

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Craig Downes a prisoner at HMP Lindholme on 30 March 2016

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

Our Vision

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

Our Values

We are:

Impartial: *we do not take sides*

Respectful: *we are considerate and courteous*

Inclusive: *we value diversity*

Dedicated: *we are determined and focused*

Fair: *we are honest and act with integrity*



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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 Craig Downes died in hospital on 30 March 2016, from drug toxicity, ten days after staff found him collapsed in his cell at HMP Lindholme. He was 37 years old. I offer my condolences to Mr Downes' family and friends.

Mr Downes had end stage kidney disease and a history of substance misuse, which apparently continued in prison. Although he often did not cooperate with his treatment, I am satisfied that he received a good standard of care at Lindholme.

There was a delay in calling an ambulance when staff found Mr Downes collapsed, but I am satisfied that this did not affect the outcome for Mr Downes and note that the Governor has subsequently issued an instruction to staff about the importance of calling an ambulance immediately in a medical emergency.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2016

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Summary

Events

1. In August 2007, Mr Craig Downes was remanded to prison, charged with grievous bodily harm. In January 2008, he received an indeterminate sentence for public protection. He had been at Lindholme since 26 February 2015.
2. Mr Downes had been diagnosed with acute kidney failure in 2003. He received dialysis in hospital, three times a week, but often terminated or refused treatment. He had a long history of substance misuse and numerous prison intelligence reports indicated that he used and traded prescription medication and illicit drugs such as 'Spice', a new psychoactive substance. He denied recent drug use and declined help from the substance misuse service.
3. Prison GPs initially prescribed Mr Downes tramadol for pain relief but replaced it September 2014, with another painkiller because of potential misuse and because he began to have seizures, which tramadol can exacerbate. Mr Downes repeatedly asked to be prescribed it again, but doctors explained why it was unsuitable because of the risks to his health.
4. At lunchtime on 20 March 2015, officers found Mr Downes collapsed on the floor of his cell, and called a medical emergency. After a few minutes, he regained consciousness. A nurse suspected that he had taken drugs. After initially denying this, he admitted that he had taken illicitly obtained tramadol. He was taken to hospital and had surgery the next evening to help his breathing. Mr Downes did not regain consciousness after the operation, and died on 30 March.

Findings

5. Staff at Lindholme worked cooperatively to help Mr Downes address his substance misuse problems. The security team shared information with other prison staff involved in his management and his offender manager. Healthcare staff referred him to the substance misuse service and explained to him why they had stopped prescribing tramadol. We are satisfied that Mr Downes received appropriate care at Lindholme for his medical and substance misuse problems. We do not consider that staff at Lindholme could have prevented his death.
6. Contrary to required emergency procedures, communications room staff did not call an ambulance immediately after they received a medical emergency code. Although this did not affect the outcome for Mr Downes, there was a delay of nine minutes before an ambulance was called. In other cases, such a delay could be critical. We have not made a recommendation about this, as the Governor subsequently issued detailed instructions to staff on the procedures to follow in medical emergencies.
7. Mr Downes was fully conscious and mobile when he went to hospital on 20 March, so escort staff used single handcuffs. On 21 March, a prison manager completed a fresh security risk assessment and reduced restraints to an escort chain. Restraints were removed before Mr Downes had surgery that evening and were not reapplied. We are satisfied that this was reasonable.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP Lindholme informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
9. The investigator obtained copies of relevant extracts from Mr Downes' prison and medical records.
10. NHS England commissioned a clinical reviewer to review Mr Downes' clinical care at the prison.
11. We informed HM Coroner for South Yorkshire (East District) of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. One of the Ombudsman's family liaison officers contacted Mr Downes' grandmother, who he had named as next of kin, to explain the investigation. His grandmother had no questions or concerns for the investigation to consider.
13. We shared the initial report with the Prison Service and they found no factual inaccuracies.
14. Mr Downes' grandmother received a copy of the initial report. She did not make any comments.

