Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Jamie Funnell, a prisoner at HMP Lewes, on 16 December 2023

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.

If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Jamie Funnell died of a heart attack caused by left ventricular hypertrophy and dilation (the left side of the heart becomes thicker and enlarged), coronary artery atherosclerosis (a condition where arteries become clogged with fatty substances), electrolyte disturbance (imbalances in body salts and minerals) owing to vomiting, and withdrawal from drugs and alcohol. He died on 16 December 2023, at HMP Lewes. He was 44 years old. I offer my condolences to his family and friends.

Mr Funnell died around 24 hours after arriving at Lewes. While his symptoms of alcohol withdrawal were initially managed well, several opportunities were missed in the last hours of his life to properly assess, monitor and treat what was a clear deterioration in his health.

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

Adrian Usher
Prisons and Probation Ombudsman **September 2024**

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Summary

Events

1. On 15 December 2023, Mr Jamie Funnell was remanded to HMP Lewes for assaulting an emergency worker. Mr Funnell had a history of substance misuse.

2. A nurse carried out Mr Funnell's initial health screen and noted that his physical observations were all within the normal range. Using recognised withdrawal assessments (known as CIWA-B and CIWA-Ar), she assessed Mr Funnell as having mild benzodiazepine withdrawal and minimal evidence of significant alcohol withdrawal. The nurse referred Mr Funnell to the substance misuse team. A nurse prescriber prescribed Mr Funnell diazepam as required and thiamine, both for alcohol withdrawal, and methadone for opiate withdrawal.

3. At 5.00am on 16 December, Mr Funnell pressed his cell bell. A nurse assessed him for alcohol withdrawal and found that his CIWA-Ar score now indicated moderate alcohol withdrawal. The nurse gave Mr Funnell diazepam.

4. At 9.20am, a substance misuse nurse reviewed Mr Funnell, who had nausea and was retching. The nurse did not record a CIWA-Ar score. He gave Mr Funnell anti-sickness medication. Later in the morning, Mr Funnell told an officer that he had vomited.

5. At about 2.00pm, the substance misuse nurse spoke to Mr Funnell through the cell observation panel. Mr Funnell said that he felt rough. The nurse was unable to complete a full clinical assessment because there was only one officer present on the wing, so in line with local protocols the cell door could not be opened.

6. At 4.00pm, the officer unlocked Mr Funnell who walked down the landing to see the substance misuse nurse and collapsed. The officer and a custodial manager (CM) helped him back to his cell, where he collapsed again. Mr Funnell became unresponsive and stopped breathing. The CM radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing).

7. Healthcare staff started cardiopulmonary resuscitation (CPR), inserted an airway, gave him oxygen and used a defibrillator. At 4.32pm, ambulance paramedics arrived and took over emergency life support. At 5.16pm, they confirmed that Mr Funnell had died.

Findings

8. The clinical reviewer concluded that the clinical care Mr Funnell received for alcohol withdrawal was not equivalent to that which he would expect to receive in the community.

9. No additional CIWA-Ar assessments were completed after Mr Funnell's initial development of alcohol withdrawal symptoms at 5.25am on 16 December. There was no objective assessment of the severity of Mr Funnell's clinical condition for much of the day until his collapse. Diazepam was not continued in line with local policy. On one occasion, a lack of staffing meant that a nurse could not conduct a

full assessment of Mr Funnell's symptoms. In combination, these factors meant that opportunities to act on Mr Funnell's potentially reversible clinical deterioration were missed.

10. The attending ambulance service paramedics were concerned with aspects of the CPR delivered by the healthcare staff.

Recommendations

- The Governor and Head of Healthcare should ensure that healthcare staff have entry to prisoner's cells on K Wing at the weekend, to allow face to face clinical assessments when required.

- The Head of Healthcare should ensure that the Standard Operating Procedure for Assessment and Management of Alcohol Dependence is revised, including that:

    - Staff are given clear guidance about how to manage alcohol withdrawal within 48 hours of arrival in custody;

    - Staff understand when and how to complete CIWA-Ar assessments and prescribe and provide medications including diazepam in line with clinical expectations.

