PRISONS AND PROBATION OMBUDSMAN for England and Wales

Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Rye Hill in April 2011

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

The man was found dead in his cell at HMP Rye Hill on the morning of April 2011. The post mortem report found that he had died of respiratory depressions including regurgitation of food particles and methadone intoxication. My sincere condolences go to his family for their loss.

The man had a long history of misusing drugs both in the community and in a custody setting. When he began his custodial sentence he commenced the Integrated Drug Treatment System (IDTS) methadone programme in an attempt to address his drug misuse. He was still on this programme when he arrived at Rye Hill.

The investigation was led by one of my investigators. Northamptonshire Primary Care Trust (PCT) is not responsible for the healthcare provided at Rye Hill and we are grateful to the Trust for undertaking an independent review of the healthcare the man received at the prison. I am also grateful to the Director of Rye Hill and his staff for their co-operation. I regret that the report has been slightly delayed.

This report covers the man's time in prison prior to his death, the events on the day that he died and the actions of all the people involved in the incident. The investigator contacted the police investigating officer who also shared information from their investigation. We would like to extend my thanks to the Northamptonshire Police for their assistance. A police investigation was carried out because of the concern of the ready availability of drugs within the prison. However their investigation concluded that there was no further action to be taken and there were no proven suspicious circumstances surrounding the death.

The man was not the first and, sadly, will not be the last, prisoner to lose his life because of drug-taking. However, there are a number of serious issues that arise in his case regarding his healthcare, particularly the rationale for prescribing and changing the dosages of medications and his evident ability to mix prescribed and illicitly obtained drugs. As a result, the report makes recommendations for improvements in healthcare at HMPs Lowdham Grange, Dovegate and Rye Hill. It also raises concerns at Rye Hill over the timing of the administration of methadone, the lack of drug specific training amongst some key staff and the need to improve the use of security intelligence regarding drug misuse. Finally, it also recommends improvement of emergency procedures at Rye Hill. I hope and expect that the Director will ensure that appropriate lessons are learned from this tragic case.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2012**

CONTENTS

Summary	5
The investigation process	7
The Man	9
HMP Rye Hill	10
Key events	14
Issues	29
Conclusion	35
Recommendations	36

SUMMARY

1. The man was serving a seven and a half year sentence for wounding with intent. He commenced his prison sentence in December 2008, moving through a number of prison establishments before arriving at Rye Hill in March 2011. He had a long history of drug misuse in the community and in custody and had been on the Integrated Drug Treatment System (IDTS) programme for a number of years. He also had a history of mental health problems.

2. When he arrived at Rye Hill, he was already on the IDTS programme, meaning that he received a 100ml daily dosage of methadone. He had struggled with drug misuse in prison and had seen his methadone dosage increase rather than decrease. He received appropriate referrals to the Rye Hill IDTS team who were happy that he could start to begin a methadone reduction programme.

3. During his stay at Rye Hill, a period of approximately two weeks, he was suspected of being involved in the misuse of drugs on the wing. He was described by some prisoners and staff as often being unsteady on his feet, although it could not be corroborated whether this was a result of the accumulation of his prescribed medication (which included mirtazapine[1] pregabalin[2], methadone and later clonazepam[3]), or indeed, non-prescribed medications (or drugs) he may have taken illicitly. Aside from the IDTS team, other wing and healthcare staff who came into contact with him had little training or experience in recognising the effects of someone who might have taken a drug overdose.

4. The man was seen by the prison doctor on 1 April. He wanted to be prescribed clonazepam because he had had an anxiety attack and said he had a family history of epilepsy. On this first occasion the doctor did not prescribe the medication. At around this time it was suggested by other prisoners that he had taken clonazepam which he obtained from another prisoner. He had also allegedly been told by a prisoner that if he faked an epileptic fit, he would be prescribed clonazepam by the doctor.

5. Five days later, the day prior to his death in April, he was seen again by the same prison doctor. He complained that he had an epileptic fit and presented with bruises to his head. He was subsequently prescribed clonazepam. No tests were however carried out to confirm that he had epilepsy. No previous entries were found in his medical record to suggest he had a family history of epilepsy.

6. That evening, having received his medication of methadone and clonazepam, two prisoners described the man as being unsteady on his feet. Staff however raised no concerns when prisoners were locked up for the evening at around 7.30pm or at roll check shortly after this at around 8.30pm. He was

---

[1] mirtazapine is used to treat depression.
[2] pregabalin is used to help control certain types of epilepsy and relieve nerve pain and can also help to relieve anxiety.
[3] clonezepan is used to treat seizures and panic disorders.

not checked upon throughout the night as he was not on suicide or self harm prevention procedures and no other concerns had been raised about him.

7. During the following morning's roll check at around 5.40am, he was unresponsive when the night duty officers checked his cell. He was sitting in a chair at the bottom of his bed, with his face on the bed. The alarm was raised and further wing and healthcare staff responded. When staff entered the cell, his face was found lying face down in vomit. He was cold and rigor mortis[4] was present. Resuscitation was therefore not attempted. Paramedics arrived soon after and confirmed his death at 6.15am.

8. The subsequent post-mortem revealed that he had died from respiratory depressions including regurgitation of food particles and methadone intoxication.

9. The investigation and associated clinical review include several recommendations. These include the need for improvements to: clinical practice, the timing of the administration of methadone, the submission of security information reports relating to drug misuse, record keeping, awareness of local procedures for entering cells during night patrol duty, first aid training for staff and staff attendance at Critical Debrief meetings following a serious incident. The majority of recommendations are for the Director and Clinical Manager at Rye Hill but there are also recommendations for HMP Lowdham Grange and HMP Dovegate.

[4] Rigor mortis is one of the recognizable signs of death that is caused by a chemical change in the muscles after death, causing the limbs of the body to become stiff and difficult to move or manipulate.

THE INVESTIGATION PROCESS

10. One of the Ombudsman's investigators was appointed to conduct the investigation into the man's death. The investigator opened the investigation on 12 April 2011, speaking with a number of staff at the prison, including the Director, the Clinical Lead, and a woman who also acted as the prison's liaison officer for this investigation. The investigator's contact details were made available to members of the Independent Monitoring Board (IMB).

