Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Anthony Masters, a prisoner at HMP Lewes, on 17 January 2022

A report by the Prisons and Probation Ombudsman

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Our vision

To carry out independent investigations to make custody and community supervision safer and fairer

Our values

We are:

Impartial: we do not take sides

Respectful: we are considerate and courteous

Inclusive: we value diversity

Dedicated: we are determined and focused

Fair: we are honest and act with integrity

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Anthony Masters died of acquired immunodeficiency syndrome and human immunodeficiency virus in a hospice on 17 January 2022, while a prisoner at HMP Lewes. He was 55 years old. I offer my condolences to Mr Masters' friends.

Mr Masters had contracted HIV before he went to prison. During his time in prison, he refused regular monitoring of his condition and antiretroviral treatment. Healthcare staff made numerous attempts to encourage him to accept treatment. The prison's mental health team regularly assessed his capacity to refuse treatment and he was fully aware of the consequences of his decision.

I am satisfied that Mr Masters received a reasonable standard of care at HMP Lewes and that his healthcare at HMP Lewes was equivalent to that which he could have expected to receive in the community.

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 **December 2022**

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Summary

Events

1. On 5 July 2021, Mr Anthony Masters was remanded to HMP Lewes charged with arson, knife possession and common assault. On 28 September, he was convicted and sentenced to one year, six months imprisonment.

2. Mr Masters had a history of mental health problems and drug and alcohol abuse. In the community, he had contracted human immunodeficiency virus (HIV). He often made threats to self-harm and prison staff frequently monitored him under the prison's suicide and self-harm prevention procedures known as ACCT, until his death.

3. Mr Masters refused to attend appointments to monitor his HIV infection and told GPs that he did not want to start antiretroviral therapy when his condition deteriorated. GPs encouraged him to attend appointments, but Mr Masters consistently refused treatment. Healthcare staff regularly reviewed Mr Masters and encouraged him to have his HIV monitored. Mr Masters did not agree, and GPs were satisfied he had the mental capacity to refuse treatment.

4. In December 2021, prison officers asked a prison GP to see Mr Masters because they noted that his mental and physical health had deteriorated. A prison GP advised Mr Masters that he needed to go to hospital. Mr Masters initially refused to go but then later agreed to go to a hospice.

5. On 15 January 2022, Mr Masters was transferred to a hospice, and he died there on 17 January.

6. The Coroner gave Mr Masters' cause of death as acquired immunodeficiency syndrome (AIDS) caused by human immunodeficiency virus (HIV).

Findings

7. The clinical reviewer concluded that the care Mr Masters received at HMP Lewes was good and equivalent to that which he could have expected to receive in the community.

8. Mr Masters refused to attend appointments to monitor his condition and he refused antiretroviral treatment. We are satisfied that healthcare staff continued to support Mr Masters, and that he had the capacity to make these decisions

9. However, the clinical reviewer was concerned that there was a lack of advance care planning for Mr Masters' final month at Lewes when arrangements began for his transfer to a hospice.

Recommendation

- **The Head of Healthcare and lead GP should ensure there is a process for advance care planning, to ensure a smooth transition from prison when prisoners are transferred for end of life care.**

The Investigation Process

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

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

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

13. We informed HM Coroner for East Sussex of the investigation. The Coroner gave us the cause of death. We have sent the Coroner a copy of this report.

14. Mr Masters did not nominate anyone to be his next of kin. He had no contact with his family.

15. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP Lewes

16. HMP Lewes is a local prison serving the courts of East and West Sussex and holds up to 692 men. Practise Plus Group provides primary care services. The prison has a healthcare centre with a full time senior medical officer. Healthcare is provided on a 24-hour basis. There is also a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Lewes was in May 2022. The inspection raised concerns about the quality of healthcare services at Lewes. They reported that the prison relied too heavily on agency healthcare staff which led to gaps in prisoner care. They found that the prison struggled to enable health services to run, and ineffective communication had led to considerable prisoner frustration.

18. Inspectors reported that reception and screening processes had been strengthened to make sure that clinical risk was prioritised. Advanced nurse practitioners saw all new arrivals to ensure continuity of their prescribed medications before a GP review. Immediate needs were identified, with appropriate onward referrals. Secondary health screens were generally completed within seven days.

Independent Monitoring Board

19. 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 January 2022, the IMB reported that they found both physical and mental healthcare services had deteriorated since their visit the previous year.

Previous deaths at HMP Lewes

20. Mr Masters was the ninth prisoner to die at Lewes since January 2020. Of the previous deaths, five were from natural causes and three were self-inflicted. There are no similarities with the previous deaths and Mr Masters' death.

Assessment, Care in Custody and Teamwork

21. ACCT is the Prison Service care-planning system used to support prisoners at risk of suicide and self-harm. The purpose of ACCT is to try to determine the level of risk, how to reduce the risk and how best to monitor and supervise the prisoner. After an initial assessment of the prisoner's main concerns, levels of supervision and interactions are set according to the perceived risk of harm. Checks should be irregular to prevent the prisoner anticipating when they will occur. There should be regular multidisciplinary review meetings involving the prisoner.

22. As part of the process, a care map (plan of care, support and intervention) is put in place. The ACCT plan should not be closed until all the actions of the care map have been completed. All decisions made as part of the ACCT process and any relevant observations about the prisoner should be written in the ACCT booklet, which accompanies the prisoner as they move around the prison. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

Key Events

23. Mr Anthony Masters had a history of mental health problems and had been sectioned under the Mental Health Act. He often made threats to harm himself in the community. He said that he had been attempting suicide since the age of 9. He had used illegal substances since he was a teenager and had abused alcohol. He had also spent several periods as a rough sleeper. Mr Masters disclosed that he contracted human immunodeficiency virus (HIV – a virus that attacks the immune system and is incurable, though antiretroviral therapy enables most people with the virus to live a long life) after injecting himself with contaminated (dirty/shared) needles.