- The Head of Healthcare should ensure that staff are competent to carry out cardiopulmonary resuscitation in line with national guidance and arrange for additional training when required.

The Investigation Process

11. HMPPS notified us of Mr Funnell's death on 16 December 2023.

12. 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.

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

14. NHS England commissioned a clinical reviewer to review Mr Funnell's clinical care at the prison. On 16 February, the investigator jointly interviewed six members of staff at Lewes with the clinical reviewer and, on 23 February, they jointly interviewed three members of staff by video link.

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

16. The Ombudsman's office wrote to Mr Funnell's mother to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Funnell's mother asked what medication Mr Funnell received at Lewes and when he received it. She asked if he had vomited before he collapsed and whether he was being held on the high dependency wing.

17. We shared the initial report with HM Prison and Probation Service. They identified one factual inaccuracy, which we have corrected in this final report.

18. We also shared the initial report with Mr Funnell's mother. She asked additional questions that are outside the remit of our investigation.

Background Information

HMP Lewes

19. HMP Lewes is a local prison serving the courts of East and West Sussex. Practice Plus Group (PPG) provides primary care services and healthcare staff are on duty 24-hours a day.

HM Inspectorate of Prisons

20. The most recent inspection of HMP Lewes was an independent review of progress in February 2024. Inspectors reported that prison leaders had overhauled early days processes to improve the experience of prisoners. They found that health services had improved significantly. Clinical support for prisoners receiving opiate-substitution therapy was very good, including regular reviews in line with evidence-based practice.

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 2023, the IMB reported that prisoners identified by the substance misuse service in Reception as needing to detox should have been located on a dedicated substance misuse service wing. However, a shortage of space meant that they were often located on the first night centre. This resulted in delays to men getting their medication, which the IMB identified as potentially life-threatening for men withdrawing from alcohol.

Previous deaths at HMP Lewes

22. Mr Funnell was the 15th prisoner at Lewes to die since December 2020. There have not been any further deaths to the end of April 2024. Eight of the previous deaths were due to natural causes, two were drug related and four were self-inflicted. There are no significant similarities between our findings in this investigation and those of the other deaths.

Key Events

23. On 15 December 2023, Mr Jamie Funnell was remanded to HMP Lewes for assaulting an emergency worker.

24. Mr Funnell had a complex medical history including a history of substance misuse and paranoid schizophrenia (a severe, long-term mental health condition). He had been to prison several times previously.

25. At around 6.00pm, Mr Funnell arrived at Lewes. The Person Escort Record (PER, a document that accompanies prisoners on all journeys, including from court to prison, and is used to highlight information including about medical risks) identified the medication that Mr Funnell had received in police custody, including prochlorperazine (used to treat nausea and vomiting). (The records available to us do not explicitly say why this medication was given to Mr Funnell, but it is often used to manage symptoms related to alcohol withdrawal.). It also noted that Mr Funnell was "alcohol dependent".

26. At around 8.20pm, a nurse carried out Mr Funnell's initial health screen. She noted that Mr Funnell engaged well and responded appropriately to questions. Mr Funnell's physical observations were all within the normal range. She noted that Mr Funnell's Clinical Institute Withdrawal Assessment Scale – Benzodiazepines (CIWA-B, used to determine the extent to which an individual is withdrawing from benzodiazepines) score was seven, (indicating mild withdrawal). She noted that Mr Funnell's CIWA-Ar (used to determine the extent of withdrawal from alcohol) score was two (indicating mild alcohol withdrawal). Mr Funnell tested positive for benzodiazepines and opiates. She referred Mr Funnell to the substance misuse team.

27. A nurse prescriber then saw Mr Funnell. She noted that Mr Funnell had not taken any illicit substances for around 48 to 72 hours because he had been in police custody. She recorded that Mr Funnell told her that he used alcohol daily and had spent around nine months in "rehab", coming out around four months earlier. Mr Funnell said that he drank three bottles of wine and two cans of very strong beer each day and that he had last used alcohol three days earlier. He also said that he used heroin every day.

