Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Trevor Monerville, a prisoner at HMP Lewes, on 18 April 2021

A report by the Prisons and Probation Ombudsman

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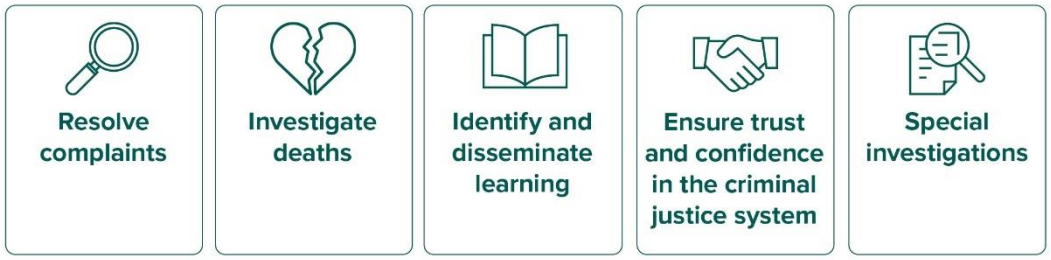
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

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 Trevor Monerville died on 18 April 2021, after being found unresponsive in his cell at HMP Lewes. The post-mortem report concluded that his cause of death was sudden unexpected death in epilepsy (SUDEP). He was 33 years old. I offer my condolences to Mr Monerville's family and friends.

Mr Monerville arrived at Lewes on 30 November 2020. He had frequent seizures and poor compliance with his epilepsy medication. He was monitored in the prison inpatient unit before being moved to a standard wing on 15 January 2021, when his seizures appeared to be under control.

Staff supported Mr Monerville using suicide and self-harm procedures (known as ACCT) for the majority of his time at Lewes. Staff stopped the last period of monitoring on 10 March.

The investigation found that the healthcare Mr Monerville received at Lewes was of a reasonable standard and was equivalent to that which he could have expected to receive in the community.

However, the clinical reviewer was concerned that when Mr Monerville was moved from the inpatient unit to a standard wing, there was no handover to primary healthcare staff and no epilepsy management plan. This meant there was a lack of healthcare oversight to manage Mr Monerville's seizures and an over-reliance on ACCT procedures, which were often used inappropriately as a way to monitor Mr Monerville's seizure activity.

I am also concerned that when Mr Monerville was moved to a standard wing, he was placed in a single cell and no one considered whether he should have a cellmate, who could have alerted staff if Mr Monerville had a seizure.

On the day Mr Monerville died, staff did not carry out a morning roll check as they should have done. Mr Monerville could potentially have been found earlier had they done so. In addition, when Mr Monerville was found lying on the floor of his cell, officers did not call a medical emergency code immediately as they should have done, which led to a short delay in the emergency response. I am satisfied that it made no difference to the outcome for Mr Monerville but it could be critical in future emergencies.

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 **March 2022**

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Summary

Events

1. On 30 November 2020, Mr Trevor Monerville was remanded in custody charged with assault, harassment and criminal damage. He was sent to HMP Lewes

2. When Mr Monerville arrived at Lewes, he told the reception nurse that he had had ten epileptic seizures in the last 48 hours. He was given epilepsy medication but the next morning, he refused to take it as he said it was the wrong dose and was being given at the wrong time. Staff persuaded him to take it in the evening.

3. On 2 December, staff found Mr Monerville lying on the floor of his cell, staring and not speaking. Nurses attended but found no evidence of seizure activity. On 3 December, Mr Monerville was moved to the prison inpatient unit so that healthcare staff could monitor him and his medication compliance.

4. On 4 December, a nurse started suicide and self-harm monitoring (known as ACCT) as Mr Monerville was low in mood and was refusing his medication and food. That afternoon, Mr Monerville had a seizure that was so severe he was taken to hospital for assessment. He was discharged that evening.

5. On 13 December, Mr Monerville had another seizure and was taken to hospital again. While Mr Monerville was in hospital, he saw a neurologist who said that it was unlikely that his seizures were caused by epilepsy.

6. On 15 January 2021, Mr Monerville's seizures seemed to be under control so he was moved from the prison inpatient unit to a standard wing. He was located in a single cell because his cell sharing risk was assessed as high. On the same day, staff stopped ACCT procedures.