11. The Ombudsman's terms of reference, and notices to staff and prisoners, were sent to the Director at the beginning of the investigation. I understand that they were displayed around the prison inviting prisoners or staff to contact the investigator should they wish to. At the time of publication of the draft report, there had been no response to the notices. During the investigation, the investigator provided verbal and written feedback to the Director, and the Controller of Rye Hill, (A Controller is employed by the Ministry of Justice to monitor the prison's performance against their contract. Controllers are employed in all privately run prisons).

12. Unlike public sector prisons, the local primary care trust is not responsible for the delivery of healthcare at Rye Hill. It is delivered by G4S, the private company that also delivers the custodial arrangements at the prison. Northamptonshire PCT are responsible for delivery of IDTS within the prison. Nevertheless, Northamptonshire PCT appointed a GP, to complete a review into the clinical care that the man received during his short stay at Rye Hill. We are grateful for this appointment. The investigator and the Clinical Reviewer reviewed the man's medical records and other prison documentation. They also interviewed a number of staff at the prison. I regret that the report has been slightly delayed due to the late submission of the clinical report.

13. We would also like to extend my thanks to the Detective Constable and her colleagues at Northamptonshire Police who shared information from the police investigation.

14. One of the Ombudsman's Family Liaison Officers, contacted the man's family, informing them of the investigation into his death. The family raised the following areas of concern:

    - They had been told by the police that the man had epilepsy. However they had no knowledge that he had this illness and would like to know when he was diagnosed as having epilepsy and what medication he was prescribed for it.

    - Was he given any un-prescribed medication by other prisoners the night before his death?

    - Was he checked upon after the evening roll check?

- Did he successfully complete his hepatitis C treatment?

- Had he been diagnosed with any mental illness?

15. His family and their legal representative received a copy of my draft report as part of the consultation process. Written representations were provided on behalf of his family in response to the findings of the investigation. A number of issues were raised including the prison's lack of medical records, the high level of medication that he was prescribed and the monitoring of this and the events on the evening leading up to the time he was discovered unconscious in his cell.

16. We are grateful to the man's family for the time they have taken to consider the report and for the feedback they have felt able to share. The investigator has considered the issues raised and has, where appropriate, amended the report to reflect their comments. It was felt, however, that some of the issues raised would be more appropriately addressed outside of this report. Our family liaison officer has sought to address these in separate correspondence to his family and legal representative.

The Man

17. He had a long history of offending behaviour. He also had a long history of using drugs from the age of 13. His first recorded conviction was in 1994 and since then he had amassed over 93 offences. Details from his Probation Pre-Sentence report show that much of his offending behaviour was an established pattern of crime to raise money to feed his drug habit.

18. As a result of his offending behaviour his education suffered and he was eventually expelled from mainstream school. He gained no formal qualifications. He spent time in custody for a number of offences and received Drug Rehabilitation Requirement Orders as part of his sentencing from the courts. He however would normally only remain drug free for a few months following release from prison before returning to misusing drugs.

19. During his period in custody and prior to arriving at Rye Hill, he attempted to address his drug misuse by participating on the IDTS Drug Rehabilitation Programme. However he also had numerous Security Incident Reports (SIRs) submitted about his misuse of drugs on the wings. He was involved in obtaining and selling prescribed and non-prescribed medication as well as bullying others to obtain medication.

HMP RYE HILL

20. HMP Rye Hill is a Category B prison located near Rugby that accommodates up to 625 prisoners, all of whom must have received a sentence of at least four years with a minimum of 18 months left to serve. It is one of 11 prisons in England and Wales contractually managed by private companies, accommodating about 11 per cent of the national prison population. Five of the privately run prisons are run by G4S Care and Justice Services, including Rye Hill.

21. The HM Chief Inspector of Prisons carried out an announced inspection of Rye Hill in July 2011. Although their report is yet to be published, when asked about drug use issues within the prison, they were able to comment as follows:

> "Prior to our inspection, the PPO's office alerted the Inspectorate to concerns around drugs misuse, prescriptions and security. We made the following findings in relation to those areas:
>
> Prisoners prescribed opiate substitutes participated in regular clinical reviews but we received many complaints about evening methadone administration, which had been introduced without service user consultation. Specialist nurse input and facilities were limited, and the work of the counselling, assessment, referral, advice and throughcare (CARAT) and the mental health teams was insufficiently coordinated. Drug testing results, drug finds and prisoner survey results pointed towards a relatively low level of illicit drug use but there was some evidence of diverted medication.
>
> Links with the police were well developed and joint work had been done to combat drugs coming into the prison, with a reasonable measure of success.
>
> Clinical governance arrangements were robust but pharmacy and medicines management procedures required review."

Independent Monitoring Board (IMB)

22. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The most recent annual report 2010-2011 published by the IMB for Rye Hill includes the following comments:

> "The Board is satisfied that over the reporting period the prison has continued to be a safe environment and that offender and staff morale has improved.

Improvements
The number of Security Intelligence Reports has remained between 500 and 600 per month leading to targeted searches for contraband.
Trends
Drug tests indicate a downward trend in drug supply
Higher levels of contraband finds indicate better intelligence.

Concerns
Contraband still manages to enter the prison"

Previous deaths in custody

23. Including the man, the Ombudsman has investigated 15 deaths in custody at Rye Hill since being given responsibility for all such investigations in 2004. Eleven of those deaths were from natural causes. One recommendation made later in this report, repeats one previously made.

Counselling Assessment Referral Advice and Throughcare (CARAT) Team

24. The Counselling Assessment Referral Advice and Throughcare (CARAT) team based in a prison provide a substance misuse service for prisoners assessed with serious drug and alcohol problems. The team work in partnership with the healthcare service and discipline staff to provide a service within the prison and also as a referral agency for ongoing support to prisoners on their release.

Cell bell

25. Each prison cell has an emergency cell bell alarm which can be activated by the prisoner to call staff. The alarm activates a buzzer in the wing office indicating the wing and cell the alarm originated from. A light also flashes outside the cell.

Critical Incident Debrief and Hot Debrief

26. A 'hot debrief' takes place immediately after a serious incident allowing staff to receive immediate support and identify anything that needs to be rectified immediately to prevent further deaths or injury. A critical debrief ordinarily takes place within two weeks after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, identify any learning points, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits of such a debrief include being able to discuss their experiences in a safe and confidential environment.

Emergency response codes

27. Emergency codes are used to summon staff to deal with a particular situation. At Rye Hill, Code 1 is used to indicate a life threatening incident or a prisoner not breathing and Code 2 to indicate incidents such as injuries from fighting or a self harm incident.

