Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lewis Finch, a prisoner at HMP Swaleside, on 5 October 2021

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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 Lewis Finch died of a drug overdose on 5 October 2021, while a prisoner at HMP Swaleside. He was 32 years old. I offer my condolences to Mr Finch's family and friends.

Mr Finch was serving a life sentence when he arrived at Swaleside in March 2021. He had mental health and substance misuse issues but declined support following a mental health assessment. He had been risk assessed as suitable for having weekly supplies of medication in his possession (as opposed to this being administered by the prison on a day-to-day basis). On several occasions Mr Finch complained that he had not been receiving his medication on time.

In September, prison officers found unauthorised items in Mr Finch's cell, including medications that had not been provided to him by the prison. The following month, he made further complaints regarding his medication. No follow up action was taken.

On the afternoon of 5 October, staff found Mr Finch unresponsive in his bed. They attempted to revive him, without success.

The clinical reviewer concluded that the clinical care extended to Mr Finch was not of the required standard and therefore not equivalent to that which he could have expected to receive in the community. She identified a range of issues regarding the continuity of Mr Finch's medication and the lack of review of his in-possession arrangement. She was also concerned about the healthcare response to the emergency call.

I am disappointed that the issues Mr Finch experienced with accessing his medication are similar to those we have found at Swaleside in previous investigations. This is a continued problem that must be addressed. However, my main concern is that when staff found a quantity of medication in Mr Finch's cell, they did not record what the medication was, nor report the finding to healthcare or substance misuse services to ensure any risks could be assessed. There was also a significant delay in healthcare staff reaching Mr Finch when the emergency alarm was raised. Although this did not impact on the outcome for Mr Finch, it might impact on individuals requiring emergency care in future.

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

Kimberley Bingham
Acting Prisons and Probation Ombudsman **November 2022**

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Summary

Events

1. In January 2020 Mr Lewis Finch was charged with murder and received a life sentence. It was not his first time in prison. Records showed that he had issues with drug and alcohol misuse. He also had a history of mental health problems and had previously attempted to take his own life.

2. In March 2021, Mr Finch transferred to Swaleside. He was identified as requiring continuity of medications he had been prescribed in the community (an anti-psychotic medication, an antidepressant, and medication to treat gastric issues). At his previous prison he had been assessed as suitable for keeping seven-day supplies of his medications in possession. This arrangement was maintained.

3. On several occasions, Mr Finch complained of irregularity in receiving his medication. Other than this he did not raise any particular issues with staff. At a mental health assessment Mr Finch said that all he wanted was a review of his medication. He was not interested in any further support. On 27 April he saw the psychiatrist, who agreed to his request to increase his medication but concluded that he did not need to be under the care of the mental health team.

4. In June, Mr Finch raised issues with his medication again, which were addressed.

5. In August, in response to concerns from Mr Finch's family, the mental health team spoke to him. He said that he was fine, had no concerns regarding his mental health and did not want any further support. Later that month, at Mr Finch's request, a doctor prescribed him some sleeping tablets.

6. On 1 September, officers found a charger cable and assorted medication in Mr Finch's cell. The items were removed and Mr Finch was charged under prison rules, but neither the healthcare department nor substance misuse services were alerted.

7. On 4 October, Mr Finch told a fellow prisoner that he had been having problems due to his medication. The message was passed on to the mental health team, but there was no follow up action taken.

8. On 5 October, Mr Finch was found unresponsive in his cell. Officers called an emergency code and provided first aid. After a period of delay, healthcare staff arrived and supported attempts at resuscitation until ambulance paramedics arrived and took over. At 5.10pm, Mr Finch was pronounced dead.

Findings

Assessment of risk

9. When officers found a quantity of medication in Mr Finch's cell, the information was not passed to the healthcare department or substance misuse services. Any ongoing risk could therefore not be assessed, nor appropriate support offered.

Mr Finch's healthcare

Medication

10. Mr Finch complained to a range of people that he had not been receiving the correct medication. We found evidence that that there were several occasions on which he did not receive it.

11. On 4 October, it was reported to staff that Mr Finch was having problems relating to his medication. Nobody spoke to or assessed him in response to this.

12. Post-mortem tests showed high levels of medication in Mr Finch's system. There were no healthcare procedures in place to ensure that prisoners were taking their medication in the way that they were supposed to.

13. Mr Finch arrived in Swaleside having been assessed in his previous prison as able to hold his medication in his own possession. This was not re-evaluated.

