer considered that Mr Wilkins' death was neither predictable nor preventable.

Emergency response

68. We are pleased that when the OSG completed the roll check of Mr Wilkins' wing she took ample time to check on his wellbeing so was able to establish that there was a problem. She appropriately requested for support from the SO. When they entered Mr Wilkins' cell and found that he was not breathing, the SO promptly called an emergency code.

New psychoactive substances

69. The use of new psychoactive substances (NPS) is an increasing problem in prisons. The Advisory Council on the Misuse of Drugs (the Government's independent statutory drug advisers) has reported that the short term harms of NPS can include paranoia, psychosis and seizures and that their long term harms are often unknown. Sudbury has a known problem with illicit substances, particularly NPS, which has had an impact in a number of deaths at the prison, including Mr Wilkins' death. Also, in November 2013, HM Inspectorate of Prisons noted that the use of NPS was a serious problem at the prison.

70. In July 2015, Sudbury introduced a Drug Supply and Reduction Strategy, which set out various plans to interrupt the supply of drugs into the prison and to reduce demand from prisoners. The strategy recognises that most illicit items enter the prison by being thrown over fences or by being smuggled in by prisoners returning from release on temporary licence. The prison used joint operations with the police; additional fencing; and intelligence led searching to combat these avenues of supply.

71. In April 2016, Sudbury introduced a Drug and Alcohol Strategy, which contained additional steps to reduce the supply and demand for drugs. These included using compact based drug testing and the use of the incentives and earned privilege scheme to benefit those prisoners who did not use drugs.

72. Following Mr Wilkins' death, the prison have also installed improved CCTV cameras to cover the prison's perimeter and stopped prisoner driven vehicles from entering the prison.

73. Both strategies contain a commitment to deliver appropriate training to staff on drug awareness. However, we are concerned that most of the staff interviewed had not received any specific training on NPS bar one officer who received a presentation from the Drug Support Team at a full staff briefing.

74. While the substance misuse team was monitoring Mr Wilkins, we are concerned that neither an officer nor healthcare staff told them that other prisoners had alleged that he was using 'Mamba' in late January.

75. We recognise that Sudbury continues to take steps to reduce the supply of drugs into the prison. However, we consider that improvements could be made in drug awareness training for staff and ensuring staff know what information should be supplied to the substance misuse service if use of drugs is known or suspected. Therefore, we make the following recommendations:

The Governor at HMP Sudbury should ensure that staff receive appropriate training on drug awareness, including new psychoactive substances, to allow them to more appropriately support prisoners suspected of or who have admitted using drugs.

The Governor at HMP Sudbury should ensure that staff pass on information about drug use, or refer prisoners suspected of or who have admitting using drugs, to the substance misuse team promptly.

Prisons & Probation Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY
Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk
T | 020 7633 4100
F | 020 7633 4141