Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Lee Hughes, a prisoner at HMP Wandsworth, on 25 December 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 Lee Hughes died from methadone and benzodiazepine misuse on 25 December 2021, at HMP Wandsworth. He was 50 years old. I offer my condolences to Mr Hughes' family and friends.

Mr Hughes had a long history of substance misuse. Following his arrival at Wandsworth, a week before his death, he was prescribed methadone and benzodiazepines for the respective effects of opiate and alcohol withdrawal. The clinical reviewer identified some deficiencies in benzodiazepine prescribing, but broadly found the management of Mr Hughes' substance use to have been appropriate.

On 24 December, healthcare staff made seven failed attempts to give Mr Hughes his medication and, on each occasion, he did not respond to their efforts to communicate with him. I am concerned that healthcare staff assumed that Mr Hughes was ignoring them or sleeping, rather than taking clinical observations to make a more informed judgement. The clinical reviewer found that this part of Mr Hughes' clinical care was not equivalent to that which he could have expected to receive in the community.

The prison and healthcare staff who went to Mr Hughes' cell responded from another fatal medical emergency elsewhere in the prison and later went on to deal with a third medical emergency. It is commendable that the small team of staff continued to deliver an essential service throughout the night.

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 **March 2023**

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Summary

Events

1. On 18 December 2021, Mr Lee Hughes was remanded to HMP Wandsworth.

2. At his initial health screen, Mr Hughes told a nurse that he drank about 140 units of alcohol a week. Mr Hughes tested positive for cocaine, cannabis, benzodiazepines and opiates and negative for methadone and amphetamine. The nurse recorded a Clinical Opiate Withdrawal Scale (COWS) score of 13, which indicated moderate opiate withdrawal, and a Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) of 13, which indicated mild alcohol withdrawal.

3. Later that day, a prison GP saw Mr Hughes, who said that he had a regular prescription of diazepam to treat the symptoms of alcohol withdrawal. The prison GP prescribed Mr Hughes a low dose of methadone (10ml, for opiate withdrawal) and vitamin B1 (for alcohol withdrawal).

4. On 20 December, a prison GP saw Mr Hughes because he told a nurse that his methadone dose was not enough. The GP completed a COWS assessment, which scored seven, indicating mild opiate withdrawal. He increased the methadone dose. On the same day, Mr Hughes was prescribed diazepam, for alcohol withdrawal.

5. On 23 December, the lead prison GP saw Mr Hughes because nurses on the wing thought that he appeared sedated and may have taken illicit drugs. The GP said that Mr Hughes' focus was on obtaining an increase in his methadone dose. The GP declined Mr Hughes' request to increase his methadone dose but did not request a drug test to identify whether he had taken an illicit substance.

Events of 24 and 25 December

6. In the afternoon of 24 December, Mr Hughes did not attend the medication hatch for his benzodiazepines and vitamin B1. During the afternoon and evening, healthcare staff visited Mr Hughes' cell seven times to try to give him his medication. On each occasion, he did not respond to their attempts to communicate with them.

7. At about 4.45am on 25 December, an operational support grade (OSG) went to Mr Hughes' cell as part of his morning roll check. He saw Mr Hughes sitting on the bed, with a white discharge coming from the right side of his mouth. The OSG could not obtain a response from Mr Hughes and therefore radioed for other staff to attend.

8. Two officers went to Mr Hughes' cell. They opened the cell door, found Mr Hughes with no signs of life and started chest compressions. At 5.07am, ambulance paramedics confirmed that Mr Hughes had died.

Findings

Clinical care

9. Mr Hughes had a long history of substance misuse and dependence. He was appropriately assessed for symptoms of opiate withdrawal on arrival and prescribed methadone in line with guidelines. However, decisions on the management and prescribing of diazepam were unclear and sometimes based on limited information. Two days before he died, a prison GP appropriately declined his request to increase his medication dose, but no action was taken to address the symptoms of intoxication with which he presented.

10. On 24 December, healthcare staff made seven failed attempts to give Mr Hughes his medication. No one assessed Mr Hughes and there appears to have been an assumption that he was ignoring staff, without consideration of an underlying health problem. The clinical reviewer found that a more formal assessment was required and that this part of Mr Hughes' clinical care was not equivalent to that which he could have expected to receive in the community.

Recommendations

- The Head of Healthcare should ensure that staff prescribe benzodiazepines for alcohol withdrawal when it is clinically appropriate, and clearly consider and record all relevant information and decisions relating to withdrawal symptoms and prescribing.