Mental healthcare

14. The clinical reviewer found that Mr Finch's mental health assessments and care plans were compliant with guidance.

Physical healthcare

15. Mr Finch arrived in Swaleside with an outstanding hospital appointment that was not followed up. He was referred for tests on arrival, for which there was no evidence of follow up.

Emergency response

16. In the emergency response there was an unacceptable delay of approximately eight minutes in healthcare staff arriving.

Recommendations

- The Governor should ensure that all unexplained medication finds are reported promptly to the healthcare department and substance misuse services.
- The Head of Healthcare should review systems for regular assessment of prisoners deemed as responsible to hold medication in their own possession.
- The Head of Healthcare should review systems to ensure that prisoners are receiving their prescribed medication.
- The Head of Healthcare should review systems for ensuring that prisoners issued medication in their own possession are taking that medication as directed.
- The Head of Healthcare should ensure that any reports of prisoners suffering potentially serious issues are properly investigated.

- The Head of Healthcare should review emergency response arrangements to ensure help reaches prisoners with minimal delay.

The Investigation Process

17. The investigator issued notices to staff and prisoners at HMP Swaleside informing them of the investigation and asking anyone with relevant information to contact him. None responded.

18. The investigator visited Swaleside. He obtained copies of relevant extracts from Mr Finch's prison and medical records.

19. The investigator interviewed eight members of staff and three prisoners at Swaleside. NHS England and Improvement commissioned a clinical reviewer to review Mr Finch's clinical care at the prison. The investigator and clinical reviewer jointly interviewed healthcare staff.

20. We informed HM Coroner for Mid Kent and Medway of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

21. One of the Ombudsman's family liaison officers contacted Mr Finch's sister, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Finch's sister asked about his mental health support, medication, and welfare checks.

Background Information

HMP Swaleside

22. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men serving sentences of four years or more. Integrated Care 24 Ltd provides primary healthcare. There is 24-hour nursing cover and a 17-bed inpatient unit. Minster Medical Group provides GP cover Monday to Friday and Medway on Call Care provides an out of hours GP service. Since April 2022, Oxleas NHS Foundation Trust have provided mental health services. Substance misuse treatment and interventions are provided by the Forward Trust.

HM Inspectorate of Prisons

23. The most recent inspection of HMP Swaleside was an unannounced inspection in October 2021. Inspectors reported disappointing outcomes for prisoners, but with pockets of good practice and leadership and staff working hard to take the prison forward. Substance misuse services were reasonably good, but aspects of medicine management were poor, with some risk assessments for in-possession medicines not updated when circumstances changed. The prescribing of medicines liable to abuse was high and some were given in-possession against national guidelines. Some emergency resuscitation equipment had not been kept in good order without evidence of regular checks.

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 30 April 2021, the IMB reported that the COVID-19 pandemic affected most areas of the prison's work. Throughout, prisoners were treated with respect. There were concerns at a rise in the manufacture of alcoholic substances, which may in part be due to the effectiveness of the reduction in the flow of illicit drugs.

Previous deaths at HMP Swaleside

25. Mr Finch was the twelfth prisoner at Swaleside to die since October 2019. Nine of these deaths were due to natural causes, two were self-inflicted, and two were due to drug misuse. We have twice made recommendations that prisoners suspected of substance misuse should be referred to substance misuse services. There have since been six further deaths, one of which was due to natural causes, four self-inflicted, and one awaiting classification. In one of these investigations we identified problems with the availability of medication, an issue we also raise in this report.

Key Events

HMP Exeter

26. In January 2020 Mr Lewis Finch was remanded to HMP Exeter, charged with murder. It was not his first time in custody. He said that he had issues with drugs and alcohol. Records showed that he had been found brewing illicit alcohol and been suspected of trading medication during previous stays in custody. He said he had a history of mental health problems and had attempted to take his own life in the past.

27. Because of the serious charge, staff opened HMPPS procedures to support those at risk of suicide and self-harm (Assessment, Care in Custody and Teamwork, known as ACCT). He told a nurse that he had smuggled some drugs into prison with him. He also began work with the mental health and substance misuse teams. ACCT procedures were closed after 11 days, after staff judged that the risk factors had sufficiently reduced.

28. In March, Mr Finch barricaded his door and smashed the observation panel, complaining that he was not getting the correct medication. Staff re-opened ACCT procedures, which remained in place for five days. In June, Mr Finch damaged his cell again, saying that his medication was not correct. ACCT procedures were opened but closed the next day.

