Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of Mr Finlay Finlayson, a prisoner at HMP Lewes, on 25 January 2019

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

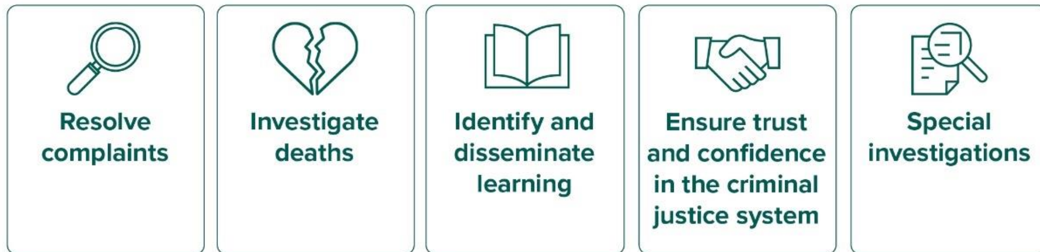
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100

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

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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 Finlay Finlayson died on 25 January 2019 at HMP Lewes as a result of a blocked blood vessel in his lungs. He was 54 years old. I offer my condolences to Mr Finlayson's family and friends.

Mr Finlayson had been diagnosed with cancer before he arrived at Lewes, although it appears it had been treated successfully. He had only been at the prison for a month before he died. The clinical reviewer is satisfied that the clinical care Mr Finlayson received at Lewes was equivalent to that he could have expected to receive in the community. She did, however, have some concerns, which I share, that healthcare staff had not obtained his community GP records and had not drawn up care plans for his mental and physical health needs.

I am also concerned that Mr Finlayson's family had already found out about his death, from his solicitor, before the prison had informed them.

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 **October 2019**

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Summary

Events

1. On 27 December 2018, Mr Finlay Finlayson was remanded into custody at HMP Lewes after being charged with attempted murder.

2. Mr Finlayson had a history of mental illness and had been treated for cancer before he arrived at Lewes. His life expectancy was not known but he had said that he did not want to be resuscitated if his heart or breathing stopped.

3. Mr Finlayson was initially located on the healthcare wing due to concerns about his mental and physical health. He requested a move to a standard wing and, when his mental health improved, he was moved to a standard wing.

4. On 25 January, a prison officer found Mr Finlayson had fallen in his cell and asked healthcare staff to see him. When Mr Finlayson's condition deteriorated, officers repeated this request and healthcare staff arrived promptly. Mr Finlayson was conscious but healthcare staff concluded that he needed a hospital assessment. Staff requested an emergency ambulance to take him to hospital.

5. Mr Finlayson then suffered a suspected cardiac arrest while healthcare staff were with him. They made no attempt to resuscitate him because of his wish not to be resuscitated. The ambulance crew arrived shortly afterwards and, at 9.16am, they pronounced Mr Finlayson dead.

Findings

Mr Finlayson's clinical care

6. The clinical reviewer is satisfied that the care Mr Finlayson received was equivalent to what he could have expected to have received in the community.

7. However, we share her concerns that healthcare staff did not obtain Mr Finlayson's community GP records and did not draw up care plans for his physical and mental health needs.

Emergency response

8. We are satisfied that prison staff acted appropriately when Mr Finlayson fell in cell and asked for help. Officers remained with him until healthcare staff arrived. Healthcare staff then observed him while waiting for an ambulance. Staff then respected his wishes not to be resuscitated when he went into cardiac arrest.

Liaison with Mr Finlayson's family

9. Mr Finlayson had been due to appear in court via videolink on the day he died. When the court contacted the prison to ask them to start the videolink, an officer told them that Mr Finlayson had died. This information was relayed to Mr Finlayson's solicitor, who contacted the family. This meant that by the time prison staff reached Mr Finlayson's family's address to break the news, they already knew.

Recommendations

- The Head of Healthcare should investigate why Mr Finlayson's electronic community GP medical records (from SystmOne) were not accessible to clinical staff and put arrangements in place to resolve the problem.
- The Head of Healthcare should ensure that patients with long-term physical health conditions are assessed, monitored and reviewed regularly, and that this is recorded.
- The Head of Healthcare should ensure that person-centred care plans are written and evaluated regularly.
- The Governor should ensure that when a prisoner dies in custody, staff handle this information sensitively and share only as appropriate, so that wherever possible, the family do not find out about the death before prison staff tell them in person.

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 him. No one responded.