Reception and induction

28. A Cell Sharing Risk Assessment (CSRA) is opened by a reception officer who completes the basic details. The CSRA is intended to provide consistent and continuing risk assessment about the prisoner's potential to harm a cellmate. While this is primarily for sharing with other prisoners, it also includes occasions when space may be shared, for example to accommodate a Listener.

29. The initial healthcare screen concentrates on the prisoner's immediate well-being. The healthscreen includes questions about the prisoner's mental health, risk of self harm or suicide and any drug or alcohol withdrawal or detoxification issues.

30. All new prisoners are located on the induction wing. Prisoners are asked about any immediate concerns, such as disability, their offence and general well being. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are given a new reception pack, and telephone pin numbers and visiting arrangements are explained.

Roll check

31. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur on a number of specified occasions during the day and night, and staff must sign that the roll is correct.

Sealed key pouch

32. Night patrol officers do not have keys to cells but carry a sealed pouch which contains a cell key which should only be used in emergencies. During the night state, the whole house block is also locked and the night patrol officers are locked within it. The house block doors can only be opened by the night orderly officer, who is in charge of the prison, and who will visit (and contact via radio) each house block throughout the night to check that everything is satisfactory. Night patrol officers can communicate with others outside of their house block by radio or using the telephone in the office.

Opening cells during night state

33. Rye Hill has local instructions relating to the opening of cells during the night state. These states that, under normal circumstances, authority to unlock a cell at night must be given by the Night Orderly Officer (NOO) / Night Manager (NM) and no cell will be opened unless a minimum of two members of staff are present one of whom should be the NM. Where there appears to be, immediate danger to life, cells may be unlocked without the authority of the NM and an individual member of staff may enter the cell on their own. Staff

have a duty of care to prisoners and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger.

Integrated Drug Treatment System (IDTS)

34. The Integrated Drug Treatment System (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on: early custody, improving the integration between clinical and CARATs services, and reinforcing continuity of care from the community into prison, between prisons, and on release into the community. The expected benefits from IDTS are:

- Reduction in self-inflicted deaths and self-harm among those most at risk
- Reduction in post release deaths
- Fewer incidents of violent aggression
- Better engagement in prison regime
- Reduction in drug taking
- Reduction in injecting behaviour
- Reduction in offending

Methadone

35. Methadone is one of a number of synthetic opiates (also called opioids) that are manufactured for medical use and have similar effects to heroin. Methadone is a drug that is similar to heroin, although it lasts a lot longer in the body. It can be prescribed legally and this is usually done to decrease the unpleasant withdrawal symptoms experienced when stopping taking heroin.

36. Once established on a regular dose, most people stay on methadone for a long time or even long-term. This is called maintenance and helps keep patients off of street drugs. Some people gradually reduce their dose and come off it. This is called detoxification or 'detox'. However, it usually takes months, and sometimes years, before most people are ready to consider detox.

KEY EVENTS

Prior to the man's arrival at HMP Rye Hill

37. The man appeared at a local Court in 2008 charged with a number of offences. He was sentenced in December 2008 to serve seven and a half years in custody. He started his prison custody at HMP Bristol before moving on to HMP Dovegate in January 2010 and then HMP Lowdham Grange in October 2010.

38. An outline of his previous medical history, recorded in his prison medical record in 2008 noted that that he had hepatitis C, liver cirrhoses (scarring of the liver), suffered from asthma and smoked. He had also misused drugs and was participating in the Integrated Drug Treatment System (IDTS) methadone programme, to address his dependence on drugs.

39. In December 2009, whilst in Bristol, his prescription for methadone was reviewed. At this time he was being prescribed 30ml of methadone per day. He however told prison staff that the dosage of methadone was not enough to address his withdrawal symptoms from drugs. As such, he was obtaining drugs illicitly (cannabis and tramadol) to use 'on top' of taking his methadone. He requested an increase of methadone to 40ml per day which was refused by IDTS staff. Subsequently, as a result of him buying medication on the wing, he was reprimanded and placed in the segregation unit. During his time in the segregation unit, it was noted that he did not display any symptoms of drug withdrawal and his methadone prescription continued on the current level.

40. During this period, he said he was also struggling with his hepatitis C treatment (interferon therapy[5]), which was now ten weeks into a six month treatment programme. To deal with the side effects of insomnia (sleeplessness) which this medication caused him, he was prescribed sporadic short periods of zopiclone (used in the treatment of insomnia).

41. A further review of his methadone prescription, on 31 December 2009, returned the same result as the previous review and so it was recommended that there should be no change to his methadone dosage.

42. As of 5 January 2010, he still remained in the segregation unit. For reasons that are unclear from the records, following a discussion within the IDTS detoxification team, his methadone prescription was increased to 40ml for a period of 12 weeks, until his hepatitis C treatment was concluded. He was then to be reviewed by the detoxification doctor with a view to reducing his methadone prescription. He remained in the segregation until his transfer to Dovegate in January 2010.

[5] Interferon is a small protein messenger called cytokine produced by the immune system in response to viral infections. Interferon therapy helps the body distinguish between cells infected by the virus and non-infected cells, targeting infected cells for destruction.

The man's stay in Dovegate

43. From the sparse medical records available to the investigator, it was noted that when he arrived at Dovegate, he was seen by healthcare staff as normal in reception. It was noted that he was currently on the IDTS programme and was taking medication including zoplicone, mirtazapine (used to treat depression) and ribavarin (used in conjunction with hepatitis C inferon treatment). He also continued to receive his hepatitis C treatment. His methadone dosage was later (end of January) increased to 55ml.

44. In May, he complained of suffering from paranoia and was referred to the mental health in-reach team (MHIT). Due to staff absences, he was not seen until 8 July by the mental health nurse for an assessment. It was decided that he would be referred to the doctor for a medication review and for consideration of how best to treat his paranoid thinking.

45. At around this time (5 July) he presented to the prison doctor with pains in his right knee. He said this had originated from an incident that occurred two years prior for which he had taken pain relief which included tramadol and cocodamol. He did not like either of these medications and was prescribed nortriptyline for neuropathic pain[6].