29. In September, intelligence reports showed that staff found fermenting liquid in Mr Finch's cell.

30. In October, Mr Finch was convicted of murder and sentenced to life imprisonment.

31. In December, staff intercepted a letter to Mr Finch that was impregnated with drugs. In the same month, an intelligence report noted a smell of cannabis coming from Mr Finch's cell.

32. In February 2021, staff opened ACCT procedures when Mr Finch said he felt low and depressed. The ACCT remained open for a week. ACCT management was introduced again on 3 March after Mr Finch's family contacted the prison with concerns about his wellbeing. They were closed the following day.

HMP Swaleside

33. On 17 March 2021, Mr Finch transferred to Swaleside. A nurse undertook his reception health assessment. Mr Finch engaged well. He said that he suffered from post-traumatic stress disorder (PTSD) and a personality disorder that was being treated with antipsychotic medication. He said that in the past he had been admitted to hospital briefly under the Mental Health Act and had been under the care of the mental health team while at Exeter. The nurse referred him for a mental health assessment.

34. In Exeter, Mr Finch had been assessed as suitable to hold his own medication (known as in-possession or IP). The nurse referred him to the doctor to review his medication. Mr Finch denied any problems with alcohol or drugs.

35. The following day, the nurse undertook Mr Finch's secondary health assessment. Mr Finch told him that he felt lethargic and reported blood in his phlegm. Tests for COVID-19 had been negative so the nurse referred him for alternative tests. We found no evidence that this was followed up.

36. On 19 March, staff made a standard welfare check on Mr Finch. He said that he had had issues with his medication but that these had now been addressed. On 24 March, he told a prison officer that his medication was not correct again. The officer sent an email to the healthcare department and in a further welfare check on 26 March, Mr Finch said that the problem had been resolved.

37. On 26 March, a health and wellbeing coordinator in the mental health team, gave Mr Finch a triage mental health assessment. Mr Finch said that he had been diagnosed with Autism Spectrum Condition (ASC) and PTSD. He said his mood was low, and he had occasional thoughts of self-harm as well as violence to others. She referred him for a full mental health assessment.

38. On 26 March, a GP carried out a medication review. In interview the GP said that while Mr Finch had been approved for IP in reception, his medication had been distributed daily until the review. It would be prescribed IP thereafter, in seven-day batches. The GP made the assessment based on records; he did not see Mr Finch in person.

39. On 12 April, an officer introduced himself to Mr Finch as his key worker (first port of call for any issues or queries). Mr Finch said everything was fine, his medication had been sorted out, he had settled onto the wing and the regime, and that he had no issues.

40. On 16 April, Mr Finch's sister telephoned the prison's Safer Custody department and said that Mr Finch had told her that he had not received his medication. A member of staff spoke to Mr Finch, who confirmed this. They contacted the Pharmacy department, and Mr Finch's location had been recorded inaccurately. They updated their records, and Mr Finch was given a supply of his medication. The same day, Mr Finch's partner telephoned the prison and said that Mr Finch had said that he felt suicidal due to not receiving his medication. Having already addressed the problem with the medication, staff contacted the mental health team, who confirmed that Mr Finch had a mental health assessment scheduled.

41. On 20 April, the health and wellbeing coordinator gave Mr Finch a mental health assessment. He said that all he wanted was a review of his prescription of quetiapine (a drug used both as an anti-psychotic and an anti-depressant) and some activities to occupy his time in his cell. He said that he had received his medication a few days late on a few occasions, which had affected his sleep and his mood. She said that she would raise this with the consultant psychiatrist. Mr Finch saw the psychiatrist, on 27 April. He told the doctor that he had previously been diagnosed with a personality disorder, but he thought that this was incorrect and that he had bipolar affective disorder instead. He denied any substance or alcohol abuse in prison. He requested an increased dose of quetiapine to help his mood swings and anxiety, to which the doctor agreed. He said that no follow up was required and Mr Finch did not need to be under the care of the mental health team as there was no evidence of severe mental disorder.

42. On 9 June, Mr Finch told a nurse that he had not been given enough quetiapine. She gave him enough for that night and the following day. On 13 June, he told his offender supervisor that his medication was still not right, but otherwise he had no concerns.