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

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

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

14. The investigation has assessed the main issues involved in Mr Finlayson's care, including his diagnosis and treatment, whether appropriate palliative care was provided, his location, security arrangements for hospital escorts, liaison with his family, and whether compassionate release was considered.

15. One of the Ombudsman's family liaison officers contacted Mr Finlayson's sister to explain the investigation and to ask whether she had any matters the family wanted the investigation to consider. She asked us to consider whether Mr Finlayson's health had been managed appropriately, and raised concerns that he had not been seen by healthcare staff when he should have been. We have addressed those concerns in this report.

16. We shared a copy of our initial report with HM Prison and Probation Service (HMPPS). They identified a factual inaccuracy which has been amended in this report. They also clarified the circumstances in which Mr Finlayson's family found out about his death and as a result, we have amended that section of our report and one of our recommendations. HMPPS provided an action plan which is annexed to this report.

17. We sent a copy of our initial report to Mr Finlayson's sister. She did not identify any factual inaccuracies.

Background Information

HMP Lewes

18. HMP Lewes is a local prison which serves the courts of East and West Sussex and holds up to 692 prisoners. Sussex Partnership NHS Foundation Trust provides primary care services. HMP Lewes has a healthcare centre with a full time senior medical officer, which makes use of specialist NHS facilities when needed. Healthcare is provided on a 24-hour basis; there is a 12-bed inpatient unit, an outpatient facility, a pharmacy and a range of clinics.

19. Following an inspection by HM Inspectorate of Prisons in 2016, Lewes was placed on special measures and remains in special measures at the time of writing. ‘Special measures’ means that HM Prisons and Probation Service has determined that a prison needs additional, specialist support to improve performance.

HM Inspectorate of Prisons

20. The most recent 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 expressed their disappointment that in the three years since their last inspection, very few of their recommendations had been fully implemented. Inspectors also expressed their disappointment that few of the action points arising from the special measures action plan had been carried out. They indicated that unless this was resolved quickly, the urgent notification procedure might have to be considered.

21. Inspectors reported that there were inconsistencies in processing healthcare applications, particularly to see a GP. They noted that many prisoners were negative about healthcare provision and that 67% regarded the overall quality as quite bad or very bad. Inspectors reported that healthcare staff were positive about the new clinical leadership but that many teams were understaffed leading to delays.

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 January 2018, the IMB reported that staff shortages had forced the prison to operate a restricted regime. The Board noted that some staff went ‘the extra mile’ to help prisoners, but that there was an increasing shortage of experienced staff.

Previous deaths at HMP Lewes

23. Mr Finlayson was the ninth prisoner to die at Lewes since January 2017, four of these deaths were due to natural causes. There were no particular similarities between any of these earlier deaths and that of Mr Finlayson. We have previously made a recommendation about family contact but the circumstances of that were different.

Findings

Mr Finlayson’s relevant medical history

24. Mr Finlay Finlayson had a history of mental health concerns. In 1999, he was diagnosed with schizophrenia. This was recorded as well-controlled and, in February 2017, it was documented as inactive.

25. In 2016, Mr Finlayson was diagnosed with cervical lymph cell metastatic squamous cell carcinoma. (This is a cancer which has originated from an unknown source in the body and spread to the lymph nodes in Mr Finlayson’s neck.) In December 2016, he had surgery and in February 2017, he began chemotherapy and radiotherapy but did not complete the course. In June 2017, it was confirmed that there were no signs of cancer. It appears that he did not attend any of his follow up appointments in 2018.

26. In June 2018, Mr Finlayson completed a Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) order which remained in place until his death. This means that no attempt at resuscitation would be made if his heart or breathing stopped. All other appropriate treatment and care would continue to be provided.

27. On 24 December, armed police arrested Mr Finlayson on suspicion of attempted murder. They reported that he held a knife to his own neck during the arrest. They struck him with a baton to disarm him. Mr Finlayson was seen in A&E and found to have a superficial injury to his abdominal wall.

28. On 27 December 2018, Mr Finlay Finlayson was charged with attempted murder and remanded to HMP Lewes. The court directed that he should be located in the healthcare wing and assessed because of concerns about his mental health.

Mr Finlayson’s clinical care

29. A nurse reviewed Mr Finlayson at a health screen on his admission to Lewes. He recorded that Mr Finlayson had a small bruise to his abdomen, which he said was due to a rubber bullet. The nurse noted that Mr Finlayson had a malignant tumour, cancer in his throat and schizophrenia. He recorded that Mr Finlayson was to be located on the healthcare wing.