46. By the beginning of August his methadone prescription had increased to 70ml daily, although he was now on a reducing dosage of 2ml a week. He was still experiencing knee pains and his medication was changed to pregabalin 100mg (used to help control certain types of epilepsy and relieve nerve pain. Can also help to relieve anxiety) until he stopped taking this in October. During September, following a number of tests, he was given the all clear in successfully completing his treatment for hepatitis C.

47. There is an apology noted on his medical record regarding the length of time it had taken for a mental health follow up appointment to be made. He was seen by a nurse on the wing on 13 October where he said he was still experiencing paranoia, one episode resulting in an altercation on the wing with another prisoner. The nurse, wanting to assess him away from the wing, made a referral for him to be seen in healthcare. He was subsequently seen on 27 October by a mental healthcare nurse. His paranoia was discussed along with coping mechanisms, which included supplying him with some in-cell activity packs.

The Man's transfer to Lowdham Grange

48. On 29 October, he was transferred to Lowdham Grange. As is normal upon arrival at a new prison, he received a reception screening which included being seen by a member of the healthcare team. The nurse who examined him noted that he was on the IDTS methadone programme with a current dose of 58ml. This was being reduced slowly. He had also been taking

[6] Neuropathic pain is a pain that comes from problems with signals from the nerves. There are various causes. It is different to the common type of pain that is due to an injury, burn, pressure, etc.

mirtazapine 30mg. In addition, he claimed to be taking pregabalin and zoplicone, although the nurse could find no current prescriptions for these drugs in his medical record. The man said he had been a poly drug user in the past. He presented as anxious and looked worried when the nurse spoke with him. His previous diagnosis of hepatitis C was noted. The nurse made referrals to the mental health team, the Counselling Assessment Referral Advice and Throughcare (CARAT) team and the prison doctor. It was also noted that he should be located in a single cell only, which remained the case throughout his prison term.

49. At the beginning of November, his methadone prescription was increased to 60ml and then 65ml. He was seen by the CARAT team worker and the prison doctor and was due to commence a 15ml benzodiazepine (drugs used to ease symptoms of anxiety and sleeping difficulty) detoxification soon because he had admitted to illicitly taking lots of different benzodiazepams. He complained of not sleeping well, having pains in his body and occasionally experiencing paranoia at night. The CARAT worker discussed harm minimisation and overdose prevention issues with him and made a referral for him to been seen by the MHIT. It was also hoped that he would reduce his intake of methadone, although this increased to 70ml around 12 November because he said he was not coping well at night.

50. On 15 November, he again told the CARAT worker that he was not coping well. He expressed concerns about his paranoia, anxiety, and his methadone and benzodiazepine detoxification programmes. The IDTS doctor reviewed his medication and his methadone dosage was subsequently increased to 80ml. His diazepam (diazepam is a benzodiazepine drug commonly used for treating anxiety and insomnia) increased to 10ml (am) and 10ml (pm) for seven days and was then to be reduced to 5ml. During this period he was also seen by the mental health nurse, to whom he complained about suffering from paranoia and anxiety. The nurse said she would speak to the doctor about his current medications. He was also to be referred to the psychology unit for bereavement counselling following the death of his sister in June 2010.

51. As the days went on, he complained that his paranoia was getting worse and he was seen again by the mental health nurse. He was offered reassurance and it was explained to him that his appointment with the MHIT was not expected to be for at least four weeks. A mental health nurse discussed with him techniques he could use in the meantime to manage his anxiety and stress.

52. His methadone was reviewed again on 1 December and increased to 100ml daily. His benzodiazepam detoxification was to continue. He was seen by the MHIT on 14 December and 21 December and a doctor on 30 December. A mental health assessment was carried out and discussions with the MHIT took place. It was later noted that he did not warrant any secondary mental health care at that time. His mirtazapine medication was to be increased to 45mg, and he was to be offered bereavement counselling again, something

he had previously refused. There is no information on his prison records to suggest he accepted this offer of counselling.

53. He was seen on 18 January 2011 by the mental health nurse when he appeared anxious and tense. He complained that the mirtazapine had not helped improve his sleep, anxiety or mood. He was still experiencing paranoia and ways of managing it were again discussed. He was advised to continue to take his medication and to be reviewed in approximately two weeks time.

54. When he attended his appointment on 1 February with the mental health nurse, he said that he had received support from a fellow prisoner in handling his anxiety and paranoia. He had not behaved aggressively in the last week, behaviour he had previously displayed. The increase in mirtazapine had still not improved his sleeping or mood and he was advised to reduce the dosage to 30mg daily. His next planned appointment with the nurse was in two weeks time.

55. Following a doctor's appointment the next day, it was noted that he had successfully stopped taking diazepam. He was now currently on a dose of 80ml of methadone daily on a 28 day decreasing plan. His current medication included pregabalin, phenergan (a sedating anti-histamine and prescribed for his insomnia), baclofen (taken for back pain) and mirtazapine.

56. On 4 February he collapsed on the wing. Healthcare staff were called and found him in a confused state with an erratic pulse. He was examined by a nuurse who believed he had misused drugs. It was noted he should have a drug and drink test the next morning (although there is no record that this was carried out). Afterwards, he admitted to his CARAT worker that he obtained benzodiazepams illicitly on the wing. He had mixed nitrazepam (benzodiazepine drug used for insomnia) and clonazepam (benzodiazepine drug used to treat seizures and panic disorder) and had experienced a "bad turn". His CARAT worker continued to offer him support and in-cell work packs to address his addiction.

57. He was later moved to the Re-integration Unit (segregation unit) where he was seen daily by nurses. He had requested this move saying that he had incurred debts as a result of his drug use. His methadone dosage was increased to 90ml and he said he was feeling well.

The man's transfer to HMP Rye Hill

58. In March 2011, he was transferred to Rye Hill and went through the routine reception screening process. The reception officer noted his Cell Sharing Risk Assessment (CSRA)[7] as high risk because of references made in his prison paperwork that he had mental health issues. He was seen by a Healthcare Assistant (HCA) who carried out a reception health screening.

[7] A CSRA is designed to assess the risk a prisoner may pose to another prisoner if they are placed into a shared cell.

The HCA had sight of the man's medical records when she made her assessment. She described him as "fine, he was chatty, he was polite, he wasn't rude, he wasn't aggressive or abusive, he was talking".