- The Head of Healthcare should ensure that staff take appropriate action when a prisoner appears to be intoxicated, including arranging for a drug screen when indicated.

- The Head of Healthcare, should review the non-attendance policy to;

    - clarify what is expected of all levels of healthcare staff if they cannot get a response from a prisoner when a critical medication is due; and
    - ensure that staff record failed attempts to medicate prisoners in the medical records.

The Investigation Process

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

12. The investigator obtained copies of relevant extracts from Mr Hughes' prison and medical records.

13. The investigator interviewed three members of staff by video and telephone on 11 May and 20 May.

14. NHS England commissioned a clinical reviewer to review Mr Hughes' clinical care at the prison. The investigator jointly interviewed eight members of staff by video and telephone with the clinical reviewer between 25 March and 3 August.

15. We informed HM Coroner for Inner West London of the investigation. She gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

16. The Ombudsman's family liaison officer wrote to Mr Hughes' sister to explain the investigation. She did not respond.

17. We shared the initial report with the Prison Service. There were no factual inaccuracies.

Background Information

HMP Wandsworth

18. HMP Wandsworth is a local category B prison in London, with a category C unit. It holds up to 1,452 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health and clinical substance misuse services are provided by South London and Maudsley NHS Foundation Trust. Change Grow Live (CGL) provide psychosocial services.

HM Inspectorate of Prisons

19. The most recent full inspection of HMP Wandsworth was in September 2021. Inspectors reported that there were not enough staff to provide even a basic regime. The infrastructure of the prison needed a lot of work; ceilings and landings were often tatty, some of the showers were awful and outside areas were strewn with rubbish.

20. Inspectors reported that there were staff vacancies in all clinical areas. They found a committed primary care team, well led by senior staff who provided a 24-hour service. Inspectors reported that doctors provided flexible prescribing to drug dependent prisoners, based on individual need. However, the administration of methadone was chaotic with patients not consistently checked to make sure they had taken their medication.

21. In June 2022, inspectors carried out an independent review of progress at Wandsworth. They reported that leaders had not been able to deliver substantial improvements to standards on the wings since their last inspection. Healthcare staffing levels had improved, a recruitment plan was in place and recruitment for most vacancies had been carried out.

Independent Monitoring Board

22. 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 May 2022, the IMB reported that staffing levels remained a serious problem throughout the year with cross deployment from non-operational departments often the only way to deliver the regime.

23. The IMB reported that up to 29 per cent of new arrivals required substance misuse treatment, predominantly methadone.

Previous deaths at HMP Wandsworth

24. There were three deaths from natural causes, nine self-inflicted deaths and a death awaiting classification at HMP Wandsworth in the two years before Mr Hughes' death. There has been one death from natural causes and two self-inflicted deaths

at Wandsworth since Mr Hughes death. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

25. On 18 December 2021, Mr Lee Hughes was remanded to HMP Wandsworth. He had served a number of prison sentences in the past.

26. When Mr Hughes arrived, a nurse conducted an initial health screen. She remembered Mr Hughes from previous periods in custody at Wandsworth and said that he looked well. Mr Hughes told her that he drank about 140 units of alcohol a week, around ten times the weekly consumption recommended by the NHS. He took a drugs test and tested positive for cocaine, cannabis, benzodiazepines and opiates. The test was negative for methadone and amphetamines. She recorded a Clinical Opiate Withdrawal Scale (COWS, a test to identify the extent to which an individual is withdrawing from opiates) score of 13, which indicated moderate withdrawal. She also recorded a Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar, to identify the extent to which an individual is withdrawing from alcohol) of 13, which indicated mild alcohol withdrawal. She referred Mr Hughes to see a prison GP.

27. Later that day, a prison GP assessed Mr Hughes, who told him that he smoked about £30 worth of heroin a day, occasionally used crack cocaine and drank two bottles of wine a day. Mr Hughes told him that he had a regular prescription of 30mg of diazepam (a benzodiazepine used to treat a range of conditions including alcohol withdrawal). He concluded that Mr Hughes had alcohol dependence syndrome. He prescribed Mr Hughes a low dose of methadone (10ml/mg), for opiate withdrawal, and vitamin B1 (thiamine), for alcohol withdrawal. (The methadone prescription would be slowly increased over the following days.) He said that he did not think that Mr Hughes required diazepam that night but said that further consideration would be made of Mr Hughes' records the following day. He said that he was concerned that Mr Hughes might be over-sedated if he had benzodiazepines that night. He planned to prescribe diazepam later in the week.