30. A prison GP re-prescribed the pain relief and antipsychotic medication Mr Finlayson had been receiving in the community. He was seen by healthcare staff every day when he collected his medication.

31. A healthcare administrator later recorded that Mr Finlayson had an appointment at Worthing Hospital booked for 25 March 2019. She noted that she rebooked the appointment as Mr Finlayson was aware of the date, and that she had tried to contact the Ear, Nose and Throat (ENT) Department to obtain his medical records but had received no reply.

32. On 29 December, a mental health nurse reviewed Mr Finlayson. She noted that on arrival at Lewes, he presented as being in pain, low in mood and with a poor appetite and sleep pattern. She observed that he was now engaging with staff, eating and drinking, and not expressing any intention to self-harm. The nurse

reviewed Mr Finlayson's previous mental health history, and noted that he had made threats to end his life at the time of his arrest. The next day, a mental health nurse recorded that Mr Finlayson had been heard intermittently shouting from his cell at unseen stimuli.

33. On 1 January 2019, a healthcare assistant saw Mr Finlayson. He told the healthcare assistant that his cancer caused him digestive problems and he often woke up with undigested food in his throat. He also said that he believed faeces were leaking out of his rectum and into his lung. The healthcare assistant recorded that Mr Finlayson had been in a variable mood with "sudden outbursts of expletives".

34. The following day, a nurse noted that he had rung his cell bell several times. She recorded that he had been observed deliberately lying on the floor of his cell but that he was unable to explain why. Later that day, a healthcare assistant noted that Mr Finlayson had been frequently heard in his cell shouting or making unusual gestures.

35. Also on 2 January, a healthcare administrator asked the ENT Department at the hospital for Mr Finlayson's records.

36. On 3 January, a psychiatrist reviewed Mr Finlayson. The psychiatrist noted that he engaged well, with good eye contact. He recorded that Mr Finlayson had no suicidal or homicidal thoughts or intentions. Later, a prison GP saw Mr Finlayson and noted that he had an active DNACPR in place and was happy for this to continue. He recorded that Mr Finlayson had an appointment for his cancer at Worthing Hospital in April. The following day, a prison GP requested the medical notes about to Mr Finlayson's cancer and treatment and a healthcare administrator confirmed that she had asked for them.

37. Healthcare staff continued to monitor and review Mr Finlayson on the healthcare unit, for both his physical and mental health concerns. These interventions were recorded in Mr Finlayson's medical notes.

38. On 7 January, a psychiatrist reviewed Mr Finlayson. The psychiatrist observed that he engaged well, with good eye contact, and looked relaxed. He noted that Mr Finlayson had no suicidal thoughts, and had a good insight and grasp of reality. The psychiatrist recorded that Mr Finlayson was fit for a normal cell location. Mr Finlayson was discharged from the healthcare unit and moved to a standard wing.

39. Also on 7 January, an employee at Mr Finlayson's community GP practice recorded in his electronic medical record that he had a prognosis of more than 12 months.

40. On 10 January, a mental health nurse reviewed with Mr Finlayson. He noted that Mr Finlayson was not experiencing any delusional or auditory hallucinations.

41. There were no further entries in Mr Finlayson's medical notes for the next nine days. On 19 January, a nurse saw Mr Finlayson after he complained of urine retention. He observed that his bladder was not enlarged but that he had slight pain at the tip of his penis. He advised staff to contact healthcare if there were any further concerns.

42. On 21 January, a nurse saw Mr Finlayson after he complained of severe abdominal pain. He said that he had not opened his bowels for a week, so the nurse gave him

a laxative and arranged for hourly checks during the night. No concerns were reported. The next morning, a prison GP saw Mr Finlayson in his cell. The GP noted that his pain had settled but prescribed a laxative.

43. On the morning of 24 January, an officer told Mr Finlayson that his scheduled family visit that afternoon had been moved to the morning. Mr Finlayson said that he did not feel very well and did not want to see his family. He told the officer that he was waiting to see a GP. The officer recorded that Mr Finlayson's "condition had deteriorated dramatically over the last few days", and that Mr Finlayson had told him that he kept falling in his cell. The officer noted that he spoke to the healthcare unit to chase up Mr Finlayson's GP appointment.

44. The clinical reviewer is satisfied that the clinical care Mr Finlayson received at Lewes, was equivalent to that which he could have expected in the community. However, she had the following concerns, which we share:

- It is not clear if prison healthcare staff had access to Mr Finlayson's community GP records.
- There were no plans in place to review Mr Finlayson's physical health needs.
- There is no evidence of any care plans to address Mr Finlayson's physical or mental health needs.

