Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Martin Brake, a prisoner at HMP Leeds, on 29 March 2020

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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 Martin Brake died on 29 March 2020, from the combined toxic effects of prescription drugs at HMP Leeds. He was 55 years old. I offer my condolences to Mr Brake's family and friends.

Most of the prescription drugs found in Mr Brake's system had been prescribed to him. The clinical reviewer was concerned that despite the known risks of prescribing that combination of drugs to Mr Brake, no one ever carried out a medication review.

Two of the prescription drugs found in Mr Brake's system had not been prescribed to him so he must have obtained them illicitly. Although Mr Brake told a prison GP that he had been buying prescription drugs from other prisoners, the GP did not pass this information onto wing staff or the substance misuse team.

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 **December 2020**

Contents

Summary

Events

1. On 1 December 2018, Mr Martin Brake was remanded in custody at HMP Leeds, charged with burglary, fraud and theft. He was subsequently convicted and sentenced to 47 months in prison.

2. Mr Brake had a history of substance misuse. He was located on an incentivised substance-free living (ISFL) wing, where prisoners are given privileges in exchange for agreeing to stay drug-free.

3. Mr Brake had chronic obstructive pulmonary disease (COPD – a group of lung diseases causing breathing difficulties) and suffered from chest infections. He also complained of pain in his arm, back and leg and in October 2019, he was diagnosed with a compressed nerve in his spine. Prison GPs prescribed a range of pain relief medication and increased the dosage on a number of occasions when Mr Brake continued to complain of pain.

4. In September and October 2019, Mr Brake told a GP that he was buying pregabalin on the wing for pain in his arm and neck. The GP did not tell wing staff or the substance misuse team.

5. On 29 March 2020 at 8.45am, an officer unlocked Mr Brake's cell and found him on the floor, unresponsive. The officer radioed a medical emergency code. The control room called an ambulance and healthcare staff attended. A nurse assessed that Mr Brake had been dead for some time and staff did not attempt resuscitation.

6. A post-mortem examination found that Mr Brake died from methadone, amitriptyline, mirtazapine, gabapentin, pregabalin and codeine toxicity. Pneumonia and ischaemic heart disease were listed as contributory factors.

Findings

7. There is no reason to consider that Mr Brake's death was anything other than accidental.

8. Mr Brake had been prescribed all the drugs found in his system apart from two (mirtazapine and pregabalin). The clinical reviewer was concerned at the high amount of central nervous system depressants (drugs that slow breathing) prescribed to Mr Brake and noted that one of the drugs prescribed (codeine) was not advocated for long-term use in prison. She was concerned that there was no evidence that a medication review had ever been undertaken.

9. Mr Brake's admission to a prison GP that he was buying pregabalin from other prisoners was a clear breach of the agreement he had signed to remain drug-free on the ISFL wing. Pregabalin is another drug which depresses the central nervous system. We are concerned that the GP did not tell wing staff or the substance misuse team.

Recommendations

- The Head of Healthcare and Head of Pharmacy should ensure that:
    - regular medication reviews are carried out for prisoners taking central nervous system depressant medications; and
    - all medications are prescribed in accordance with national guidance (*Drug misuse and dependence/ UK guidelines on clinical management /the orange book 2017*).
- The Governor and Head of Healthcare should agree an information sharing protocol so that if staff become aware that a prisoner is buying or otherwise obtaining illicit, prescription or other drugs, they are clear on what information should be shared and with whom.
- The Head of Healthcare should share this report with GP A to ensure he is aware of the Ombudsman's findings and understands his responsibility to share information with prison staff where it is appropriate.

The Investigation Process

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

11. The investigator obtained copies of relevant extracts from Mr Brake's prison and medical records.

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

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

14. One of the Ombudsman's family liaison officers contacted Mr Brake's mother, to explain the investigation and to ask if there were any matters she wanted the investigation to consider. She did not respond to our letter.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies however they challenged recommendation 2, which we have reworded to reflect their concerns.

Background Information

HMP Leeds

16. HMP Leeds is a local prison which can hold a maximum of 1,218 prisoners who are on remand, convicted or sentenced. The prison serves the courts of West Yorkshire. Care UK provides health services, including mental health services. The prison has 24-hour primary healthcare cover.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Leeds was in December 2019. Inspectors found that the prison continued to face significant challenges but had improved in many areas since the previous inspection. There was good local leadership of healthcare services and clinical records were of high quality.