7. On 25 January, staff restarted ACCT procedures after Mr Monerville said that he wanted to be dead. Staff continued ACCT monitoring until 10 March.

8. On 18 April, at 9.47am, an officer unlocked Mr Monerville's cell and saw him lying face down on the floor. She called another officer for help. The other officer used his radio to call for healthcare staff. The officers then turned Mr Monerville over and realised he was not breathing. They called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties) and started cardiopulmonary resuscitation (CPR). At 10.05am, paramedics arrived. They took over CPR, but at 10.59am they pronounced Mr Monerville dead.

9. The post-mortem report concluded that the most likely cause of Mr Monerville's death was sudden unexpected death in epilepsy (SUDEP).

Findings

10. The clinical reviewer found that Mr Monerville's healthcare was of a reasonable standard and was equivalent to that he could have expected to receive in the community.

11. However, she was concerned that when Mr Monerville was moved from the prison inpatient unit to a standard wing, there was no handover to primary healthcare staff

and no epilepsy management plan in place to monitor Mr Monerville's seizures. As a result, there was a lack of healthcare oversight to manage his seizure activity and an over-reliance on ACCT.

12. We are concerned that staff did not consider giving Mr Monerville a cellmate after he was moved to a standard wing. A cellmate could have alerted staff if Mr Monerville had a seizure. We consider that the cell sharing risk assessment should have been reviewed to see if a cell share was possible.

13. The day staff did not carry out a morning roll check on the day Mr Monerville was found. It is possible therefore, that he could have been found earlier.

14. There were also delays in calling the code blue. Although the clinical reviewer was satisfied that the delay in calling the code blue did not affect the outcome for Mr Monerville, it could be critical in future emergencies.

Recommendations

- The Head of Healthcare should ensure that when a prisoner is discharged from the inpatient unit, a formal discharge summary (including a management plan if appropriate) is handed over to primary care.
- The Head of Healthcare should ensure that all patients with epilepsy and/or seizure activity have an epilepsy management plan, that includes a plan to monitor seizure activity.
- The Governor and Head of Healthcare should ensure that all staff are fully trained and understand the purpose of the ACCT process and that prisoners are only monitored using ACCT in appropriate circumstances.
- The Governor should ensure that staff review a prisoner's cell sharing risk assessment if it would be beneficial for them to have a cellmate.
- The Governor should ensure that roll checks are properly carried out and that staff understand their responsibilities to check there are no immediate issues that need attention.
- The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.
- The Governor should share this report with Officer A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.

The Investigation Process

15. 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.

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

17. NHS England commissioned an independent clinical reviewer to review Mr Monerville's clinical care at the prison. The clinical reviewer conducted joint interviews with the investigator. All the interviews were conducted by telephone or video because of the COVID-19 restrictions.

18. We informed HM Coroner for East Sussex of the investigation. The coroner gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

19. The Ombudsman's family liaison officer contacted Mr Monerville's mother to explain the investigation and to ask if the family had any matters they wanted the investigation to consider. Mr Monerville's family raised concerns about the management of the ACCT process, whether Mr Monerville should have been sharing a cell, his mental health care and the management of his seizures. These issues have been addressed in our report and in the clinical review.

20. Mr Monerville's family solicitor received a copy of the initial report, they raised a number of questions that have been addressed through separate correspondence.

21. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS pointed out two factual inaccuracies and this has been amended accordingly. Their action plan is annexed to this report.

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 full inspection of HMP Lewes was conducted in January 2019. Inspectors reported that their findings were "deeply troubling and indicative of systematic failure within the Prison Service". They found that in the three years since their last inspection, very few of their recommendations had been fully implemented, and that few of the action points arising from the special measures action plan had been carried out. They concluded that, far from delivering better outcomes, two years of special measures had coincided with a serious decline in performance.

18. HMIP carried out an Independent Review of Progress in December 2019 to review the prison's response to the key recommendations from its earlier inspection. They found that good or reasonably good progress had been made in response to two-thirds of the areas they reviewed and that the prison had a new sense of purpose and direction.

19. They reported that health governance structures had improved, and healthcare staff now received clinical and managerial supervision. Care for prisoners with long-term health conditions had also improved but was undermined by the large number of prisoners who did not attend their appointments. The mental health service was better than at the inspection, and more interventions were available.