59. He said that he suffered from paranoia and mental health problems. The HCA made a referral for him to be seen by the MHIT. He also had a long history of drug misuse, especially in the prison environment. This included a history of benzodiazepine misuse. The man reported that he had illicitly taken diazepam two days prior to his transfer. He arrived on a daily dose of 100ml methadone, which was confirmed within his medical records. (At some point this dosage had obviously increased from the 90ml daily dose prescribed in Lowdham Grange).

60. New prisoners who arrive and are on medication from the previous prison are referred for assessment by the doctor within five days. The man was to be referred to the IDTS team who visited Rye Hill on Tuesday and Wednesday each week. Until then, he would receive his current daily dose of methadone. (Methodone at Rye Hill is administered only in the evenings, as opposed to most prison establishments where it is administered in the mornings.) He said he had no current thoughts of self harm or suicide. In addition it was recorded that he was being prescribed the following medication:

- Mirtazapine 45mg Once daily (pm)
- Pregabalin 300mg Twice daily (am + pm)
- Salbutamol inhaler (for asthma) Self administered in-possession (from 30 March)
- Qvar 50 inhaler (for asthma) Self administered in-possession (from 30 March)

61. The HCA assessed the man as being high risk for sharing a cell, stating her concerns that he had mental health issues, was on the IDTS programme and had displayed previous behavioural problems in prisons towards others.

62. Following the completion of his reception screening, he was taken to the induction wing, Farley Unit. His personal officer[8], Prison Custody Officer introduced himself to him and explained the prison rules and regulations. The man was noted to appear "Quite angry and awkward".

63. A Prison Custody Officer (PCO) who worked on the Farley wing, recalled when the man arrived from Lowdham Grange was located in the segregation unit there. Staff were therefore informed to keep an eye on him owing to previous problems with his behaviour. He attended the Farley wing office soon after his arrival and on a number of other occasions saying that he wanted his methodone. The PCO said he believed that the matter was resolved by healthcare.

[8] Prisoners' are assigned a personal officer who will act as a first port of call to assist and answer any queries the may have.

64. Over the coming days, he was described as a prisoner who tended to keep himself to himself and generally stayed in his cell, often appearing to be asleep. He would leave his cell at meal times but did not socialise much on the wing. The PCO said that he was noticeable to staff as he appeared to be on “a lot of medication and he did seem quite, sort of drained and he was tired all the time”.

65. He was seen by a member of staff from the CARAT ‘s team on Tuesday 29 March. They discussed his long history of using drugs and his current dosage of methadone (100ml). He said he had been on this dose for about five weeks. He also said that he suffered from anger and paranoia and had previously self medicated with benzodiazepines. He did however want to reduce his intake of methadone. It was agreed that they would look at his triggers for using drugs. It was also noted that an IDTS doctor would liaise with the MHIT for him to be seen.

The man’s relocation to Davies unit

66. He was relocated onto Davies unit on the next day (Wednesday 30 March) following completion of his induction. He also attended an appointment with the Community Psychiatric Nurse (CPN) from the MHIT for an initial screening. She noted that he engaged well during the screening interview and arranged to see him again to conduct a more detailed assessment.

67. He was also examined by the IDTS doctor. (It is recorded in his medical records that this appointment took place on Thursday 31 March. The doctor confirmed at interview that this date was incorrect as the IDTS clinics were only open on Tuesday and Wednesdays. The author of the entry was noted as IDTS Nurse, who confirmed she was not present at the time but made the entry the following day at the doctor’s request). The doctor told the investigator that this examination took place on the wing as the usual medical centre room was in use by another practitioner. It was therefore not possible to conduct a urine test which would detect the man’s use or not of cocaine, amphetamines, benzodiazepams, diazepam, methadone, opiates and Subutex.

68. Following the doctor’s examination, it was noted in his medical record that he was currently on 100ml methadone daily. He also said he had previously used heroin for 15 years (smoking and injecting), taken benzodiazepines orally and also previously used crack/cocaine daily. He also said he experienced leg pains for which he was previously prescribed pregabalin.

69. The following morning, 31 March, he received his secondary health screening assessment carried out by a nurse. The nurse had over ten years nursing experience, although had only been at Rye Hill since February 2011. She had no previous experience of and had received no specific training for dealing with patients who were opiate or methadone dependent.

70. The nurse noted the man’s basic health observations including his height, pulse and weight. He also said that he had previously stayed in a psychiatric

hospital and had contact with psychiatric services in the community. The nurse said that he was in a relaxed and talkative mood during the interview. He said he had epilepsy but had not had a seizure for years. (He had made no mention of having epilepsy when examined by the doctor the previous day.)

71. The following morning, 1 April, the man presented himself at the doctor's clinic and was seen by a doctor. He had received some bad news from home that had upset him and told the doctor he had had an anxiety attack and wanted to be prescribed clonazepam (a drug he appeared to have some knowledge of as he said he had been prescribed it in the community). He also said he had a family history of epilepsy, although this was not documented by the doctor. In addition, the doctor later told the investigator at interview that he had a discussion with the man about a different medication called Epilim (also used for treatment of epilepsy). His response to this was that he had taken Epilim in the past and it caused him to have dryness of the mouth. As such he did not want to take it again. Again, this conversation is not recorded in his medical record.

72. The doctor's entry in the man's medical record concludes with a diagnosis of mixed anxiety and a depressive disorder. As he was already taking mirtazapine, he was advised to take zopiclone 7.5 mg for a week at nights and was given his first dose of zoplicone that afternoon.

73. The investigator interviewed a prisoner who was located on Davies unit at the same time as the man. He had also known the man from Lowdham Grange. The prisoner said that about one or two days after arriving on the wing, the man started to take Rivotril (a benzodiazepine also known as clonazepam) which he had allegedly obtained from another prisoner. This prisoner had also apparently told the man that if he made an appointment to see the doctor and complained of having had an epileptic fit, he would be prescribed this medication. The prisoner who was located on Davies unit at the same time as the man told the investigator that the man had not had any fits and his claims to the doctor were made purely in order to gain additional medication. He said that he had told the man that he was taking too many drugs and at times he looked "a proper mess, stumbling" around. However, he added that he did not think the drug use was generally a big problem on the wing and staff tended to act swiftly if they suspected its misuse.

