Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Robert Dewey, a prisoner at HMP Elmley, on 2 May 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 Robert Dewey was found dead in his cell at HMP Elmley on 2 May 2021. The post-mortem report found that he died from morphine toxicity. He was 51 years old. I offer my condolences to Mr Dewey's family and friends.

Mr Dewey had been in prison for only three days. He had been prescribed an extensive list of medications in the community, including morphine, which continued to be prescribed to him in prison.

The clinical reviewer could not say for sure whether the morphine prescribed to Mr Dewey could, of itself, have caused the toxic levels found in his body at post-mortem. However, he noted that the morphine dose was significant and that it was prescribed alongside another controlled drug, gabapentin, which can have adverse effects when prescribed in combination with opioid drugs (such as morphine).

The clinical reviewer was concerned that that there is no evidence that healthcare staff properly considered whether it was appropriate to prescribe the full list of medications to Mr Dewey. For this reason, the clinical reviewer concluded that the clinical care that Mr Dewey received was not equivalent to that he could have expected to receive in the community.

I am also concerned that the resuscitation attempt was not appropriate in Mr Dewey's case as he was dead when found. This is an issue we have raised with Elmley before.

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 2022**

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Summary

Events

1. Mr Robert Dewey was convicted of sexual assault on 2 November 2020. On 29 April 2021, he was sentenced to 12 months imprisonment and sent to HMP Elmley.

2. Mr Dewey had several medical conditions for which he had been prescribed a large variety of medications. The prison obtained his medication list from his community GP electronic records on the day he arrived at Elmley and the same medications were prescribed by a nurse prescriber. A prison GP saw Mr Dewey on 1 May. She wrote that she had reviewed his medication but she gave no details of the review.

3. At around 9.00am on 2 May, when an officer unlocked Mr Dewey's cell for him to collect his medications, she realised he was unresponsive. She called a medical emergency code.

4. The nurse who attended found that Mr Dewey was cold and she assessed he was in the initial stages of rigor mortis (stiffening of the body after death) and that resuscitation would not be appropriate. However, shortly afterwards another nurse thought she detected a little warmth and healthcare staff decided to start cardiopulmonary resuscitation (CPR). CPR continued until ambulance staff arrived about half an hour later. They pronounced Mr Dewey dead at 9.44am.

5. A post-mortem examination found that Mr Dewey died from morphine toxicity.

Findings

6. Mr Dewey was prescribed morphine (zomorph) at Elmley. The clinical reviewer said that he did not have the specialist knowledge to say whether the morphine prescribed could, of itself, have produced the toxic level of morphine found in Mr Dewey's body at post-mortem. However, he noted that the level prescribed was significant and that it was prescribed in combination with another controlled drug, gabapentin, that is known to interact with opioid drugs such as morphine.

7. The clinical reviewer was concerned that healthcare staff at Elmley did not properly consider the appropriateness of prescribing the list of medications in the dosages and combination given. He was also concerned that a nurse prescriber prescribed the medications rather than a GP. He concluded that Mr Dewey's clinical care was not equivalent to that he could have expected to receive in the community.

8. The attempt to resuscitate Mr Dewey was inappropriate in the circumstances.

Recommendations

- The Director of Health and Justice at NHS England should consider whether in addition to methadone and buprenorphine, all controlled drugs which have been prescribed in the community, should be reviewed before they are restarted in prison.

- The Head of Healthcare at Elmley should ensure that when a prisoner arrives at the prison, their medication is reviewed promptly and the rationale for continuing with any community prescribed controlled drugs is recorded in their medical record.
- The Head of Healthcare should share a copy of this report with the GP who reviewed Mr Dewey's medication and discuss the Ombudsman's findings with them.
- The Head of Healthcare should ensure that healthcare staff fully understand the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Elmley informing them of the investigation and asking anyone with relevant information to contact him.

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

11. NHS England commissioned an independent clinical reviewer to review Mr Dewey's clinical care at the prison.

12. 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.

13. The Ombudsman's family liaison officer contacted Mr Dewey's next of kin, his partner, to explain the investigation. She had several questions about whether the prison was aware of Mr Dewey's health conditions. The answers to these questions can be found in this report and the clinical reviewer's report.