18. Initial health screening arrangements were good with suitable referrals to relevant healthcare professionals, including substance use and mental health. Prisoners had prompt access to a range of primary care services and clinic waiting times were acceptable. The management of long-term conditions was good.

19. Inspectors found the prison had developed a more effective strategic approach to restricting drug supply, reducing demand and building on recovery initiatives and there was good collaboration between the prison and substance use services. Both the clinical team and the drug alcohol recovery team (DART) provided a good service but were 'stretched'. The ISFL unit on A Wing provided excellent support enabling prisoners with drug and alcohol issues to move towards recovery. Prisoners on the wing signed a compact agreeing to the aims of the unit and to voluntary drug testing.

Independent Monitoring Board

20. 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 December 2018, the IMB welcomed the extra £1 million funding as part of the Ten Prisons Project, which it considered wisely spent - in part on a body scanner for the new Reception Unit.

21. The Board identified the availability and use of psychoactive substances as posing particular challenges and were also concerned about the number of mobile phones found in the prison.

22. Urgent medical cases could see a GP immediately, but otherwise average waiting time was 20 days and the board expressed its concern at the unacceptably high number of prisoners who did not attend.

Previous deaths at HMP Leeds

23. Mr Brake's death was the 22nd at Leeds since March 2018. Of the previous deaths, 12 were from natural causes, eight were self-inflicted and one was drug-

related. There were no similarities between Mr Brake's death and the previous deaths.

Key Events

24. On 1 December 2018, Mr Martin Brake was remanded in custody at HMP Leeds, charged with burglary, fraud and theft. (He was later convicted and sentenced to 47 months in prison.)

25. At his initial health screen, Mr Brake told the nurse that he had a history of substance misuse including crack cocaine, heroin, cannabis and psychoactive substances (PS). He said that he had chest issues from smoking crack cocaine. (In May 2018, he had been diagnosed with chronic obstructive pulmonary disease (COPD – a group of lung diseases that cause breathing difficulties.) The nurse referred him to the Drug and Alcohol Recovery Team (DART).

26. Mr Brake was allocated a cell on A Wing, an incentivised substance-free living (ISFL) wing where incentives and privileges are offered to remain drug-free. Mr Brake signed an ISFL compact (agreement) to remain drug-free on the wing. For the first three nights he was monitored for signs of withdrawal by the Integrated Drug Treatment Service (IDTS). Mr Brake was prescribed buprenorphine (an opiate substitute) in the community, but as buprenorphine is not prescribed at Leeds, he was prescribed methadone instead.

27. Mr Brake was allocated a drugs worker who knew him from previous sentences. At their first meeting on 4 December, Mr Brake said that he did not want to engage in group work as he had done this previously. The drugs worker saw Mr Brake approximately every 13 weeks to monitor his progress.

28. In January 2019, a prison GP diagnosed Mr Brake with a chest infection and prescribed antibiotics and codeine (a painkiller - one to two 30mg tablets taken as required).

29. On 28 February, Mr Brake told a prison GP that he was experiencing ongoing pain in his right arm. The GP prescribed a daily dose of 25mg amitriptyline (a painkiller) and increased Mr Brake's codeine dose to 120mg a day (60mg twice a day).

30. On 1 March, prison staff conducted an intelligence-led search of Mr Brake's cell during which they found tobacco, paper impregnated with 'Spice' (PS), and Rizla cigarette papers that later tested positive for heroin.

31. On 2 May, a letter sent to Mr Brake apparently from his solicitors was confiscated after it tested positive for 'Spice'.

32. On 12 June, after Mr Brake reported back spasms that caused him to pass out, prison GP A increased Mr Brake's codeine medication to 180mg a day (60mg three times a day) and referred him to the neurology service.

33. On 16 June, Mr Brake underwent a random drug test. No illicit drugs were detected. On 23 June, staff conducted an intelligence-led search of Mr Brake and his cell. No drugs or prohibited items were found.

34. On 4 September, Mr Brake told GP A that he had been buying pregabalin on the wing. (Pregabalin is a prescribed drug, used to treat epilepsy, anxiety and nerve pain, but is also widely abused as it can increase the euphoric effects of other drugs, such as opioids and heroin. It is highly tradeable in prison.) GP A recorded

this information in Mr Brake's medical record but did not share it with wing staff or DART. GP A prescribed gabapentin (300mg twice a day), for Mr Brake's continued neck and arm pain and referred him for a magnetic resonance imaging (MRI) scan (uses magnetic and radio waves to produce detailed images of the inside of the body).