28. Prison staff allocated Mr Hughes a single cell on E Wing, the first night and induction unit.

29. On 19 December, a pharmacy technician assessed Mr Hughes in his cell. She recorded that Mr Hughes was well known to the prison and that he had a community prescription for diazepam to manage the symptoms of alcohol withdrawal. She noted that methadone was prescribed for him on arrival, plus benzodiazepines and Librium (for alcohol withdrawal). (This entry appears to be incorrect and there is no evidence that either benzodiazepines or Librium had been prescribed at this time.) She recorded that she could not locate a summary care record (GP service medical record) for Mr Hughes.

30. On 20 December, a prison GP saw Mr Hughes because he told the nurse that his slowly increasing dose of methadone (currently at 15ml) was not enough. He recorded that Mr Hughes told him that he was prescribed 40ml methadone in the community. He noted that Mr Hughes' urine drug screen detected no methadone and had indicated that Mr Hughes used heroin and not methadone. He completed a COWS score, which was seven and which indicated mild opiate withdrawal. He decided to increase the methadone dose to 30ml, in 5ml increments.

31. Later that day, a worker from Change Grow Live (CGL, providers of psychosocial substance misuse services) completed an initial assessment. Mr Hughes told her that he had not engaged with a community drug and alcohol team. (This contradicted what he had previously said about community engagement.) Mr Hughes said that he would work with the team. She added Mr Hughes to the list to be allocated a CGL worker.

32. On the same day, Mr Hughes was prescribed diazepam (for alcohol withdrawal).

33. On 21 December, Mr Hughes received 25ml of methadone.

34. On 22 December, Mr Hughes received 30ml of methadone and a total dosage of 16mg of diazepam. A nurse recorded COWS and CIWA-Ar scores of two, both of which indicate minimal withdrawal symptoms.

35. On 23 December, Mr Hughes received 30ml of methadone and 14mg of diazepam. (It is unclear why Mr Hughes received a smaller dose of diazepam than the previous day.)

36. The lead prison GP, who also works part-time as a substance misuse specialist GP, and the worker from CGL assessed Mr Hughes. The GP said that he saw Mr Hughes because nurses on the wing thought that Mr Hughes appeared sedated and may have taken illicit drugs. (There is no further information in the medical records explaining how they reached this conclusion.) He said that Mr Hughes walked into the room and appeared lucid for the first ten minutes of the consultation. He said that Mr Hughes' focus was on obtaining an increase in his methadone to 40ml per day. He said that Mr Hughes was quite aggressive with him, and he was concerned that he may be assaulted. He said that he wanted to gather objective evidence about Mr Hughes' withdrawal and manged to take his pulse, which was normal. Mr Hughes told him that he had other symptoms of withdrawal including stomach cramps, but he refused treatment to relieve these. He said that they both observed tremors in Mr Hughes which stopped when he was distracted so they could have been exaggerated. He said that during the review Mr Hughes appeared drowsy and he said that this was due to a poor night's sleep. He declined Mr Hughes' request to increase his methadone prescription. Neither the GP nor the worker from CGL referred Mr Hughes for a drugs test despite the nurses' concerns that he had taken illicit drugs.

Events of 24 and 25 December

37. At 9.44am on 24 December, a medical technical officer gave Mr Hughes his morning medication, including methadone. He said that he could not clearly remember giving Mr Hughes his medication but thought that he must not have had any concerns as he did not make a note on the medication chart.

38. In the afternoon, Mr Hughes did not attend the medication hatch for his diazepam and thiamine. The pharmacy technician tried to administer the medication three times between 2.00pm and 6.00pm.

39. At 6.00pm, the pharmacy technician and the medical technical officer went to Mr Hughes' cell with an officer to try to give him his medication. They shouted to him through the door but got no response. The medical technical officer said that the

officer opened the door, they shouted to him from the doorway, but there was still no response. He told us that he thought that Mr Hughes was asleep. The medical technical officer said that because Mr Hughes' medication was on the 'critical medication list' he informed the duty nurse. He said that he told the nurse that they had been unable to give Mr Hughes his medication because he was asleep, so they added a 'task' on the medical record for this to be completed. It is unclear if they told the nurse that they had tried several times to see Mr Hughes, and it appears that the nurse was being asked to ensure that the task was completed rather than that they were concerned that Mr Hughes was unresponsive.