28. The nurse said that she was mindful of the potential risk of substance withdrawal and because of this she prescribed Mr Funnell 10mg diazepam for alcohol withdrawal, which she noted should only be given if clear objective signs and symptoms of alcohol withdrawal developed. She also prescribed 10ml methadone for opiate withdrawal and 100mg thiamine (vitamin B1) for alcohol withdrawal. She referred Mr Funnel for a review by the substance misuse team.

29. Mr Funnell was allocated a cell on K Wing, the detoxification stabilisation unit.

Events of 16 December 2023

30. At 5.00am on 16 December, Mr Funnell pressed his cell bell. An officer responded and Mr Funnell told him that he could "feel a seizure coming on". The officer radioed for healthcare staff to attend. Nurse A saw Mr Funnell and assessed him for alcohol

withdrawal. The nurse noted that during the assessment Mr Funnell was visibly shaking and vomited clear liquid. He noted that Mr Funnell's respiratory rate was 18 breaths per minute, that his blood oxygen saturation was 97% (normal) and that his pulse rate had increased to 107 beats per minute (raised). The nurse recorded a CIWA-Ar score of 18. (This indicated that Mr Funnell had moderate alcohol withdrawal. A score of more than 20 would indicate severe withdrawal.) The nurse gave Mr Funnell 10mg diazepam, two paracetamol tablets and gave him a drink.

31. At 9.20am, Nurse B, a substance misuse nurse, reviewed Mr Funnell, who told him that he had nausea and retching. The nurse told us that Mr Funnell appeared clinically stable, alert and fully orientated and that he did not observe any shaking, excessive sweating or hallucinations. The nurse did not record a CIWA-Ar score, a Clinical Opiate Withdrawal Scale score (COWS, to determine the extent of opiate withdrawal) or a National Early Warning Score (NEWS, a tool to detect and respond to clinical deterioration). The nurse gave Mr Funnell 10mg metoclopramide (anti-sickness medication), 10ml methadone and 100mg thiamine.

32. Officer A was working on K Wing and said that Mr Funnell had vomited and been retching that morning, and that he had the appearance of "someone who was detoxing".

33. At around 10.30am, Officer A unlocked Mr Funnell so that he could shower or exercise, which he declined. Mr Funnell told him that he wanted to stay in bed.

34. At around 12.00pm, Officer A unlocked Mr Funnell for his lunch. He said that Mr Funnell was still in bed, so he took him some food to his cell. He said that Mr Funnell looked generally unwell.

35. At about 2.00pm, Officer A went back to Mr Funnell's cell after he pressed his cell bell. He spoke to Mr Funnell through the observation panel. Nurse B also spoke to Mr Funnell, who said that he was feeling "rough" and asked for diazepam and methadone. The nurse was unable to complete a full clinical assessment because there was only one officer present on K Wing and security procedures therefore meant that he was unable to open the cell door. The nurse did not give Mr Funnell any medication.

36. Officer a said that, at 3.00pm, Mr Funnell rang his cell bell and asked for pain relief. He told Mr Funnell that he would be unlocked for his clinic and medication at 4.00pm. He did not tell Nurse B of this conversation.

37. At around 4.00pm, Officer A unlocked Mr Funnell for his medication. Mr Funnell walked down the landing towards the clinic and collapsed. He went to help him, with a Custodial Manager (CM), and called Nurse B to help them. The officers walked Mr Funnell back to his cell where, outside, he collapsed again. Officer A said that as he fell, they caught him and walked him into his cell.

38. Nurse B placed Mr Funnell in the recovery position because his breathing was shallow. The CM radioed for healthcare assistance. The nurse then identified that Mr Funnell was unresponsive and not breathing and the CM radioed a medical emergency code blue (which indicates that a prisoner is unconscious or having difficulty breathing).