35. On 9 October, GP A saw Mr Brake who told him that he was still buying pregabalin on the wing. GP A recorded this in Mr Brake's medical record but did not share this information with wing staff or DART, GP A increased Mr Brake's gabapentin to 900mg a day.

36. The next day, Mr Brake had his MRI scan, which showed compression of the spinal nerve. On 22 October, a prison GP increased Mr Brake's gabapentin dose to 1200mg a day (600mg twice a day) and on 30 October, GP A increased it again to 1800mg a day (600mg three times a day). Mr Brake said the pain in his neck had worsened and he had constant numbness in his right hand. GP A referred him to the spinal surgeon.

37. Mr Brake was employed at the prison as a painter. On 20 November, he told GP A that he had a big job on but still had pain in his arm. GP A increased his gabapentin to 2700mg a day (900g three times a day). When Mr Brake returned on 4 December, still complaining about pain in his arm, GP A increased his gabapentin again, to 3000mg a day (900g morning and evening, and 1200mg at lunchtime) and doubled his amitriptyline from 25mgs to 50mgs a day.

38. On 18 February, a nurse referred Mr Brake to a GP after he complained of a dry cough and shortness of breath. GP A examined Mr Brake on 26 February, and arranged an urgent chest X-ray, which showed reduced lung volume and scarring of the lung tissue. GP A referred Mr Brake for a CT scan (which uses X-rays and a computer to produce detailed images of the inside of the body).

Events of 28/29 March

39. On 28 March at 4.06pm, Mr Brake was locked in his cell by an officer. At 8.24pm, an (OSG) completed the evening roll count. She shone her torch into Mr Brake's cell and had no concerns.

40. Mr Brake was not checked during the night and did not ring his cell bell, though the OSG passed his cell several times while checking other prisoners. On 29 March at 5.53am, the OSG completed the morning roll count and again shone her torch into Mr Brake's cell. She told the investigator that she did not specifically remember checking Mr Brake, but was confident that if he had been on the floor at that time she would have noticed.

41. At 8.45am, two officers began unlocking cells and serving breakfast (during the Covid-19 pandemic prisoners were served breakfast in their cell). An officer tried to open Mr Brake's cell door but there was something obstructing it. She managed to get the door partially opened, far enough to get inside and immediately noticed Mr Brake lying on the floor with his feet against the door.

42. Mr Brake was not moving or responding so an officer immediately radioed a code blue (a medical emergency code used when a prisoner is unconscious or having

breathing difficulties). An officer called out Mr Brake's name and felt for a pulse on his neck. She tried to move him into the recovery position but his body was rigid.

43. A nurse was at the medication hatch a short distance from Mr Brake's cell when she heard the code blue. She immediately made her way to the cell. Mr Brake was still face down on the floor. He was not moving; his skin was mottled and his feet cyanosed (blueish discoloration).

44. With the help of other officers who had arrived, the nurse turned Mr Brake onto his back. He was not breathing and had no pulse. His body was stiff, his face and chest were cyanosed and his skin was cold. She was satisfied that he was dead and had been for some time. She did not attempt resuscitation as she considered it futile and undignified.

45. The ambulance crew arrived at the cell at 9.05am and a minute later, a paramedic confirmed that Mr Brake had died.

Contact with Mr Brake's family

46. After Mr Brake's death, the prison appointed an offender supervisor as the family liaison officer (FLO). Mr Brake had not nominated a next of kin, so the FLO went through his prison records to find someone suitable.

47. However, at 10.00am, the FLO took a call from Mr Brake's sister who asked if it was true that her brother was dead. After confirming her identity, the FLO told her that Mr Brake had been found dead in his cell that morning. He offered his condolences. They discussed how to inform Mr Brake's mother who lived near to his sister, but over 200 miles from Leeds. They agreed that Mr Brake's sister would go to her mother's house and, once there, the FLO would telephone them. The FLO telephoned as planned, he offered his condolences and they discussed funeral arrangements and the return of Mr Brake's property. Things were made more difficult due to the restrictions following the COVID-19 pandemic as prison FLOs were not able to visit family members and all liaison had to be done by phone.

48. The FLO stayed in contact with the family, including Mr Brake's brothers. On 2 April, he returned Mr Brake's property to one of his brothers at his home. Mr Brake's sister asked to visit the prison and the FLO agreed to arrange this once the COVID-19 restrictions were lifted.