Background Information

HMP Lindholme

15. HMP Lindholme is a medium security prison near Doncaster, which holds approximately 1,000 men. Nottinghamshire Healthcare Foundation NHS Trust provides healthcare services. These include a daily GP clinic and some specialist services.

HM Inspectorate of Prisons

16. The most recent inspection of HMP Lindholme was in February 2013. Inspectors reported some significant problems at the prison. The availability and use of illicit drugs was high. Actions to address this were poor, partly due to the lack of involvement of the treatment services in the strategy to reduce supply and use. However, they found that healthcare provision was reasonably good, with a range of services that met prisoners' needs.

Independent Monitoring Board

17. 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 2016, the IMB were concerned about the supply and use of drugs, particularly the increasing use of new psychoactive substances (NPS). Although healthcare staffing had been problematic, the Board was satisfied that medical care was adequate.

Previous deaths at HMP Lindholme

18. There have been six deaths at Lindholme since the beginning of 2015. Of those we have already investigated, there were no significant similarities with the circumstances of Mr Downes' death.

New psychoactive substances (NPS)

19. NPS are an increasing problem across the prison estate. They are difficult to detect, as they are not identified in current drug screening tests. Many NPS contain synthetic cannabinoids, which can produce experiences similar to cannabis. NPS are usually made up of dried, shredded plant material with chemical additives and are smoked. They can affect the body in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Psychological effects can include psychosis and hallucinations, depression and suicidal thoughts, antisocial or paranoid behaviour and emotional and erratic behaviour.
20. In July 2015, we published a Learning Lesson Bulletin, which identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies because of the links between NPS and debt and bullying.

Key Events

21. On 25 August 2007, Mr Craig Downes was remanded to HMP Doncaster, charged with grievous bodily harm and subsequently convicted. On 18 January 2008, he received an indeterminate sentence for public protection, with a minimum period to serve of three and a half years. The Parole Board had never considered he was suitable for release.
22. In 2003, Mr Downes had been diagnosed with end-stage kidney failure. He continued to receive dialysis three times a week at hospital.
23. Mr Downes had a history of substance misuse, which apparently continued in prison. Staff submitted numerous security reports about his poor behaviour in prison, including trading and misusing illicit drugs such as 'Spice', a new psychoactive substance (NPS). He was often uncooperative with his medical treatment including refusing procedures, being abusive to hospital and escort staff, and reducing the length of his dialysis by discharging himself from hospital, against medical advice. In 2013, he ran away from hospital after receiving dialysis and was found several hours later. He sometimes contrived to be admitted to hospital by aggravating his condition, such as by drinking excess water.
24. On 29 January 2014, a psychiatrist assessed Mr Downes' capacity to make decisions about his treatment and to help hospital staff produce a behavioural agreement with the aim of improving his compliance with treatment. He found no major mental illness or any reason why he could not honour decisions about his treatment.
25. Mr Downes' had frequent contact with prison healthcare staff, as he took several prescribed drugs, including warfarin (a blood-thinning medication), which required regular monitoring. He spent some periods in hospital as an inpatient. During 2014, Mr Downes had several seizures. Doctors referred him to a neurologist, who was unable to determine the cause. The seizures continued throughout his time in prison.
26. In September 2014, doctors stopped Mr Downes' prescription of tramadol (an opioid painkiller which is often traded and misused by prisoners) as they had caught him trying to conceal it several times. They gave him amitriptyline as an alternative. On 16 December, Mr Downes asked a prison GP to re-prescribe tramadol, and the doctor explained the reasons against this. On 27 January 2015, after further requests and formal complaints, a GP and a nurse prescriber and pain specialist jointly reviewed Mr Downes. They explained that, although tramadol remained an option, it was not the best one for him, as it was unsuitable for people who suffer from seizures. They could not agree to change back to tramadol, particularly as he had refused to try the full dose of amitriptyline.
27. On 26 February 2015, Mr Downes transferred to HMP Lindholme. At his initial health screen, a healthcare worker noted his medical conditions, prescriptions and outstanding hospital appointments. Mr Downes told her he had misused drugs in the past, but not currently. He declined to be referred to the prison's substance misuse service. (Security reports suggested that Mr Downes' misuse of drugs continued at Lindholme.)