45. We make the following recommendations:

The Head of Healthcare should investigate why Mr Finlayson's electronic GP medical records (from SystmOne) were not accessible to clinical staff and put arrangements in place to resolve the problem.

The Head of Healthcare should ensure that patients with long term physical health conditions are assessed, monitored and reviewed regularly, and that this is recorded.

The Head of Healthcare should ensure that person-centred care plans are written and evaluated regularly.

Emergency response

46. On the morning of 25 January, Officer A was working on Mr Finlayson's wing. He recorded that he was walking past Mr Finlayson's cell at approximately 7.45am when he heard him ask for help. He looked through Mr Finlayson's observation panel and saw that he was lying on the floor very close to the cell door. He went to the wing office to get assistance and returned with two officers, including Officer B. Officer A tried to open the cell door but could not do so because Mr Finlayson was pressed against it. He asked Mr Finlayson to move away from the door so they could open it. Shortly afterwards, Officer A left to undertake other duties.

47. Officer B recorded that when she arrived, Mr Finlayson was on the floor with his head touching the door. He appeared to be in a lot of pain and was screaming for help. She recorded that between 7.37am and 7.45am, she requested assistance from healthcare staff by radio. Shortly after Officer A left, officers managed to open

the door and entered Mr Finlayson's cell. They helped Mr Finlayson onto his bed and then closed his cell while they unlocked the rest of the wing. Officer B remained outside the cell until this was completed but, after a couple of minutes, she re-entered Mr Finlayson's cell and remained with him. At about 7.50am, she asked a Supervising Officer (SO) to chase healthcare staff up.

48. Officer B recorded that shortly afterwards, Mr Finlayson asked to use the toilet in his cell. She cleared a way for him then turned her back for reasons of decency. She heard Mr Finlayson fall so she turned around to assist him and called to the SO for help. They managed to get a response from Mr Finlayson but Officer B observed that he was very short of breath.

49. The SO recorded that when healthcare staff did not arrive, he made a further call on the radio. At approximately 8.10am, he radioed for healthcare staff again and healthcare staff then called him back on the wing office phone. The SO explained the situation. Healthcare staff arrived at Mr Finlayson's cell at about 8.15am. The SO recorded that he discussed the situation with two nurses in his office, and the decision was made to send Mr Finlayson to hospital. The SO called the control room to request an emergency ambulance. The control room log records that an emergency ambulance was requested for Mr Finlayson at 8.45am.

50. Healthcare staff did not make an entry in Mr Finlayson's medical records about this incident. A healthcare incident report recorded that a radio call was received at approximately 7.50am requesting healthcare assistance for a prisoner who had fallen in his cell. In a statement, Nurse A recorded that she was working with Nurse B when, at approximately 8.00am, a radio call came through for a nurse to see Mr Finlayson after he had fallen. Nurse B attended while Nurse A continued with her duties. Nurse B observed that Mr Finlayson had a cut above his eyebrow, was confused and had an accelerated heart rate.

51. Nurse A recorded that at approximately 8.35am, she went to the wing to see whether Nurse B needed any assistance. When she arrived, she discussed Mr Finlayson's condition with officers and Nurse A. They agreed to send him to hospital to be assessed and officers requested an emergency ambulance at about 8.45am. Nurse B remained with Mr Finlayson to await the ambulance. Nurse A noted that she heard a 'cardiac-arrest' call over the radio at approximately 9.10am. She made her way back to Mr Finlayson's cell, collecting emergency equipment on the way. She noted that Mr Finlayson had stopped breathing and had no pulse. Nurse A recorded that Mr Finlayson had a valid DNACPR on his cell door, so no resuscitation was attempted.

52. The ambulance crew arrived at Mr Finlayson's cell shortly afterwards at 9.14am. At 9.16am, they pronounced Mr Finlayson dead.

53. The post-mortem concluded that Mr Finlayson died from a pulmonary thromboembolism (a blocked blood vessel in his lungs).

54. We are satisfied that when staff first saw that Mr Finlayson had fallen in his cell, he did not appear to require emergency attention. Prison staff remained with him and chased healthcare staff when his condition deteriorated. Healthcare staff appropriately monitored Mr Finlayson while they waited for the ambulance. When Mr Finlayson went into cardiac arrest, the decision not to resuscitate was in keeping with his wishes and was appropriate.