43. An officer saw Mr Finch for regular key work sessions, and Mr Finch did not raise any problems.

44. In July, Mr Finch's sister contacted the prison and said that she was concerned about Mr Finch's behaviour. A member of the mental health team spoke to Mr Finch on 2 August. He said that he was fine and would speak to his sister to reassure her. He had no concerns regarding his mental health and did not want the support of the mental health team. The nurse noted that he appeared ordered and logical, with no evidence of hallucinations, delusions or thought disorders. He told Mr Finch how to ask for support if he needed it.

45. On 20 August, Mr Finch told a GP that he was struggling to sleep and asked for some Zopiclone (a drug used for insomnia). The doctor reviewed his medication and advised him that he would prescribe sleeping tablets. He also referred Mr Finch for blood tests and an electrocardiogram (ECG, tests of the heart's function) to check his general health. An appointment was made for a blood test on 24 August, but on the day Mr Finch declined to attend. The nurse asked the GP if she should follow this up, but the doctor said that it was Mr Finch's decision to make. On 28 August, Mr Finch smashed some glass in his cell, and was put on a disciplinary charge for damaging prison property. The next day he told the officer that he did not remember what had happened. The officer asked if he was struggling and Mr Finch said that while things sometimes got him down, he was not struggling. He was in contact with his family and had no issues.

46. On 1 September, staff found a charger cable and assorted medication in Mr Finch's cell. They were confiscated and Mr Finch was charged under prison rules. No-one informed the healthcare department or substance misuse services.

47. Mr Finch did not attend his ECG appointment on 19 September. On 24 September, he moved to a new cell. An officer saw him on the 29 September, and he said that he had settled well and was getting on with staff and prisoners.

48. On 4 October, Mr Finch told a fellow prisoner, that he had been having hallucinations. He attributed them to receiving his medication at irregular times. The prisoner said that he was due to see the psychologist and offered to raise this with her. Mr Finch accepted the offer. That afternoon the prisoner told a member of staff what Mr Finch had said. She sent an email to the mental health team. The following morning she received a reply telling her that Mr Finch's records indicated that he was given his medication to hold IP. As such, he was able to take his medication at a time that suited him. If he had any difficulties, he would need to raise this with the healthcare team, who were responsible for distributing medication.

Events of 5 October 2021

49. While distributing food packs on the afternoon of 5 October, an officer reached Mr Finch's cell at approximately 4.05pm. Mr Finch was in bed under the duvet but the

officer thought that he did not look well. He spoke to him and touched him, but Mr Finch did not respond. The officer called a second officer, who was nearby, and on looking at Mr Finch he used his radio to call a code blue emergency (meaning a prisoner not, or having difficulty, breathing). This prompted the control room to request an ambulance. (Ambulance Service records show that this request was received at 4.07pm.) The officer felt for a pulse but, unable to find one, helped the second officer move Mr Finch onto the floor and began to perform cardiopulmonary resuscitation (CPR). Other prison officers arrived and assisted with attempts to resuscitate Mr Finch. They applied a defibrillator (a machine that monitors, and in some case restarts, the heart) but the machine advised that staff should continue with CPR.

50. A nurse was the designated emergency response nurse. She was in a different area of the prison that was busy and noisy and initially missed the emergency call on her radio. When she heard the repeated emergency call she used her radio to say she was on her way, but that any nurses on the wing should be asked to attend. She made her way to Mr Finch's cell, estimating that this took eight minutes. (This tallies with the estimates of prison officers who were at Mr Finch's cell.) On arrival she said that she needed the emergency bag from the healthcare office on the wing, a prison manager, asked a Custodial Manager (CM) to get it. The nurse joined the officers in attempting to resuscitate Mr Finch. The CM was unable to access the healthcare office as it was locked, but two other nurses arrived with emergency equipment. They tried to insert an airway, but Mr Finch's passages were blocked so they used a suction machine to try to clear them. The nurse asked for all available healthcare staff to attend and continued to try to revive Mr Finch until ambulance staff arrived and took over. At 5.10pm, Mr Finch was pronounced dead.

Contact with Mr Finch's family

51. A Custodial Manager (CM) was appointed as family liaison officer. He identified Mr Finch's sister as his next of kin and, at 6.02pm, informed her of Mr Finch's death. In line with Prison Service guidance, Swaleside offered a contribution to the costs of Mr Finch's funeral.

Support for prisoners and staff

52. After Mr Finch'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.

53. The prison posted notices informing other prisoners of Mr Finch'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 Finch's death. Staff spoke to prisoners on his wing individually.