Key events on 3 April

74. On the morning of 3 April, a PCO told the investigator that she arrived on duty (on Davies unit) at 7.30am and received a handover from the night duty officer. She told him that it had been a quiet night, except for her having to attend the man's cell in response to him pressing his emergency cell bell (each cell on a wing has a cell bell which is to be used in an emergency to request staff assistance). When she responded and arrived at his cell, the night officer looked through the observation panel to see him appearing to be walking around bumping into the furniture. She described the appearance of his pupils as "very large". He said he was okay and had pressed his cell bell accidentally. The night duty officer told the PCO that she had not smelt any

hooch (illegal alcohol made by prisoners) but he had not appeared right. The night duty officer also said that she “couldn’t be bothered” to submit an SIR for drugs because she had previously done so having smelt cannabis on the wing, and nothing appeared to have been done about it.

75. The PCO said she was aware of the drug problems the wing faces, especially as its exercise yard was the closest to the prison perimeter walls and, as such, attracted “throw-overs” (contraband or drugs that are thrown over the prison walls from outside) from time to time. Nonetheless she felt it important that he submit an SIR with the information that was passed onto him by the night duty officer. The PCO said that the normal procedure once security had received an SIR that related to drug misuse, was for a mandatory drug test (MDT) to be carried out within 72 hours.

76. Following on from this, an SIR summary sheet also noted that when the man and two other prisoners were unlocked on the morning of 3 April, their cells spelt of cannabis. An MDT was to be completed on all three prisoners. (At the time of his death, no records were found in his prison records to indicate whether an MDT was carried out.)

77. Later on the same day, a PCO submitted an SIR (timed at 4.30pm). It stated that the man had been seen by staff with grazes to his nose. Another prisoner was seen with a cut on his arm. The SIR was submitted to the security department where it was believed, through intelligence that both of these prisoners were involved in trading drugs at Rye Hill. This information was to be passed on to the Residential Manager and the Healthcare Manager for information and they were to be monitored by wing staff.

78. In addition, the SIR summary sheet (entry also dated 3 April), detailed that from intelligence received, it was alleged that the man and two other prisoners were “robbing” cells on the wing to pay for their drug debts. They were also selling medication. All three prisoners had some form of bruising to their body, but all refused to say how they got them when questioned by staff.

79. A PCO who also worked on Davies unit told the investigator that the man’s general behaviour on the wing was good. He was aware that he was on the IDTS programme and looked at times “quite anxious”. He also noticed on occasions that the man and other prisoners’ behaviour was suspicious after medication issue time. There was a suspicion that prisoners were swapping their medications and so staff were to be aware and vigilant, and to submit SIRs if necessary. He was also known to associate with the prisoner who allegedly supplied him Rivotril, who was known to misuse medication.

Key Events on 4-5 April

80. On 4 April the man attended the asthma clinic. He was seen by HCA and was given a change of inhaler. The HCA described his mood and appearance as much the same as when she assessed him on his arrival at Rye Hill. He was polite and she had no cause for her concern. He told her he had a history of epilepsy, something he had not mentioned during his reception screening.

The HCA noted his medical record that he should be seen by the doctor “re epilepsy”.

81. Around this time, the PCO who attended the man’s cell in response to him pressing his emergency cell bell said that the man had approached her and asked if he could start on an education class. He appeared keen and the PCO said she would look into it for him. In general, the PCO said his presentation was normally quite sleepy or a bit wobbly due to the medication he was taking.

82. The next day, 5 April, around 4.00pm, the man was seen by the CPN who conducted a follow up mental health assessment. He engaged well throughout the interview, although he was described as quiet at times. The CPN noted he was still taking mirtazapine but had stopped taking olanzapine (an antipsychotic drug commonly used to treat schizophrenia and moderate to severe episodes of bipolar disorder) shortly after coming into prison two years ago because he did not get on with the prison doctor. He spoke of having some paranoid thoughts and that when he was on Olanzapine, this medication helped. A referral was made for him to be seen by the psychiatrist at the next available clinic to review this.

Key events during the day on 6 April

83. On the morning of 6 April (9.50am) the man saw the doctor he had seen at the Clinic. He complained of having had an epileptic fit. When examined, the doctor found he had a bruise over the right side of his head and face. He said he wanted clonazepam, a dosage of 3mgs three times a day, a dosage he said he had been prescribed before.

84. The doctor said he reviewed the man’s medical record and was aware that he was on the methadone programme. There was also no record of him being prescribed clonazepam in custody. He told the investigator that he talked to him about referring him to a neurologist (A neurologist is a doctor specialising in diseases and illnesses of the nervous system and brain) who would conduct tests to confirm whether or not, he suffered from epilepsy. The man was against this referral stating it would be not be timely and was concerned about having another fit. No record of this conversation or the suggestion of a referral was recorded in his medical record.

85. The doctor then prescribed him clonazepam. However, only at what he considered a minimum dose, 2mgs three times a day. The man expressed his unhappiness at the dosage level and said he would complain to his solicitor. The doctor noted his medical record “Diagnosis: Epilepsy” and that he had a history of epilepsy and had had a fit in the last few days. Clonazepam was prescribed for 28 days.

86. The PCO who also worked on Davies unit said he spoke with him in the morning about an issue he was having with his television. He then saw him again whilst he (the man) was queuing for his food at lunch time between

11.30am and 12.00pm. He described him as looking as he normally did since his arrival on Davies unit, including having tired eyes.

87. A Nurse told the investigator that she had been at Rye Hill for approximately 12 months. As well as carrying out general nursing duties, she also dispensed medication on the wings from the hatches. She had not received any specific training for dealing with prisoners with drug issues.

88. She explained that she had not had much contact with the man as he was new. On this day, her duty was working at the medical hatch between 11.30am and 12.30pm. Nursing staff had a copy of the prisoner's prescription chart and would check this against their prison identification card when they presented at the hatch. The man attended the hatch to receive his first dose of clonazepam. It was 2mg which was diluted in water. He was supervised to ensure that he consumed the medication. The Nurse described him at that time as in a "bubbly" mood.

89. Later that afternoon, the IDT's doctor, IDT's Nurse and the CARAT worker, saw the man at his request for a follow up substance misuse assessment and CARATs review. He said he was doing well on his current dose of methadone (100ml). The doctor said he appeared focussed and it was agreed by all, including the man, that he should reduce his current dose by 2ml a week. When the dosage reached 70ml, the doctor said that the man's care would then be evaluated again. The man requested that the new dose (the 2ml reduction from 100ml) start on 11 April. The nurse said that he was on a high dose of methadone for a prison environment but he looked okay and was pleased with the reduction planned.