20. The inspectors concluded that, overall, this was a promising review and the Governor and her senior managers were taking the prison in the right direction.

Independent Monitoring Board

21. 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 January 2021, the IMB noted that Practice Plus Group (PPG) took over the provision of healthcare from Sussex Partnership Foundation Trust in April 2020 and had had a hugely beneficial impact on the healthcare provided in HMP Lewes.

22. PPG had kept residents informed and clinics running throughout the pandemic, with waiting list times which the IMB considered to be no longer than those in the general community. There had been improved healthcare coverage during evenings and weekends and better out of hours prescribing.

Previous deaths at HMP Lewes

23. Mr Monerville was the eighth prisoner to die at Lewes since April 2019. Of the previous deaths, five were from natural causes and two were self-inflicted. We have previously made recommendations to the Governor about ensuring staff call a medical emergency code when they discover a medical emergency.

Assessment, Care in Custody and Teamwork

24. 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.

25. 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

26. On 30 November 2020, Mr Trevor Monerville was remanded in custody for assault by beating, harassment, criminal damage and assault by beating an emergency worker. He was sent to HMP Lewes.

27. When Mr Monerville arrived at Lewes, a nurse completed the initial health screen. He recorded that Mr Monerville had several long-term health conditions including epilepsy, schizophrenia, depression and asthma. Mr Monerville told the nurse that he had had ten epileptic seizures in the last 48 hours.

28. The same evening, a prison GP saw Mr Monerville and noted that he had been drinking heavily in the community so would need to be located on the substance misuse wing for detoxification. There was no space available on the substance misuse wing so Mr Monerville was located on a wing nearby where he was monitored closely by healthcare staff.

29. Mr Monerville arrived at Lewes with several boxes of medication, but the instructions on the boxes were not clear. In addition, it was difficult for the prison GP to understand exactly what medication Mr Monerville was on because Mr Monerville refused to give consent for the GP to access his Summary Care Record (SCR – details a person's medical history including prescribed medications). The GP tasked administrators to obtain Mr Monerville's medical and neurology records from his community GP to ascertain how his epilepsy was being managed. (The prison received the GP records on 4 December.)

30. Staff gave epilepsy medication to Mr Monerville on the day he arrived but the next morning, he refused to take it. He said it was the wrong dose and was not being given at the correct times. Later that day, staff found Mr Monerville lying on the floor hyperventilating. Nurses assessed that he was having an anxiety attack. Mr Monerville told them that staff had tried to give him the wrong medications so he had refused them. He also said that he had refused food because it was not appropriate for a Rastafarian diet. That evening, staff persuaded him to take his medication.

31. On the morning of 2 December, staff found Mr Monerville lying on the floor of his cell, staring and not speaking. Nurses attended to him and sat him in a chair. Mr Monerville said he had not eaten for three days. Nurses found no evidence of seizure activity. Later that day, Mr Monerville was found unresponsive on his bed, drooling from the mouth. A nurse took his observations, which were normal, and he sat up. Again, the nurse found no evidence of seizure activity.

32. In the early hours of 3 December, a nurse saw Mr Monerville in his cell because staff suspected he was having a seizure. The nurse found him lying face down but his observations were normal. When he came round, he appeared confused. Later that day, staff moved Mr Monerville to the prison inpatient unit so that healthcare staff could monitor him and his medication compliance.

33. On 4 December, a nurse started suicide and self-harm prevention procedures (known as ACCT) as Mr Monerville was low in mood and was displaying unusual behaviour including refusing his medication and food. That afternoon, Mr

Monerville had a seizure and was taken to hospital for assessment. He was discharged that evening with confirmation of prescribed epilepsy medication.

34. On 5 December, Mr Monerville refused to take his medication because he said it was the wrong dose. However, he ate all the food given to him.

35. On 6 December, Mr Monerville had another seizure. He was taken to hospital again, where he was admitted. Mr Monerville was discharged from hospital on 11 December with some slight alterations to his medication. Staff stopped ACCT monitoring.