Information after Mr Finch died

54. Intelligence reports submitted after Mr Finch died showed that prisoners had speculated that he might have used spice (a synthetic cannabinoid) around the time of his death.

Post-mortem report

55. Post-mortem reports concluded that Mr Finch died as a result of a fatal level of dihydrocodeine in his system, along with a high level of quetiapine and zopiclone. A low level of alcohol was detected, which may have been due to post-mortem changes in Mr Finch's body. Toxicology tests included tests for new psychoactive substances; none were found. Drug misuse and fatty liver disease contributed to his death.

Findings

Assessment of risk

56. When prison officers found a quantity of medication in Mr Finch's cell on 1 September, they were placed in evidence bags and he was put on a disciplinary charge. However, no note of the type of medication was made and the information was not passed to the healthcare department or substance misuse services. The prison was unable to locate the evidence when it was requested by our investigator. There was no evidence of any further action on the disciplinary charge, which might have provided a further opportunity for prison officers to inform healthcare staff of the excess medication.

57. This was a serious oversight and one that carried significant risks. Mr Finch died from overdosing on medication, specifically dihydrocodeine, which had not been prescribed to him. Had the healthcare team been informed of the findings in Mr Finch's cell, they could have reviewed Mr Finch's capacity to hold his own medication and any other risks presented by the medication that was identified. If they had been able to confirm that the medication found had not been prescribed to him, the prison would have had an indication that Mr Finch was possibly misusing substances. They could then have taken appropriate action to try to prevent this and referred him to substance misuse services. We are disappointed that we are repeating the following recommendation to Swaleside, having identified similar issues in previous investigations:

    The Governor should ensure that all unexplained medication finds are reported promptly to the healthcare department and substance misuse services.

Mr Finch's healthcare

Medication

58. Mr Finch complained on several occasions of not receiving the correct medication. Members of his family also telephoned the prison to report that he had told them this. Records show that Mr Finch did not receive his prescribed medication on three occasions.

59. On 4 October, a psychologist passed on a message to the mental health team that Mr Finch had complained of issues relating to his medication. The response was that he was issued his medication IP, so could take it whenever he wanted. While it was the case that he had been issued his medication, Mr Finch had made it known that he had been suffering from hallucinations and distress. The outcome was that no action was taken, and nobody spoke to him.

60. Post-mortem tests on Mr Finch showed high levels of quetiapine in his system. We are unable to say whether he had stockpiled his prescription medication or obtained them from illicit sources, but the Ambulance Service report noted a box of quetiapine in his cell dated August. In interview, the Head of Healthcare said that during the COVID-19 pandemic, healthcare staff were unable to accompany prison officers to check prisoners' cells for excess amounts of medication. Instead, they

relied on prison officers reporting finding excess medication during cell checks. There are no other healthcare procedures in place to ensure that prisoners are taking their medication as they are supposed to.

61. Mr Finch arrived in Swaleside having been assessed in his previous prison as able to hold his medication in his own possession. This was not re-evaluated at any time after his arrival. In their most recent report HMIP noted concerns regarding medicine management, including risk assessments for in possession medication. We make the following recommendations:

The Head of Healthcare should review systems for regular assessment of prisoners deemed as responsible to hold medication in their own possession.

The Head of Healthcare should review systems to ensure that prisoners are receiving their prescribed medication.

The Head of Healthcare should review systems for ensuring that prisoners issued medication in their own possession are taking that medication as directed.

The Head of Healthcare should ensure that any reports of prisoners suffering potentially serious issues are properly investigated.

Physical healthcare

62. Mr Finch arrived in Swaleside with an outstanding hospital appointment that was not followed up. When he complained of lethargy and blood in his phlegm, he was referred for tests. We found no evidence that these were undertaken.

Emergency response

63. The emergency response nurse took approximately eight minutes to reach Mr Finch's cell. She requested the assistance of other nurses en route, who did not arrive until after she did. The clinical reviewer noted that the timing of the healthcare response was not adequate. We make the following recommendation:

The Head of Healthcare should review emergency response arrangements to ensure help reaches prisoners with minimal delay

Mental healthcare

64. The clinical reviewer noted that Mr Finch's mental health assessments and care plans complied with relevant guidance. He was seen and assessed on several occasions in his cell, which was good practice.

The clinical reviewer concluded that overall, the healthcare provided to Mr Finch was not equivalent to that which he could have expected to receive in the community.

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