90. The doctor said he noticed bruise to his face and asked him what had happened. He replied that he had had a fit and had already seen another doctor about it.

Key events during the evening on 6 April

91. That evening between 4.45pm and 5.30pm, the man attended the medication hatch[9] to receive his second dose of clonazepam, administered by the nurse who dispenses medication on the wing. The Nurse told the investigator that although he seemed quieter, she was not concerned about his mood. Between 6.15pm and 6.30pm, the nurse again saw him to give him his daily dose of methadone. Two members of the nursing team have to be present to administer this drug. The methadone is measured by a machine and swallowed by the prisoner who must immediately follow this by drinking a cup of water to ensure the methadone has been consumed. The nurse then talked to him to ensure that he had swallowed the methadone and not tried to conceal it. He gave her no concerns having taken his medication. Prisoners would have been out on the exercise yard and on association around this time and until about 7.15pm, when they would be locked back into their cells.

[9] A hatch through which medication is dispensed to prisoners.

92. Another prisoner told the investigator that he saw the man around 6.30pm, shortly after he had received his methadone. They were in the exercise yard outside. He was “looking out of space” and did not respond to him when he greeted him. The prisoner said he also observed the man in the exercise yard after he had received his evening medication and later described him as “wobbling all over the wing”. Following association and exercise, around 7.30pm, prisoners returned to their cells which were then locked by staff. The prisoner said he saw him “stumbling” as he walked into his cell.

93. A prisoner told the investigator that the man came to his cell that evening for a chat. (The investigator was unable to confirm whether this occurred before or after the man had received his methadone medication). Whilst they talked in the prisoner’s cell, the prisoner who allegedly gave him Rivotril had appeared outside the doorway wanting to speak to the man. The prisoner said he told the man to stay away from him. After about ten minutes he left the cell as he said he had to do something. The prisoner believed he was going to see the prisoner who allegedly gave him Rivotril to obtain drugs. Shortly after, the prisoner went to find the man. When he did, he described him as being unsteady on his feet. The prisoner said that staff did notice the man who he said was locked back into his cell by a landing PCO. However, the landing PCO told the investigator that he was on leave at this time. (three PCOs told the investigator that they were all on duty that evening, but did not recall who locked the man back into his cell.)

94. From his interview with the police, the prisoner who allegedly gave the man Rivotril said that he had never seen the man take drugs of any sort during his short time on Davies unit. The man had, however, asked him on two occasions for rivotril. The prisoner said that he told the man that he would not give it to him and if he wanted it he should go and get it from the doctor.

95. The prisoner told police that he spoke to him around the time prisoners were being locked in their cells for the night. He described him as “normal” and did not seem to be “high, wobbly, unsteady on his feet“.

96. A PCO was required to carry out patrol duty on Davies unit on the evening of 6 April. This task entails checking each prisoner was in their cell and that the cell doors are locked and secure. This check would take place at between 7.30pm and 8.45pm and would include a roll check around the beginning and end of this period. A later roll check would be carried out with the night duty officer, whose duty would begin around 8.30pm. Once the roll check numbers had been rung through and checked by the Communications Unit, the patrol officer’s duty would end and they would leave the prison. The PCO said she had no contact with the man while carrying out patrol duty that evening.

97. Another Davies unit PCO said that the evening roll check was carried out at 7.40pm. This duty was shared amongst the officers on the wing. She could not recall if she had checked on him at the time the roll check was conducted, however she said that no issues arose during checking and he raised no concerns.

98. One of the PCO's was on duty on Davies unit from 5.30pm until 7.45pm. This was not the usual wing that he worked on and so he was not familiar with the prisoners on it. Part of his duty would be to complete the roll check on the wing. He said he could not recall if he had checked the landing on which the man's cell was. However, if he did, he raised no concerns to note about any of the prisoners. This also applied to another PCO who could not recall any significant issues arising.

99. A further PCO was the night patrol duty officer on the 6 April covering C and Davies unit. The wings each have two landings, holding approximately 75 prisoners each. She began her shift at 8.30pm and checked each cell door was secure and locked. This included conducting a roll check of the prisoners. Throughout the night, those prisoners on suicide and self harm procedures and those deemed at risk of attempting escape are checked at pre-arranged intervals. All other prisoners are not checked upon until the following morning, at the next roll check, starting at 5.30am.

100. Whilst conducting the evening roll check, the PCO said that she smelt cannabis coming from a cell opposite the man's. She also smelt burning plastic (which she believed was possibly the scent of heroin) from another cell nearby. She opened the cell observation panel of the cell opposite the man's to be met with abuse when she questioned the smell that was coming from inside. She made a note of the two cell numbers with the intention of submitting an SIR in the morning, before going off duty. (Because of the discovery of the man the following morning, the PCO said she had not completed the SIR.)

101. The PCO recalled nothing significant occurring on the wing after checking the man's cell during the roll check. He did not press his cell bell throughout the night.

Events on the morning of 7 April

102. Having begun her morning roll check, the night PCO, along with another PCO, arrived at Davies unit at around 5.40am. The other PCO had been working on A and B wings. Along with the PCO, they would start their respective roll checks at the same time and thus share the responsibility for the checking of each of the four wings, concluding on Davies unit.

103. Having arrived to check the cells on Davies unit second landing, the man's cell door observation panel was opened by the PCO. His bed looked un-slept in and his cell was "immaculate, very tidy". The television was on. He was sitting in a chair at the bottom of his bed although his face was on the bed, almost looking as if he was lying on his bed. She knocked on his door to get a response using the words "morning, wake up are you okay". He did not respond nor move. As the PCO observed him further, she noticed that part of his back (which was exposed) and arm looked purple. With part of his chest in view, it looked as if he was not breathing. The PCO said that her first aid training certificate had expired. However believing the man was dead, called

the other PCO, who was checking cells on the opposite side of the landing, to come to the man's cell.

104. The PCO completed the checking of three cells and then made her way to the man's cell. This took no longer than 30 seconds. When she looked through the observation panel, she saw the man was sat on a chair at the end of his cell, slumped over. The PCO said she had had her first aid training earlier in the year (although prison records provided to the investigator state that at that time, her first aid certificate had expired) and described the man's arms as mottled and blue. The two officers continued to call his name but he still failed to respond.