Mr Finlayson's location

55. Mr Finlayson was appropriately located in the healthcare unit when he first arrived at Lewes. On 28 December, an occupational therapist reviewed him. She noted that his mental state was settled but that he had mobility issues. She recorded that a joint approach would be necessary before Mr Finlayson could be relocated onto a standard prison wing. A nurse later observed that he was able to move about well during periods of association.

56. On 1 January, a healthcare assistant recorded that Mr Finlayson wanted to leave the healthcare wing and live on a standard wing. Over the next few days Mr Finlayson repeated his request to move to a cell on a standard wing.

57. On 7 January, a psychiatrist assessed Mr Finlayson and considered him suitable for a standard location. He was discharged from the healthcare unit and moved to a standard wing. On 10 January, Mr Finlayson told a nurse that he was struggling to share a cell. On 15 January, he was moved to a single cell on the wing.

58. We are satisfied that Mr Finlayson was appropriately located during his time at Lewes. The prison initially located him in the healthcare unit, but respected his wishes to move to a standard wing once it was safe to do so. Staff appropriately moved Mr Finlayson to a single cell after he requested this.

Liaison with Mr Finlayson's family

59. On the day Mr Finlayson died, he was due to appear in court via videolink. When the court contacted the prison to ask them to start the videolink, an officer told them that Mr Finlayson had died. This information was relayed to Mr Finlayson's solicitor, who contacted the family to pass on their condolences.

60. Mr Finlayson's next of kin was his sister. After his death, the prison appointed a family liaison officer (FLO).

61. At 1.46pm, the FLO and a prison chaplain visited Mr Finlayson's sister at her house. Mr Finlayson's sister told them that she already knew that her brother had died because Mr Finlayson's solicitor had informed her. The FLO said that he had wanted to make sure he had the correct information before visiting.

62. On 1 February, the Governor, the FLO and a prison chaplain met Mr Finlayson's sister at the prison. The prison chaplain conducted a religious service for her in Mr Finlayson's cell.

63. Mr Finlayson's funeral was held on 22 February. The prison contributed to the costs in line with national guidance.

64. Prison Service Instruction (PSI) 64/2011, Safer Custody, says, "Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source."

65. We are concerned that Mr Finlayson's family knew of his death by the time prison staff reached them to break the news in person. We accept that the circumstances

were difficult and unusual, in that Mr Finlayson was due to appear in court that day and the court wanted to know why he was not present at the videolink as arranged. We consider that the prison would have had to tell court staff that Mr Finlayson had died, but that they should have made it clear to them that Mr Finlayson's next of kin had not yet been informed of his death and that this information should be treated as confidential until his family had been told. We make the following recommendation:

The Governor should ensure that when a prisoner dies in custody, staff handle this information sensitively and share only as appropriate, so that wherever possible, the family do not find out about the death before prison staff tell them in person.

Compassionate release

66. Prisoners can be released from custody before their sentence has expired on compassionate grounds for medical reasons. This is usually when they are suffering from a terminal illness and have a life expectancy of less than three months. Prisoners on remand, like Mr Finlayson, can be considered for release on bail in similar circumstances. Mr Finlayson had a prognosis of more than a year and we are satisfied that there was no necessity for the prison to have considered release on bail.

67. Mr Finlayson was still on remand at the time of his death, and so compassionate release was not considered. We are satisfied that this was appropriate.

Inquest

68. At the inquest, held on 19 March 2024, the jury reached a narrative verdict:

"We the jury consider that Vinney's care was affected by the following issues, the absence of which may have delayed or changed the circumstances of his death. There was confusion and uncertainty about his medical conditions caused by information sharing and permissions issues with SystmOne, leading to an over reliance on Vinney's own statements. Some poor record keeping on SystmOne and confusion over when to reference the system. This affected both plans and reporting of interactions. Failures in communication between agencies and shifts, not helped by the numbers of different staff and agencies involved, high demand and challenging workloads and associated delays in accessing healthcare. This was particularly relevant between 21 and 24 January 19. In particular we note: a lack of quantifiable evidence, e.g. NEWS scores or notes of proportionate follow-ups and recorded observations between 21 and 24/1/19 which may have allowed any deterioration in Vinney's condition to be missed. On 25/1/19 there was a grave and unacceptable failure in communications with two or three emergency radios switched off in contravention of prison rules and protocols. This was then compounded by a delay in timely response, i.e. the proposal of a phone call rather than an in-person response, which may have been longer had it not been for decisive intervention from comms. This was followed by unacceptable indecision on calling an ambulance, in which perceptions of Vinney's mental health were a factor, and should have been automatic on account of his head injury."

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Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
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T I 020 7633 4100