39. The staff pulled Mr Funnell onto the landing and Nurse B started cardiopulmonary resuscitation (CPR). Another nurse and an Emergency Care Technician (ECT) arrived and supported Nurse B. The ECT left the scene to collect the emergency bag and defibrillator, returned and inserted an airway and gave Mr Funnell oxygen through a bag-valve-mask. The healthcare staff used a defibrillator, which indicated no shockable rhythm. A nurse carried out chest compressions.

40. Prison staff in the control room telephoned the ambulance service and, after they had given details of the medical emergency, transferred the call to the wing office where the officers with Mr Funnell gave up-to-date information.

41. At 4.32pm, ambulance paramedics arrived and took over emergency life support. At 5.16pm, they said that Mr Funnell had died.

42. The paramedic crew told a senior officer that they were concerned about the quality of basic life support and CPR delivered by prison healthcare staff, particularly regarding Mr Funnell's airway management, chest compression technique, and use of the defibrillator. They later completed a written report to highlight these issues.

Contact with Mr Funnell's family

43. Lewes appointed an officer as the family liaison officer and another officer as the deputy family liaison officer. That evening, the family liaison officer and a chaplain went to Mr Funnell's mother's house and informed her that he had died.

Support for prisoners and staff

44. After Mr Funnell's death, the Head of Safer Custody 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.

45. The prison posted notices informing other prisoners of Mr Funnell'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 Funnell's death.

Post-mortem report

46. A post mortem examination established that Mr Funnell died from a heart attack caused by left ventricular hypertrophy and dilation (the left side of the heart becomes thicker and enlarged), coronary artery atherosclerosis (the arteries that supply blood to the heart muscle become hard and narrow due to the build-up of fatty materials), electrolyte disturbance (imbalances in body salts and minerals) owing to vomiting, and withdrawal from drugs and alcohol.

47. The clinical reviewer noted that the left ventricular hypertrophy and coronary artery atherosclerosis had not previously been diagnosed. He found that they meant that Mr Funnell's risk of a significant cardiac event (such as cardiac arrest) would be notably increased and that he would be more susceptible to cardiac complications associated with alcohol and drug withdrawal.

48. Toxicology tests showed that Mr Funnell had taken methadone (low in comparison to the range that is typically seen in individuals who have been receiving a daily prescription), benzodiazepines, codeine and paracetamol. The report found that these substances did not materially contribute to Mr Funnell's death.

Findings

Substance misuse management

49. The clinical reviewer found that Mr Funnell was appropriately assessed and referred when he arrived at HMP Lewes on 15 December. Prescribing of (as required) diazepam and methadone was appropriate to his symptoms and withdrawal scale scores. When Mr Funnell presented with symptoms of alcohol withdrawal at around 5.00am on 16 December, the clinical reviewer found that he was appropriately given diazepam in line with Practice Plus Group's (PPG) Standard Operating Policy for Assessment and Management of Alcohol Dependence.

50. However, the clinical reviewer concluded that the overall care Mr Funnell received for alcohol withdrawal was not equivalent to that which he would expect to receive in the community.

51. While the provision of diazepam when Mr Funnell presented with symptoms in the early morning of 16 December was appropriate, the clinical reviewer found that follow up care was not in line with PPG policy. The policy states that a reducing regime of diazepam should commence when a prisoner's CIWA-Ar score exceeds 10 within 48 hours of arrival at Lewes. Instead, when Mr Funnell's score was recorded as 18, he received one 'as required' dose with no further provision. Mr Funnell did not receive another dose of diazepam and there was no further proper assessment of his withdrawal or CIWA-Ar score.

52. At 9.20am on 16 December, when a substance misuse nurse reviewed Mr Funnell, his clinical observations were recorded. However, the nurse did not obtain a current CIWA-Ar score. Later in the day, when Mr Funnell said that he felt unwell, and having vomited earlier in the day, the nurse did not clinically assess him or record a current CIWA-Ar score, and instead simply recorded a welfare check. The clinical reviewer found that simple welfare checks were contrary to PPG policy and should not be used in the observation of prisoners at risk of alcohol withdrawal complications.