14. The initial report was shared with Mr Dewey's partner. She did not make any comments.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS found no factual inaccuracies. NHS England rejected the clinical reviewer's recommendation, that consideration should be given to reviewing all controlled drugs that had been prescribed in the community before they are restarted in prison. They said that this was because existing protocols laid down in the document, 'Royal College of General Practitioners Safer Prescribing in Prisons Guidance for Clinicians 2019', provided sufficient safeguards. The HMPPS action plan is annexed to this final report.

Background Information

HMP Elmley

16. HMP Elmley holds around 1,100 prisoners, remanded or sentenced, in six houseblocks, with a mixture of single and double cells. Integrated Care 24 Ltd provides 24-hour primary healthcare services, with input from Minster Medical Group. Oxleas NHS Foundation Trust provides mental health services.

HM Inspectorate of Prisons

17. The most recent full inspection of HMP Elmley was in April 2019. Inspectors reported that health provision was reasonably good. There was a range of primary care services, although the wait for nurse triage appointments was considered to be too long. The inpatient unit was well-run. A GP was available every day. Inspectors also found that non-attendance for healthcare appointments had reduced since the previous inspection.

18. The inspectors reported a particular issue with gabapentin (one of the drugs prescribed to Mr Dewey). They said many prisoners were dissatisfied that following the reclassification in 2019 of gabapentin as a controlled drug, they were prescribed alternatives. They also said that there was an active multidisciplinary approach to the management of pain, and the provision included a GP who specialised in pain management.

19. The inspectorate also carried out a short scrutiny visit at Elmley in April 2020, during the COVID-19 pandemic. Inspectors reported that there had been a good leadership and management response to a fast-changing situation and management oversight of healthcare was effective. Most routine health provision, such as external hospital appointments had stopped temporarily due to the risks of COVID-19, but there had been an increased focus on oversight and supporting those most at risk.

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 31 October 2020, the IMB reported that, given the conditions due to COVID-19, the treatment of prisoners was as fair as possible, although with a large number of staff affected by the pandemic, interactions between prisoners had to be limited. They commented that despite continued problems with illicit drugs getting into prison, they felt that steps taken by Elmley to tackle this were positive.

Previous deaths at HMP Elmley

21. Mr Dewey was the 12th prisoner at Elmley to die since May 2019. Eight of the previous deaths were from natural causes, two were self-inflicted and one was drug related. We have expressed concerns in another recent case about an inappropriate attempt at resuscitation.

Key Events

22. Mr Robert Dewey was convicted of assault and sexual assault on 2 November 2020. On 29 April 2021, he was sentenced to 12 months imprisonment and sent to HMP Elmley.

23. Prison records show that Mr Dewey had several health conditions including chronic obstructive pulmonary disease (COPD - the term for a group of serious lung diseases), asthma, epilepsy, a hernia, ankylosing spondylitis (a condition primarily causing back pain, but which can affect other joints) and depression. He used a walking frame to move about.

24. When he arrived at Elmley, a nurse saw Mr Dewey to conduct a standard health screening. Mr Dewey's partner told the PPO that she was concerned that as Mr Dewey was an alcoholic, he would have suffered from the effects of withdrawal. However, Mr Dewey told the healthcare staff at his screening interview that he did not have a problem with alcohol, and the clinical reviewer has noted that there were no recorded signs of withdrawal problems after he went to prison, but that he had been prescribed medications associated with alcohol treatment.

25. Mr Dewey had been prescribed a large variety of medications before coming to prison. When he arrived at Elmley, a member of staff obtained the list of his medications from the electronic records of his community GP and added them to his SystmOne record (the clinical electronic record used by the prison). The screening nurse referred him to a nurse prescriber and the same evening, she prescribed the full list of medications. There is no record that she met Mr Dewey.

26. Mr Dewey did not hold his medications in possession in his cell and had to go and collect them from healthcare staff three times a day. He was, therefore, seen regularly by healthcare staff in the short time he was in the prison. Mr Dewey did not raise any concerns with them.

27. On 1 May, a prison GP saw Mr Dewey. He told her that he had had a seizure two months ago which had been triggered by stress, but before that he had not had a seizure for two years, and it appeared that his current epilepsy medication had controlled his seizures. Mr Dewey also discussed his abdominal wall hernia with the GP and said that he would prefer to wait for possible surgical treatment after he got out of prison in a few months. The GP recorded that she had reviewed Mr Dewey's medications, but she did not enter any details.