49. Mr Brake's funeral took place on 30 April. The prison contributed towards the cost in line with Prison Service instructions.

Support for prisoners and staff

50. After Mr Brake's death, a senior 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. A member of the staff care team offered support and arrangements were made to support prisoners on the wing. The Head of Healthcare also offered support to healthcare staff.

51. The prison posted notices informing other prisoners of Mr Brake'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 Brake's death.

Post-mortem report

52. A post-mortem examination found that the most likely cause of Mr Brake's death was acute mixed methadone, amitriptyline, mirtazapine, gabapentin, pregabalin and codeine toxicity. The pathologist noted, 'The levels of methadone and amitriptyline were within the fatal range. These substances are recognised to cause death through combined sedative and respiratory depressant effects.'

53. The pathologist also noted that Mr Brake had pneumonia, which would have made him more susceptible to the effects of respiratory depression, and his severe ischaemic heart disease would have further compromised his cardiorespiratory function and contributed to death.

Findings

Drugs prescribed to Mr Brake

54. The post-mortem examination concluded that the most likely cause of Mr Brake's death was the combined toxic effects of methadone, amitriptyline, mirtazapine, gabapentin, pregabalin and codeine. All these substances had been prescribed to Mr Brake apart from mirtazapine (an antidepressant) and pregabalin.

55. Mr Brake was prescribed methadone (an opioid substitute) throughout his time at Leeds. The dose remained the same. Mr Brake was prescribed codeine from January 2019, amitriptyline from February 2019 and gabapentin from September 2019. Prison GPs repeatedly increased the medication doses when Mr Brake continued to complain of pain: codeine was initially prescribed at between 30-60mg a day but had been increased to 180mg a day by June 2019; amitriptyline was initially prescribed at 25mg a day but had been increased to 50mg by December 2019; gabapentin was initially prescribed at 600mg a day but had been increased to 3000mg a day by December 2019.

56. The clinical reviewer found that Mr Brake was prescribed a high amount of central nervous depressants (namely methadone, codeine, amitriptyline and gabapentin). She noted that codeine is not advocated as a long-term pain-relieving medication in prison due to its highly addictive and tradeable nature and should be prescribed with caution alongside gabapentin due to its depressive effects on the central nervous system. She was concerned that she could see no evidence of any medication reviews in Mr Brake's medical records. We therefore recommend:

    The Head of Healthcare and Head of Pharmacy should ensure that

    - **regular medication reviews are carried out for prisoners taking central nervous system depressant medications; and**
    - **all medications are prescribed in accordance with national guidance (*Drug misuse and dependence/ UK guidelines on clinical management /the orange book 2017*).**

Prescription drugs obtained illicitly

57. All the substances found in Mr Brake's body when he died had been prescribed to him apart from mirtazapine and pregabalin. It appears that Mr Brake obtained these prescription medications illicitly.

58. On two occasions, in September and October 2019, Mr Brake told GP A that he had bought pregabalin on the wing. GP A recorded this information in Mr Brake's medical record, but he did not tell wing staff or the substance misuse team. Mr Brake was already prescribed a significant quantity of drugs that have a depressive effect on the central nervous system. Pregabalin also has this effect. At interview, Prison GP A told the clinical reviewer that he was reassured that Mr Brake only purchased pregabalin for pain relief and that he stopped buying it when his prescribed pain medication was increased. Clearly this was not the case as Mr Brake had taken pregabalin before he died.

59. We accept that there may be considerations relating to patient confidentiality and that both the IDTS and DART had access to Mr Brake's medical records. However, Mr Brake lived on a drug-free wing and the purchasing of pregabalin clearly breached the agreement he signed. The apparent ready availability of prescription drugs to buy or trade is a concern and is something that discipline staff should have been made aware of. We recommend:

The Governor and Head of Healthcare should agree an information sharing protocol so that if staff become aware that a prisoner is buying or otherwise obtaining illicit, prescription or other drugs, they are clear on what information should be shared and with whom.

The Head of Healthcare should share this report with Prison GP A to ensure he is aware of the Ombudsman's findings and understands his responsibility to share information with prison staff where it is appropriate.

Clinical care

60. The clinical reviewer was satisfied that Mr Brake received appropriate care for his chest-related issues.

61. She found that the care he received for his substance misuse issues was not equivalent to that which he could have expected to receive in the community.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100