28. The next day, a prison GP reviewed Mr Downes' medical record. For the benefit of other healthcare staff, he recorded a description of Mr Downes' diagnosis of Goodpasture's Syndrome, a rare autoimmune disease in which the immune system attacks the lining of the kidneys and lungs. He also noted his history of poor cooperation and drew attention to a GP's review of Mr Downes' pain relief. Mr Downes' prison and medical records at Lindholme noted his persistent poor behaviour during treatment.
29. On 3 August, while receiving dialysis, Mr Downes asked to see his hospital consultant and said that he was still in pain. He said that at Doncaster prison he used to receive 200mg of tramadol before his dialysis, which had been effective in controlling his pain. The consultant wrote to the prison stating that he was content for prison doctors to prescribe 200mg of tramadol on alternate days or, alternatively, refer him to the pain clinic for advice on his management.
30. A prison GP noted that there had been several reliable intelligence reports that Mr Downes had been using Spice and other drugs and he had had several seizures. On 10 August, he held a multidisciplinary meeting, which included a member of the substance misuse service, to assess Mr Downes' pain and seizures and to offer support for substance misuse. The GP told him that tramadol was unsuitable, as it could make his fits worse or more frequent. He explained their concerns about his drug use and warned him about the risks to his health. Mr Downes admitted that he had been caught with a package of Spice in the visits hall, but said that he had not used Spice recently. The GP agreed to refer him to a neurologist to investigate his seizures and to contact the renal unit about his dialysis and safe medication options.
31. On 14 August, a prison GP wrote to the hospital consultant for advice about Mr Downes' reported seizures and falls, and the prescription of tramadol. The consultant replied on 1 September, advising the GP to refer Mr Downes to the neurology department and the pain clinic. Because of the possibility of misuse and addiction, he advised that Mr Downes should only take tramadol dispensed to him by hospital staff immediately before his dialysis sessions.
32. On 12 November, a neurologist at the hospital assessed Mr Downes and asked the prison for further details about his seizures. (The prison GP sent these details on 5 February 2016.) The neurologist referred Mr Downes to a consultant cardiologist.
33. Because of continuing concern about Mr Downes' drug use, healthcare staff referred Mr Downes to the substance misuse service again. On 3 February 2016, a worker from the substance misuse team assessed him and Mr Downes admitted to taking various illicit drugs in the past. However, he told her that since he had been in prison he had only used Spice for five months in 2012. They discussed the dangers of Spice, at length, and the risks of overdose from different drugs. Mr Downes declined treatment and discharged himself from the service.
34. On 4 February, a nurse and Mr Downes discussed his pain management. She noted that he was very vague about his symptoms. He mainly spoke about his need for tramadol and would not consider other forms of pain relief. She told him she would not recommend tramadol because of his fits. He became angry and

demanded a complaint form. That day, he made another formal complaint about pain relief and not being prescribed tramadol. A reply on 26 February, noted that staff had placed him on the GP list to review this and that he was already on the pain management waiting list.