53. The clinical reviewer described the lack of additional CIWA-Ar assessments as a critical error which meant that there was no objective assessment of the severity of Mr Funnell's condition for much of the day. He concluded that this meant that opportunities to act upon potentially reversible clinical deterioration could have been missed.

Staffing on K Wing

54. We were told that a lack of prison staff availability was the reason why Mr Funnell could not be unlocked for an in-person review at 2.00pm on 16 December. Local policy is that a cell cannot be unlocked unless two prison officers are present. Instead, one officer was working alone on K Wing, as standard on a Saturday.

55. PPG policy states that, "For patients who are displaying severe withdrawal or are at higher medical risk during detox, increased face-to-face observations will be required. This will require physical access to the patient and opening cells during the night. A process for this should be agreed with the prison. If clinicians are

unable to access the patient the reasons for this and any escalation should be clearly documented". There is no evidence that the lack of staff to unlock Mr Funnell's cell was escalated to a duty manager.

56. At 2.00pm, Mr Funnel should have had a face-to-face assessment. The clinical reviewer said that it is possible that an opportunity to recognise a deterioration in Mr Funnell's health was missed by not carrying out a full clinical assessment at that time. Given the nature of the population on K Wing, it is likely that face-to-face clinical assessments will often be required to ensure prisoner safety. It is concerning that staffing levels at the weekend do not easily allow this. We make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff have entry to prisoner's cells on K Wing at the weekend, to allow face to face clinical assessments when required.

PPG Policy

57. While the clinical reviewer identified some areas of PPG policy that were not followed, he also found that the Standard Operating Policy for Assessment and Management of Alcohol Dependence was potentially unclear. The policy contained contradictory advice about the frequency of monitoring and dosage based on CIWA-Ar scores that were not always defined in the policy. The policy is currently under review. We make the following recommendations:

The Head of Healthcare should ensure that the Standard Operating Procedure for Assessment and Management of Alcohol Dependence is revised, including that:

- **Staff are given clear guidance about how to manage alcohol withdrawal within 48 hours of arrival in custody;**
- **Staff understand when and how to complete CIWA-Ar assessments and prescribe and provide medications including diazepam in line with clinical expectations.**

Emergency response

58. The attending ambulance service paramedics highlighted several technical issues with the quality of the CPR delivered by the healthcare staff. The clinical reviewer identified that they were concerned that:

- There was a delay in oxygen delivery to Mr Funnell as the oxygen cylinder was not initially connected to the bag-valve-mask.
- There was inadequate initial airway management.
- Chest compressions were not being carried out correctly. Compressions were applied to Mr Funnell's abdomen rather than his thorax. National UK resuscitation guidelines advise that high-quality chest compressions with minimal interruption and early defibrillation remain priorities in cardio-pulmonary resuscitation.

- Mr Funnell's clothing had not been removed and was covering the defibrillator paddles creating a potential fire risk.

59. The clinical reviewer noted that the nurses who attended the emergency response were trained to Intermediate Life Support (ILS), which is refreshed annually. He concluded that, overall, the timeliness of the emergency response was satisfactory. He said that while the issues raised by the ambulance service paramedics were concerning, it is debatable if these issues would have materially changed the outcome for Mr Funnell.

60. We make the following recommendation:

The Head of Healthcare should ensure that staff are competent to carry out cardiopulmonary resuscitation in line with national guidance and arrange for additional training as required.

Good practice

61. The control room operator transferred the ambulance service telephone call to the wing office to obtain direct, up to date information from the medical emergency.

62. The duty manager arranged for both vehicle gates at the front of the prison to be opened simultaneously which meant that the ambulance paramedics quickly entered the prison and were promptly at Mr Funnell's side.

Inquest

63. The inquest into Mr Funnell's death concluded on 30 September 2025. The jury concluded that his death was due to the effects of drug and alcohol withdrawal that was exacerbated by a series of omissions by healthcare and prison staff.

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