36. On 12 December, Mr Monerville refused his morning medications but accepted his afternoon medications.

37. On 13 December, Mr Monerville had another seizure and was admitted to hospital. While he was in hospital, he was seen by a neurologist who said that his seizures were unlikely to be epileptic in nature and that, if so, medication would not help. He was diagnosed with non-epileptic attack disorder and referred to the neuropsychiatry service with a view to weaning him off epilepsy medication. Due to the demands on the neuropsychiatry service, Mr Monerville's appointment was delayed and he was not seen before he died. In the meantime, he continued to be prescribed anti-epileptic medication.

38. Staff monitored Mr Monerville using ACCT from 14 to 18 December and from 27 December.

39. On 6 January 2021, Mr Monerville had a telephone consultation with a psychiatrist. The psychiatrist prescribed a new antidepressant medication (mirtazapine) and recommended that Mr Monerville should be referred for psychological therapy. He was referred on 12 January. (At the time, there was an average waiting list of three months and Mr Monerville was not seen before he died.)

40. On 15 January, Mr Monerville's seizures appeared to be under control so he was moved from the prison inpatient unit to a standard wing. Prior to Mr Monerville being moved, a professionals' discharge meeting was held attended by healthcare and prison staff. Staff noted that Mr Monerville had not suffered any seizures for over two weeks, and that the view of the hospital was that the seizures were non-epileptic. Mr Monerville was located in a single cell on the wing, because staff had assessed his cell sharing risk as high. (Lewes was unable to provide Mr Monerville's Cell Sharing Risk Assessment so we did not see the reasons for staff's assessment that he was high risk.) Staff stopped ACCT monitoring.

41. On 21 January, staff recorded that Mr Monerville was refusing to take his medication because he thought that it was being administered at the wrong time. (The medication was being given at a different time because the regime on the standard wing was different from that in the inpatient unit, but it was still within the prescribing guidelines.)

42. On 25 January, a supervising officer (SO) started ACCT procedures after Mr Monerville told him that he was not taking his medication and wanted to be dead. He refused his medications the next day but took them on 27 January.

43. At the subsequent ACCT reviews, Mr Monerville told staff that he missed taking his medication sometimes because of the amount he slept. Staff stressed to him the

importance of taking his medication. Mr Monerville also said that his food was going missing, that he was struggling with the noise on the wing and that he thought his seizures were brought on by stress.

44. On 18 February, healthcare staff saw Mr Monerville after he reported suffering a seizure.

45. On 3 March, Mr Monerville refused to attend an ACCT review because he said that the actions that had been agreed in the previous review had not been completed. An SO and a member of the mental health team went to his cell and chatted to him but he did not engage much. He said that he did not think his medication was working and wanted to see a psychologist. The SO recorded that the ACCT procedures would remain in place due to Mr Monerville's seizures, and that he should be monitored twice a day and three times at night.

46. On 7 March, healthcare staff were called by wing staff. A nurse saw Mr Monerville who said he had felt as if he was going to fit but that he had not passed out.

47. On 10 March, an SO led an ACCT case review. A member of the mental health team was also present. During the review Mr Monerville said that he had had a number of seizures in the past two weeks. He also said he was feeling much happier and had no thoughts of self-harm. It was agreed that the ACCT would be closed.

48. A week later, a safer custody officer completed a post-closure check (a post-closure welfare check is welfare check carried out by a member of the Safety Team to check on how well the prisoner is coping during the post closure period with fewer formalised interactions with staff). He recorded that Mr Monerville had not been on the ACCT because of self-harm but as a means to check his seizures. He also documented that he would create a sheet that staff could use to maintain two hourly observations on Mr Monerville to monitor his frequent seizures. (Although the officer did create a monitoring sheet, we saw no evidence that this was ever implemented by wing staff.)

49. CCTV shows that at 5.03am on 18 April, an operational support grade (OSG) carried out a roll check (count) of prisoners on Mr Monerville's spur. CCTV shows that he shone his torch into Mr Monerville's cell. He said that he saw Mr Monerville lying on the bed and that he appeared to be asleep.