35. Just before midday on 20 March, prisoners collected their lunch and officers locked them in their cells. Shortly afterwards, two officers started a routine security count to establish all prisoners were present on the wing. In a statement for the prison, one officer said that he had looked through the observation panel in Mr Downes' cell door and saw that he was unsteady on his feet. Mr Downes did not respond when he asked him if he was okay. He decided to finish checking the other cells and then go back to see Mr Downes.
36. When the officer checked Mr Downes again, he was slumped on the floor with his head resting against the wall. He called a colleague and they both went into the cell. Mr Downes snorted as he breathed, and twitched slightly. He said that he looked as though he had collapsed rather than fallen. His lunch was still on his plate and he had food around his mouth. He radioed a code blue emergency (which indicates circumstances such as when a prisoner is unconscious or not breathing).
37. A nurse, a pharmacy technician and more officers responded. The nurse noted in a statement and in his medical record that Mr Downes was sitting on his bed, disorientated. His blood pressure and pulse were high, his eyes were blood shot, pupils fixed and pin point and his speech was slurred. He vomited, had a nose bleed and his extremities were blue. Mr Downes then became more lucid. She suspected he had taken drugs but he repeatedly denied this. She then asked for an ambulance to be called. A little later, Mr Downes admitted to her that he had taken 200mg of tramadol, which he had obtained from another prisoner.
38. The ambulance arrived at the prison at 12.23pm. Paramedics noted that Mr Downes' cheek and tongue were swollen and he was finding it hard to swallow. They decided to take him to hospital. Prison staff completed an emergency risk assessment and healthcare staff indicated that there were no objections to the use of restraints. Mr Downes walked to the stretcher. Two officers accompanied him and used handcuffs to restrain him. At 1.02pm, the ambulance left the prison and arrived at the hospital at 1.21pm.
39. The following afternoon, a prison manager reviewed Mr Downes' risk and decided that the restraints should be reduced to an escort chain (a long chain with a light handcuff at each end, one of which is attached to the prisoner and the other to an officer).
40. At 6.20pm on 21 March, a surgeon told the escort officers that he intended to operate on Mr Downes shortly, to help his breathing. The officers removed the escort chain before he went for surgery and it was not used again. After the operation, Mr Downes was taken to the critical care unit, where he remained unconscious. When he came round briefly, hospital staff placed him in an induced coma.
41. Mr Downes did not recover and, on 29 March, his condition deteriorated. On the morning of 30 March, a nurse telephoned staff in the critical care unit, who

informed her that he was unlikely to recover and that he might die by the end of the day. Mr Downes died at 1.19pm that day. His family were with him at the time.

Contact with Mr Downes' family

42. On 21 March, the prison contacted Mr Downes' grandmother, who was due to visit him in prison the next day. They arranged for her to visit him in hospital instead. On 25 March, a Supervising Officer (SO) was appointed as the prison's family liaison officer and she spoke to Mr Downes' grandmother. Several members of his family visited him on 26 March.
43. On 30 March, when hospital staff informed the prison that Mr Downes' condition was deteriorating, the prison arranged transport to take his family to the hospital. A prison manager and the deputy family liaison officer arrived at the hospital after his death. He offered Mr Downes' family his condolences and support. He remained in contact with Mr Downes' grandmother, to return his property and discuss the funeral arrangements. In line with national policy, the prison contributed to the cost of Mr Downes' funeral, which was held on 14 April.

Support for prisoners and staff

44. While the SO was at the hospital, he debriefed the escort staff and offered his support and that of the staff care team.
45. The prison posted notices informing other prisoners of Mr Downes' death, and offering support.

Post-mortem report

46. The report of the post-mortem examination concluded that, on the balance of probabilities, the cause of Mr Downes' death was drug toxicity, with chronic kidney disease contributing to, but not causing his death. No toxicology tests were performed, as the hospital had disposed of the blood samples taken after Mr Downes' was admitted to hospital. The hospital had not tested for drugs. The pathologist noted that Mr Downes was at heightened risk of drug toxicity, as his chronic kidney disease would have impaired his ability to excrete drugs.