28. On the evening of 1 May, Mr Dewey did not raise any concerns with wing or healthcare staff. However, he told his cellmate that he was feeling a little dizzy. His cellmate said the next day that the last time he was aware of Mr Dewey was around midnight when he heard him snoring.

29. On the morning of 2 May, at around 4.14am, a night patrol officer, shone a torch into Mr Dewey's cell. Another visual check was made at 5.09am. Nothing unusual was seen.

30. The next time the cell was checked was around 9.00am, when an officer unlocked Mr Dewey's cell door and called out to him for him to go and collect his medications. She thought he was asleep and called for him a second time. When he did not respond, she went over and checked him more closely and felt his pulse and

noticed that he had been sick. She immediately called to one of her colleagues who radioed a code blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and prompts the control room to call an ambulance).

31. A nurse arrived very soon after the code blue was called as she was already close by. Officers were preparing to carry out CPR, but she advised that it was not appropriate as Mr Dewey appeared to be cold and in the initial stages of rigor mortis as his limbs were stiffening and his jaw was locked.

32. The emergency call handler was put through to an officer on the wing at around 9.08am. The officer told her that he had no medical expertise, but said he had been told by a healthcare member of staff in Mr Dewey's cell that they thought he was dead and had rigor mortis, and that he was cold and had no pulse.

33. At around the same time as the officer was telling the ambulance call handler that it appeared that Mr Dewey was dead, the decision was made by nurses to start CPR. A second nurse who had arrived at Mr Dewey's cell shortly beforehand, had initially agreed that the signs were that death was irreversible. But she thought she detected some warmth on Mr Dewey's sternum (breastbone), and so the two nurses agreed to attempt resuscitation.

34. At about 9.10am, staff moved Mr Dewey out of his cell onto the wing landing to give more room for the resuscitation attempt. CPR continued until the ambulance staff arrived. (They arrived at the prison at 9.36am and reached Mr Dewey at 9.42am.)

35. A paramedic declared Mr Dewey dead at 9.44am.

Contact with Mr Dewey's family

36. The prison appointed a supervising officer as the family liaison officer (FLO). She telephoned Mr Dewey's next of kin, his partner, shortly after 10.00am to let her know about his death. Mr Dewey's partner was very shocked by this unexpected news and in normal circumstances the FLO would have visited her to deliver it in person, but unfortunately was unable to do so because of the restrictions in place because of COVID-19. She explained this in a follow up call. She also supported Mr Dewey's partner over the following days with making funeral arrangements and arranged a visit to the prison for her.

37. In line with national policy, the prison contributed to the costs of Mr Dewey's funeral, which took place on 24 May.

Support for prisoners and staff

38. A prison manager carried out a debrief for the staff who were involved in the emergency response. A prison chaplain, a member of the Care Team, offered support. Follow up support was given to Mr Dewey's cellmate. The prison posted notices informing other staff and prisoners of Mr Dewey's death and offering support.

Post-mortem report

39. The post-mortem report concluded that the cause of Mr Dewey's death was morphine toxicity. Epilepsy was given as a background condition that contributed to but did not cause Mr Dewey's death.

Findings

Morphine toxicity

40. The post-mortem examination found that Mr Dewey died from morphine toxicity. The clinical reviewer said that he did not have the specialist knowledge to comment on whether the dose of morphine prescribed to Mr Dewey could, of itself, have produced the toxic level of morphine found in Mr Dewey at post-mortem. However, he noted that the dose of morphine prescribed to Mr Dewey was significant (120mg) and was not a starting dose (which is typically 5-10mg every four hours to a total of perhaps 30mg daily).

41. The clinical reviewer also noted that while tolerance to opiates may develop quickly, it can also be lost very quickly, even over a few days. Mr Dewey's medical record indicates that he was given his first dose of morphine at Elmley on 30 April, a day after his arrival. He was in court on 29 April so it is possible that he missed a couple of days of medication.

42. The clinical reviewer considered that the potential for morphine overdose in Mr Dewey's case was extremely high and would have been increased further by the interaction with his other medications, particularly gabapentin. He found that Mr Dewey's care fell short of the standard that he could have expected to receive in the community. The clinical reviewer's concerns are addressed further below.