40. Later in the evening, Nurse A noted that at 8.42pm, 8.47pm and 8.55pm, she attempted to give Mr Hughes his medication. (She made these entries in Mr Hughes' medical records at 6.05am on 25 December.) She said that she looked through the cell door observation panel and could see Mr Hughes sitting upright on his bed and breathing, but that he did not respond to her.

41. At 9.10pm, two nurses went back to Mr Hughes' cell with an officer. Nurse A said that the officer opened the cell door and that she entered the cell and called Mr Hughes' name. She said that she saw Mr Hughes in the same position as she had previously seen him, and that he opened his eyes briefly and then closed them. She said that Mr Hughes was not having difficulty breathing and he was not sweating. Nurse B said that he stood at the cell door and did not enter. The nurses said that they were aware that Mr Hughes was a potential risk to female staff and could be threatening and abusive to staff. They also said that prisoners frequently refused to engage. The nurses said that they did not consider assessing his vital signs or trying to record a formal assessment of his level of consciousness. Nurse A was not aware that nurses had earlier recorded that Mr Hughes appeared intoxicated.

42. At about 9.30pm on 24 December, an Operational Support Grade (OSG) carried out the night roll check on E Wing. He said that he saw Mr Hughes standing in his cell with a vape pen in his hand. He said that Mr Hughes appeared drowsy. He did not speak to Mr Hughes.

43. At about 4.45am on 25 December, the OSG went back to Mr Hughes' cell as part of his morning roll check. He saw Mr Hughes through the observation panel sitting on the bed, leaning against the wall with his legs off the bed and his head leaning on his right shoulder. He said that he initially thought that Mr Hughes was asleep. He saw that Mr Hughes had a vape pen in his right hand and noticed a white discharge from the right side of his mouth. He knocked on the door to wake Mr Hughes, but he did not respond. He then radioed for other staff to come to the cell. He said that he did not radio a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing) because he did not think that Mr Hughes had a "big problem", and he did not think he was unconscious or dead. He said that because there had already been a medical emergency in the prison that night, he wanted to ensure he was vigilant to any further potential incidents, which was why he asked the response team to attend.

44. A Custodial Manager (CM), and two officers went to Mr Hughes' cell from C Wing where they had been dealing with another medical emergency. (The officers responded to a prisoner hanging in his cell and had carried out cardiopulmonary

resuscitation until the arrival of ambulance paramedics, who confirmed that the prisoner had died.)

45. Officer A saw Mr Hughes sitting on the bottom bunk with his back to the wall, slumped forward. Officer B said that he saw Mr Hughes sitting on his bed and it looked like he had fallen asleep while watching the television, which was on. The officers knocked and kicked the cell door but did not get any response. Officer A opened the cell door and held Mr Hughes' right forearm and found that it was cold to touch. Officer B said that Mr Hughes' arm was very cold and that when he shook him there were no signs of life. The officers lifted Mr Hughes out of the cell and onto the landing. Officer A started chest compressions.

46. Nurse B went to Mr Hughes' cell and found that Mr Hughes was unresponsive, not breathing, was pale and had blue lips and fingers. He was unable to record a blood oxygen saturation reading. He gave Mr Hughes two doses of naloxone.

47. Ambulance paramedics went to Mr Hughes' cell directly from the incident on C Wing. At 5.07am, an ambulance paramedic confirmed that Mr Hughes had died.

Contact with Mr Hughes' family

48. After Mr Hughes died, two officers from HMP Swansea went to his mother's address in Swansea. A neighbour told the officers that Mr Hughes' mother had died, but that his sister lived nearby. The officers went to Mr Hughes' sister's home and told her that he had died.

49. Mr Hughes' funeral took place on 31 March. The prison contributed to its cost in line with national instructions.

Support for prisoners and staff

50. After Mr Hughes' death, the Head of Operations 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.

51. The governing governor posted notices informing other prisoners of Mr Hughes' 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 Hughes' death.

Post-mortem report

52. A post-mortem examination established that Mr Hughes died from methadone and benzodiazepine misuse.

53. Toxicology tests showed that Mr Hughes had 25 ug/ml of methadone in his blood and benzodiazepine in his urine. This level of methadone is considered to be potentially fatal in those without a tolerance. The report notes that use of other drugs with methadone, especially those that depress respiration (such as benzodiazepines), increases the risk of death.

Inquest

54. At an inquest held between 26 and 29 February 2024, the Coroner concluded that Mr Hughes death was drug related misadventure contributed to by neglect. The Coroner completed a Regulation 28: Report to prevent future deaths. She was concerned that:

- Clinicians were relying too heavily on what patients told them (symptoms) rather than looking for evidence (physical signs) of withdrawal. She said that objective signs of withdrawal should be used to determine whether methadone should be prescribed rather than the COWS score which contains many subjective factors and may be more easily manipulated by a prisoner.