24. On 5 July 2021, Mr Masters was remanded to HMP Lewes charged with arson, knife possession and common assault. On 28 September, he was convicted and sentenced to one year and six months in prison.

25. Mr Masters told healthcare staff that he had immunodeficiency syndrome (AIDS), bipolar disorder, Asperger's syndrome, autism and was a sociopath. He said that he did not want any medical intervention to monitor these conditions. Healthcare staff asked for a full review of Mr Masters' community medical record to establish if this was correct. However, they never received a copy. Healthcare staff made an appointment for Mr Masters to be reviewed by the prison's sexual health clinic.

26. Mr Masters refused to attend an appointment with the prison's sexual health clinic despite encouragement from prison nurses. He said that he was refusing any treatment because he wanted to kill himself by letting the process of the disease progress naturally. He said that he hoped to contract pneumonia and not recover. Prison staff monitored him under the Assessment, Care in Custody and Teamwork (ACCT) frequently, until his final hospital admission. Healthcare staff prescribed medication and offered regular support. Mr Masters was offered but refused the COVID-19 vaccine.

27. On several occasions, healthcare staff asked Mr Masters to attend healthcare for tests and GP appointments. He always refused. They also completed referrals to hospital specialists, but Mr Masters regularly failed to attend the appointments. The sexual health team at the Royal Sussex County Hospital were updated about his decisions.

28. On 25 October, Mr Masters was transferred to HMP Rochester. However, as Rochester did not have 24 hour healthcare, he was transferred back to Lewes, three days later, on 28 October.

29. On arrival at Lewes, Mr Masters was verbally abusive and refused to engage with staff. He demanded a single cell with a television. Healthcare staff noted that he was extremely thin, lethargic, and dehydrated. He refused to attend his secondary health screen. Throughout the month of November, Mr Masters refused to attend any healthcare appointments. He refused blood test requests, weight loss assessments and mental health appointments.

30. On 24 December, a prison GP visited Mr Masters in his cell because wing staff were concerned that his mental and physical health had deteriorated. She

discussed his current presentation with Mr Masters, and he decided that he did not want anyone to resuscitate him if his heart or breathing stopped. She considered that Mr Masters had the capacity to make this decision and concluded that given his deteriorating health and refusal to have treatment, the order was appropriate. Mr Masters declined to attend any appointments to monitor his HIV infection.

31. Later that day, Mr Masters slipped in his cell. Healthcare staff attended and noted that he did not have any injuries, but his condition was deteriorating. He was incontinent, was unable to stand unaided and had lost all mobility and strength. A nurse spoke to Mr Masters and persuaded him to go to hospital for end of life care as healthcare staff would struggle to manage his symptoms. Healthcare staff sent him to hospital. Two officers escorted him, and they did not use restraints.

32. Mr Masters was later transferred to Brighton Royal Sussex Hospital on 26 December. In hospital, he refused all medication offered to him. Hospital staff arranged for the hospital mental health team to see him, but he refused to engage with them.

33. On 30 December, Mr Masters told prison staff that he did not want to be considered for compassionate release. He said that a transfer to a hospice was his favoured option. Staff commenced arrangements for funding and finding suitable accommodation for him.

34. On 15 January 2022, Mr Masters was transferred to Mulberry House Hospice and he died there on 17 January.

35. Prison enquiries found that Mr Masters had never nominated anyone as his next of kin, and he had no contact with any family or friends.

Support for prisoners and staff

36. After Mr Master's death, the duty governor debriefed the escorting staff to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

37. The prison posted notices informing other prisoners of Mr Master'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 Master's death.

Cause of death

38. The Coroner accepted the cause of death provided by a prison doctor, and no post-mortem examination was carried out. The prison doctor gave Mr Masters' cause of death as acquired immunodeficiency syndrome (AIDS) caused by human immunodeficiency virus (HIV).

Findings

39. The clinical reviewer concluded the care Mr Masters received at HMP Lewes was broadly equivalent to that which he could have expected to receive in the community.

40. Prison GPs and healthcare staff ensured that Mr Masters was fully aware of the consequences of refusing antiretroviral treatment. Mental health specialists assessed that he had the capacity to refuse treatment on a regular basis. The clinical reviewer considered that Mr Masters' decision to refuse treatment limited his healthcare options. Healthcare staff continued to engage with him and offered appropriate support. We are satisfied that Mr Masters was treated well at HMP Lewes.

41. The clinical reviewer was, however, concerned that there was no evidence of advanced care planning which would have ensured a smoother transition from prison to community services towards the end of Mr Masters' life. We note however, that by December 2021, Mr Masters' physical health was deteriorating, and staff explored different options to ensure he was comfortable. We recommend:

    The Head of Healthcare and lead GP should ensure there is a process for advance care planning to ensure a smooth transition from prison when prisoners are transferred for end of life care.

42. The clinical reviewer made a number of recommendations about local operating policy procedures, follow up and sharing of information with secondary services, which we do not repeat in this report but which the Head of Healthcare will need to address.

Inquest conclusion

43. The inquest into Mr Masters death took place on 14 April 2023, and concluded that Mr Masters died from acquired immunodeficiency syndrome, caused by human immunodeficiency virus and was from natural causes.

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