Findings

Clinical care

47. Mr Downes arrived at Lindholme in February 2015, with end-stage kidney failure that had been diagnosed 12 years before. The prison facilitated dialysis at a local hospital three times a week. Healthcare staff made appropriate arrangements for other routine healthcare appointments and referred him promptly for assessment by specialists when he experienced new symptoms, such as seizures. Mr Downes did not always cooperate with his treatment and had a difficult relationship with prison and hospital staff. He frequently stopped his dialysis before completing the cycle, interfered with the medical equipment, discharged himself from hospital against medical advice and manipulated admissions to hospital as an inpatient.
48. Pain management was a longstanding problem for Mr Downes. He initially received tramadol for pain relief, but doctors stopped prescribing it, and explained to him that it was unsafe for those prone to seizures. In spite of this, he continued to demand re-prescription of tramadol.
49. Mr Downes' misuse of drugs appears to have continued in prison. At his initial health screen when he arrived at Lindholme in 2015, he declined a referral to the substance misuse service. Several security intelligence reports indicated that he was involved in trading and using drugs, mostly Spice, a new psychoactive substance. (The prison's security manager said that an increasing volume of such drugs had been smuggled into the prison.) It was also reported that Mr Downes sought prescribed medication from other prisoners. Security staff shared this information with healthcare and wing staff and Mr Downes' offender supervisor.
50. In August 2015, a prison doctor convened a multidisciplinary meeting, including the substance misuse service. They warned Mr Downes of the danger of using illicit drugs and the risks to his health. In February 2016, a few weeks before his death, healthcare staff referred him to the substance misuse service. However, he discharged himself after the initial assessment meeting. After he collapsed on 20 March, Mr Downes admitted that he had taken tramadol obtained from another prisoner. The medical record of the other prisoner showed he received 200mg of tramadol daily and a security intelligence report completed a week before, suggested that he had been selling his medication.
51. We consider that Mr Downes received a good standard of healthcare at Lindholme, equivalent to that he could have expected in the community. We are satisfied that staff at Lindholme actively helped him to address his suspected substance misuse and could not have prevented Mr Downes' death.

Emergency response

52. Prison Service Instruction 3/2013 requires that governors must have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening medical emergency. The PSI explicitly states that when a medical emergency is called over the radio network, an ambulance must be called immediately and local procedures should ensure this. It says it

should not be a requirement for a member of healthcare staff or a manager to attend the scene before emergency services are called.

53. The communications room log noted several actions in response to Mr Downes' collapse. At 11.55am, there was a request for healthcare staff to go to Mr Downes' wing (the name of the person who made the request was not recorded). At 11.56am, an officer radioed a code blue emergency, stating that the supervising officer was at the scene. An entry, at 11.59am, noted that the officer would inform the communications room if an ambulance was needed. The next entry was at 12.11pm, when it was recorded that a second call had been made for an ambulance. The time of the first call was not logged, but the Ambulance Service record showed that they had received the call at 12.04pm.
54. Staff in the communications room did not telephone for an ambulance until eight minutes after the code blue call. The Head of Security acknowledged that an ambulance should have been requested immediately. Despite several requests in the first few weeks of our investigation, Lindholme was unable to supply evidence that they had a local medical emergency protocol at the time of the emergency, as PSI 3/2013 requires. However, on 9 May 2016, the Governor issued guidance in Notice to Staff 38/2016, emphasising the key requirements in medical emergencies, particularly the need to call an ambulance immediately a medical emergency code is received.
55. We are satisfied that the delay in requesting an ambulance did not affect the outcome for Mr Downes, but in other emergencies such as delay could be critical. As the Governor has now issued up to date guidance to staff outlining their responsibilities during medical emergencies, we do not make a formal recommendation about this.

Use of restraints

56. When prisoners have to travel outside prison, a risk assessment determines the nature and level of security arrangements, including restraints. The Prison Service has a duty to protect the public but this has to be balanced with a responsibility to treat prisoners with humanity. Any restraints used should be necessary and decisions should be based on the security risk taking into account factors such as the prisoner's health and mobility. Decisions should be kept under review as circumstances change.
57. After Mr Downes collapsed, he regained consciousness and was able to walk to the ambulance stretcher. Officers initially used handcuffs to restrain him, but the restraints were reduced to an escort chain the next day. Restraints were removed before he had surgery later that evening and were not reapplied. We are satisfied that managers appropriately reviewed the need for restraints and removed them promptly.

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