50. At 9.47am, Officer A went to Mr Monerville's cell to unlock him for medication. When she opened the cell door, she saw that he was lying face down on the floor. Officer A called Mr Monerville's name but he did not respond so she called her colleague to come to the cell. About a minute later, Officer B arrived at the cell. He called Mr Monerville's name, and when he did not answer he called over the radio for healthcare staff to attend. Officer A and B then turned Mr Monerville over and realised that he was not breathing. At 9.50am, Officer B called a code blue (a medical emergency code used to indicate that a prisoner is unconscious or having breathing difficulties) and started cardiopulmonary resuscitation (CPR).

51. A minute or so later healthcare staff arrived and continued with CPR. At 10.05am paramedics arrived and took over CPR, but at 10.59am, they pronounced that Mr Monerville was dead.

52. After Mr Monerville's death, a significant amount of stock piled medication, including medication for his epilepsy, was found in his cell.

Contact with Mr Monerville's family

53. On 18 April, when Mr Monerville died, the prison appointed an SO and an officer as the family liaison officers (FLOs). The officer called Mr Monerville's next of kin, his mother, to tell her that Mr Monerville had died. Both FLOs provided Mr Monerville's family with support.

54. The prison tried to contact Mr Monerville's family several times to offer to contribute towards his funeral. The family did not return the calls so the prison were unable to contribute to the funeral costs.

Support for prisoners and staff

55. After Mr Monerville'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.

56. The prison posted notices informing other prisoners of Mr Monerville'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 Monerville's death.

Post-mortem report

57. The post-mortem report said that this was a sudden death, but that Mr Monerville's heart was normal, with no significant coronary disease. The pathologist noted that there was no tongue bite present which may be seen in epileptic seizure activity, but that its absence did not exclude seizure activity. There was also no urine in the bladder which may also be associated with seizure activity. Having excluded other possibilities, the pathologist concluded that sudden unexpected death in epilepsy (SUDEP) appeared to be the most likely cause of death.

Findings

Clinical care

58. Mr Monerville suffered from frequent seizures. Although he was prescribed epilepsy medication, he frequently refused to take it. He was appropriately taken to hospital on several occasions. However, a hospital consultant assessed that Mr Monerville's seizures were unlikely to be epileptic in nature and referred him instead to a neuropsychiatry service with a view to weaning him off epilepsy medication (though he was not seen before he died). The prison told the clinical reviewer that Mr Monerville was treated as an epileptic patient regardless.

59. The clinical reviewer concluded that the clinical care Mr Monerville received at Lewes was of a reasonable standard and was equivalent to that he could have expected to receive in the community. This included the care he received for his mental health.

60. However, the clinical reviewer was concerned that when Mr Monerville was moved from the prison inpatient unit to a standard wing, there was not a thorough handover process between the inpatient unit and primary care. There was a pre-discharge meeting on 15 January, but when Mr Monerville was moved to a standard wing, the healthcare oversight to manage his seizure activity was lacking. The clinical reviewer considered that if there had been a proper handover/discharge there would not have been such an over-reliance on ACCT to monitor Mr Monerville's seizures.

61. The clinical reviewer commended the safer custody officer for developing an observation chart, but she considered that there should have been a more formal management plan led by healthcare and that this should not have been left to prison staff.

62. We make the following recommendations:

    The Head of Healthcare should ensure that when a prisoner is discharged from the inpatient unit a formal discharge summary (including a management plan if appropriate) is handed over to primary care.

    The Head of Healthcare should ensure that all patients with epilepsy and/or seizure activity have an epilepsy management plan, that includes a plan to monitor seizure activity.

ACCT management

63. Mr Monerville was monitored using ACCT for the majority of his time at Lewes. His last period of ACCT monitoring ended on 10 March 2021.

64. The purpose of the ACCT process is to support prisoners. Mr Monerville said that he felt supported by the ACCT process and it was noted in his post-closure review that he said he *"felt supported by some officers and that staff were really good".*

65. We consider that overall, ACCT procedures were well managed. However, we are concerned that staff were not clear about the reasons for Mr Monerville being on an

ACCT and different members of staff recorded different reasons as to why Mr Monerville was being monitored using the ACCT process. Some staff recorded that it was a way to monitor Mr Monerville's seizures, which is not a reason to use the ACCT process. Monitoring of seizures should be managed by way of a clinical epilepsy management plan and should not be left to prison officers. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are fully trained and understand the purpose of the ACCT process and that prisoners are only monitored using ACCT in appropriate circumstances.