- That prescribing of drug treatments for withdrawal should only be undertaken by substance misuse practitioners, who should therefore be more experienced as to when, whether and how much to prescribe.

- That guidelines are followed without sufficient consideration as to whether they apply to the individual patient.

- That practitioners when prescribing consider whether time spent in custody prior to remand may have reduced an individual's tolerance to opiates, especially when methadone is to be prescribed with a synergistic agent such as benzodiazepine.

- That methadone should be withheld and or reduced if the patient/prisoner is showing signs of sedation.

- That there should be tests available for illicit drugs for near patient testing to allow a clinician to better assess a patient showing signs of intoxication.

Findings

Clinical care

Prescribing

55. Mr Hughes had a long history of substance misuse and dependence. The clinical reviewer found that he provided particularly difficult challenges for prison healthcare management. Mr Hughes gave healthcare staff different accounts of his history and any background information he gave was therefore unreliable. He was not registered with a community GP and had not engaged with community health or drug services. This made it difficult for healthcare staff to rely on what he told them and to check his community prescribing. Healthcare staff were unable to find a summary care record for him.

56. At his initial health screen on 18 December, Mr Hughes' CIWA-Ar score was 13. The clinical reviewer found that he should have been offered a benzodiazepine that night for alcohol withdrawal. Instead, Mr Hughes was not given a benzodiazepine until 20 December. The clinical reviewer also identified that the approach to the management of Mr Hughes' benzodiazepine regime was unclear, and decisions were sometimes made based on limited information.

57. The clinical reviewer found that a prison GP's agreement to incrementally increase Mr Hughes' methadone was appropriate and that the dose prescribed was within guidelines. She found that another GP appropriately declined Mr Hughes' request to increase his prescription on 23 December, when his symptoms did not warrant the requested change. However, the clinical reviewer identified that healthcare staff should have arranged a urine drug screen, given that Mr Hughes had symptoms of intoxication at this time.

58. The clinical reviewer did not identify any significant omissions or failings in how Mr Hughes' substance misuse was managed at Wandsworth. Nonetheless, the post-mortem report concludes that his death was due to methadone and benzodiazepine toxicity. We do not know if Mr Hughes had obtained either methadone or benzodiazepines illicitly in the days before his death and no other substances were found in his body post-mortem.

Events of 24 December

59. During the afternoon and evening of 24 December, healthcare staff made seven attempts to give Mr Hughes his medication at his cell. On each occasion he did not respond to them, despite them having shouted and gone into the cell to try to speak to him.

60. The clinical reviewer found that it would have been appropriate to attempt to assess and record Mr Hughes' vital signs, with the minimum of a pulse check and level of consciousness assessment. Instead, healthcare staff appeared to assume that Mr Hughes was deliberately ignoring them rather than making a judgement based on clinical assessment and in consideration of the length of time that they had attempted to engage with him. It is concerning that no one appeared to consider that Mr Hughes might have been suffering the effects of drug intoxication.

61. The clinical reviewer found that this part of Mr Hughes' clinical care was not equivalent to that which he could have expected to receive in the community.

62. We make the following recommendations:

The Head of Healthcare should ensure that staff prescribe benzodiazepines for alcohol withdrawal when it is clinically appropriate and clearly consider and record all relevant information and decisions relating to withdrawal symptoms and prescribing.

The Head of Healthcare should ensure that staff take appropriate action when a prisoner appears to be intoxicated, including arranging for a drug screen when indicated.

The Head of Healthcare should review the non-attendance policy to;

- **clarify what is expected of all levels of healthcare staff if they cannot get a response from a prisoner when a critical medication is due; and**
- **ensure that staff record failed attempts to medicate prisoners in the medical records.**

Support for staff

63. The response officers who attended Mr Hughes' cell came immediately from another medical emergency in which they had tried to resuscitate a prisoner who died. Soon after Mr Hughes' death, they had to respond to another medical emergency, which did not result in a death. It is extremely rare for prison staff to experience two sudden deaths at a prison on one day. Before prison and healthcare staff left the prison at the end of their shift, a governor held a comprehensive debrief of the events of the night shift. We are satisfied that suitable levels of support were offered to the prison and healthcare staff and commend the staff who attended the scene for their efforts to help Mr Hughes and other prisoners that night.

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