43. It is possible that Mr Dewey obtained additional morphine by illicit means or that he stored the morphine he was given so he could take it at a later date. However, there is no evidence that Mr Dewey was involved in obtaining or trading illicit medication or drugs at Elmley, and the fact that he had to take his morphine at the medication hatch in front of healthcare staff would have limited the opportunity for storing it for use at a later date.

Clinical care

Review of Mr Dewey's prescriptions

44. When Mr Dewey arrived at Elmley, prison healthcare staff had access to the list of medications Mr Dewey was prescribed in the community. A nurse prescriber prescribed Mr Dewey with the complete list.

45. The clinical reviewer noted that the list of medications was extensive and included a number of drugs with known potential for serious interactions and side effects, some of which were the subject of specific prescribing guidelines within the prison system. Although it was in line with policy, he was concerned that the medications were prescribed before a review to consider whether Mr Dewey needed all the medications and whether they should be prescribed in combination with each other and at the dosages listed. He also noted his concern that there was no record in Mr Dewey's clinical record that he had been asked if he had been taking his community medications as prescribed.

46. Of particular concern were zomorph (morphine sulphate - an opiate – discussed above) and gabapentin, both of which are controlled drugs (which means there are legal restrictions on their possession and handling). Gabapentin was reclassified as

a controlled drug in 2019, due to its potential for dependence, misuse and the risk of severe respiratory depression, particularly when taken with other medications such as opioid pain killers (such as morphine). In January 2019, the Director for Health and Justice at NHS England issued guidance to prisons requiring all prisoners on controlled drugs such as gabapentin to be formally reviewed "in order to ensure prescribing is clinically indicated and in line with national clinical guidance". Although the prison GP wrote that she had reviewed Mr Dewey's prescriptions, she gave no indication of what her considerations were. This is surprising given the directions to prisons about controlled drugs and given that, as reported in the last HMIP report, Elmley had previously withdrawn gabapentin from prisoners.

47. We make the following recommendations.

The Director of Health and Justice at NHS England should consider whether in addition to methadone and buprenorphine, all controlled drugs which have been prescribed in the community, should be reviewed before they are restarted in prison.

The Head of Healthcare at Elmley should ensure that when a prisoner arrives at the prison, their medication is reviewed promptly and the rationale for continuing with any community prescribed controlled drugs is recorded in their medical record.

The Head of Healthcare should share a copy of this report with the GP who reviewed Mr Dewey's medication and discuss the Ombudsman's findings with them.

Resuscitation

48. The nurse who responded to the code blue on the morning of 2 May said Mr Dewey felt cold and seemed to be in the initial stages of rigor mortis as his limbs were stiffening and his jaw was locked. She advised the prison staff that it was not appropriate to start CPR as Mr Dewey was dead. When a second nurse arrived in the cell a short time later, she thought that there was a little warmth on Mr Dewey's chest and she thought that his spondylitis could be a factor in the joint stiffness. As a result, the nurses decided to start CPR.

49. This change of mind about resuscitation resulted in some confusion with the ambulance service. The investigator has seen the body-worn video camera (BWVC) footage, and during the course of the resuscitation, healthcare staff can be heard asking if the ambulance crew had been made aware of the situation. It appears that this message did not get through, because the ambulance staff were not expecting CPR to be taking place when they arrived.

50. Because of the initial information from the prison, the call handler assessed the ambulance response as category 2 (expected average response time of 18 minutes and 90% of responses within 40 minutes), rather than category 1 (expected average response time of 7 minutes and 90% of responses within 15 minutes).

51. However, there is no suggestion that the outcome would have been any different for Mr Dewey if the ambulance crew had been aware that CPR was taking place and had arrived sooner. Throughout the resuscitation attempt, Mr Dewey's teeth remained clenched shut, and at no time was it possible to insert an airway. The

paramedics did not consider that the resuscitation had been appropriate, and the clinical reviewer said that the accounts indicated that Mr Dewey had been dead for some time. We recommend:

The Head of Healthcare should ensure that healthcare staff fully understand the circumstances in which resuscitation is inappropriate, in accordance with European Resuscitation Council Guidelines.

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