66. The clinical reviewer noted that Mr Monerville was regularly assessed from a mental health perspective during ACCT reviews. However, she noted that the regular mental health representative at the reviews was a trainee occupational therapist and not a trained mental health professional. We understand that since April 2021, qualified mental health professionals now attend ACCT reviews, so we do not make a recommendation.

Cell sharing risk assessment

67. The clinical reviewer said that it is difficult to monitor a person's seizure activity in prison, as in all community settings. She noted that this risk is often managed by prisoners sharing a cell, so the cellmate can call for help in an emergency.

68. Mr Monerville had been assessed as a high risk prisoner and was therefore in a cell on his own. However, Prison Service Instruction (PSI) 20/2015, The Cell Sharing Risk Assessment, makes clear this is not an automatic bar to a cell share where it is deemed necessary for support purposes and where the risk can be managed safely. We consider that, given the severity of Mr Monerville's seizures, staff should have reviewed Mr Monerville's cell sharing risk assessment and looked into the possibility of him sharing a cell.

69. We cannot say whether this would have changed the outcome for Mr Monerville, but if he had had a cellmate, the cellmate would have been able to press the emergency cell bell to alert staff that he was having a seizure. We make the following recommendation:

The Governor should ensure that staff review a prisoner's cell sharing risk assessment if it would be beneficial for them to have a cellmate.

Roll check

70. CCTV shows that at 5.03am on 18 April, an OSG carried out a roll check of prisoners and looked into all the cells on Mr Monerville's spur. He shone his torch into Mr Monerville's cell and said that he saw Mr Monerville lying on the bed and he appeared to be asleep.

71. When the day staff came on duty at around 7.30am, they did not complete a roll check of the wing as they should have done. Over two hours later, at around 9.47am, Mr Monerville was found lying face down on his cell floor.

72. We cannot say if the failure to complete a roll check affected the outcome for Mr Monerville but, if the roll check had been done, he may have been discovered earlier.

73. When the investigator asked the prison why a roll check was not completed they said that the Governor has since issued a notice to staff about the handover process and the importance of a roll check when coming on duty

74. We consider that it is critical that staff understand the importance of roll checks to ensure this does not happen again. We make the following recommendation:

The Governor should ensure that roll checks are properly carried out and that staff understand their responsibilities to check there are no immediate issues that need attention.

Emergency response

75. Prison Service Instruction (PSI) 03/2013, Medical Emergency Response Codes, requires prisons to have a local protocol which gives guidance on efficiently communicating the nature of a medical emergency. It directs that staff should use a code blue for any emergency where a prisoner has symptoms such as unconsciousness and fitting.

76. When Officer A went to Mr Monerville's cell she found him lying on the floor. When Officer A could not get a response from Mr Monerville she shouted to Officer B to assist her. Officer B went to the cell and then used his radio to call for medical assistance. He then turned Mr Monerville onto his side and then, when he realised he was not breathing, he called a code blue.

77. We consider that Officer A should have called a code blue as soon as she realised that Mr Monerville was not responding. When Officer B attended the cell and found that Mr Monerville was not responding he should also have called a code blue (if Officer A had not already done so). Although the clinical reviewer was satisfied that the delay did not affect the outcome for Mr Monerville, such a delay could be critical in future emergencies. We make the following recommendations:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that they use the correct medical emergency code to communicate the nature of the emergency effectively.

The Governor should share this report with Officer A and Officer B and arrange for a senior manager to discuss the Ombudsman's findings with them.

Inquest

78. At the inquest, which concluded on 25 September 2023, the jury gave a narrative conclusion. They found that the communication between all the organisations involved, the monitoring systems, the sharing of medical documentation and the engagement with Mr Monerville's family were inadequate for his individual needs. They considered the staff shortages at Lewes and the pandemic but noted that

there were still not systems in place to oversee vulnerable people in Mr Monerville's position, whose circumstances did not warrant ACCT management.

79. The jury found from their observation of some witnesses that there was a lack of empathy for the people in their care and tenuous accountability for taking ownership. They also found that the lack of systematic observations after the ACCT was closed, alongside no care plan and no seizure diary, contributed to the insufficient and unacceptable management of Mr Monerville's care.

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