105. The PCO used her radio (the battery in the other PCO' radio was dead, an issue that occurred with radios and that the Director told the investigator had since been rectified) and contacted the Communications Unit. This was recorded on the Communication Log as occurring at 5.42am. She requested that the Night Manager (NM) (the officer who is in charge of the prison overnight), and healthcare staff attend the wing. She added that night duty officers carry a sealed key pouch and would not enter a cell during the night state unless it was an emergency. In such cases, and if the seal on the pouch had to be broken to enter a cell, three members of staff should always be present.

106. A PCO conducting the roll check on F wing when he heard a call over his radio (around 5.45am) for "all available staff to Davies (Davies unit), cell 61". He attended immediately along with his PCO colleague who was also on the wing. Patrol Officer PCO (Patrol Officers only carry keys to the prison gates and therefore cannot enter cells) met them at the F wing foyer and escorted them to Davies unit. The PCO arrived at his cell (within a few minutes) to find the two PCOs outside the cell. They both told him that they believed the man to be dead. As he looked through the cell door observation panel, the Night Orderly Officer (NM), arrived and used her keys to open the cell door.

107. The NM confirmed that she had acknowledged the emergency call on her radio to attend Davies unit and did so with a patrol officer. She ran to the wing which took about two minutes.

108. With the cell door unlocked, the PCO conducting the roll check on F Wing entered first. He saw the man sat in a chair, slumped over to the right hand side with his face resting on the top of duvet on the bed. He had vomited. Having placed his hand on his shoulder and called out his name, the PCO found him to be cold and rigid. The PCO, who was first aid trained, believed that he had been dead for some time.

109. A PCO told the investigator that he was in the administration building when he heard the alarm call over his radio requesting that "all available staff attend Davies Unit (Davies unit)", at about 5.45am. As a patrol officer with keys to the prison gate and the nearest officer to the healthcare unit, the NM had instructed him to collect the nurse en-route.

110. A Nurse had been employed at Rye Hill since January 2011, working the night shift. When the nurse heard the call over her radio requesting that Hotel 2 (healthcare nurse) make their way to Davies unit, cell 61, she reacted immediately. By the time she had grabbed the emergency bag and oxygen from the healthcare office, she was met by the PCO who was in the administration building, who escorted her to Davies unit.

111. They arrived at Davies unit within two minutes. The PCO who was in the administration building was about ten yards in front of the nurse and placed the emergency bags on the floor as he approached the man's cell. He saw the cell door being opened and a PCO entering as he got closer. When he looked into the cell, he could see the sitting in a chair at the end of his cell. When the nurse who is employed at Rye Hill since January 2011 arrived she went straight into the cell. The PCO who was conducting the roll check on F Wing briefed her on the condition he had found the man in.

112. When the nurse had heard that the prisoner's name she recalled that one of the night duty nurses had mentioned his name to her over a week previously. The man had apparently tried to obtain an additional dose of methadone following his arrival at Rye Hill. The sending prison (HMP Lowdham Grange) sent a fax through to confirm that he had already had his daily dose of the methadone in the morning before transfer and he was duly informed of this. The nurse told the investigator that some prisoners often tried to obtain extra medication and indeed she had been approached many times by prisoners with this in mind.

113. The nurse saw that the man was on a chair at the end of the cell with his head on the bed. When she put her hand on his neck to check his pulse, he was cold. As rigor mortis was present she said this was an indication that he had been dead for a long time. Resuscitation was therefore not appropriate.

114. All staff left the cell. The NM had already requested that an ambulance be called (recorded as occurring at 5.47am). She also contacted the Communication Unit to activate the death in custody procedures which would involve informing the man's family of his death and contacting the necessary agencies such as the police, the prison's Duty Director and the Director. The cell was sealed with a log taker appointed to record those who entered and left the cell.

115. Two ambulance paramedics arrived at the prison at 6.02am and were immediately escorted to the cell by PCO Lamb. The nurse re-entered the cell with the paramedics. Having checked for signs of life with their medical equipment, they confirmed his death at 6.15am. They believed he had been dead for around six hours.

After confirmation of the Man's death

116. With the death in custody procedures already initiated, the Director had arrived at the prison. He conducted a hot debrief meeting with all staff that attended the man's cell. The police and the members of the Care and

Support Team were also present. Prisoners on the wing were also offered support.

117. The man's next of kin was listed as his mother who lived in Swindon, some distance away from the prison. At the prison's request, the local police notified her of his death as they were able to do this without delay. This was immediately followed up by a visit from the prison Family Liaison Officers, who arrived at his mother's house at 12.10pm. His sister was also present. They explained the circumstances in which the man was found as well as what would happen next. When the FLOs left his mother's house, they ensured she had the relevant contact telephone numbers for the prison. The next day one of the prisons Family Liaison Officers contacted his mother to discuss the funeral arrangements. Financial assistance was also offered. Thereafter, the prisons Family Liaison Officer kept in regular contact with the man's mother ensuring that arrangements for the funeral went as smoothly as possible.

Post Mortem report

118. Within the conclusions of the post mortem report, the pathologist said,

"From my examination and taking into account the toxicology findings, there was clear evidence of respiratory depression from methadone ingestion and coupled with the effect of vomiting, with regurgitation of food particles, this would have further compromised respiration. The other substance found in his body in my view played only a minor or no significant part in causing his death."

119. The cause of the man's death was confirmed as,

a. Respiratory depression including regurgitation of food particles.
b. Methadone intoxication

Criticial De-brief meeting

120. Although a critical debrief meeting was arranged for 28 April 2011, no staff attended.

ISSUES

Clinical care

121. A clinical reviewer reviewed the man's prison and associated records. He has made 15 recommendations, a number of which are endorsed and therefore reproduced in this report. Although the report refers to the most pertinent ones, the clinical review report will be shared with the Head of Healthcare at Dovegate, Lowdham Grange and Rye Hill and the PCTs so they are aware of all recommendations that the clinical reviewer has made.

122. In respect of the man's care at Rye Hill, the clinical reviewer has noted that the care he received from the IDTS team was in line with what care a similar patient would have received in the community. However, in referring to his physical health there was concern that clonazepam was initiated by the doctor in the absence of an established diagnosis of epilepsy. Furthermore, that the starting dose of clonazepam was not commensurate with the British National Formulary[10] (BNF) guidance nor initiated by a neurologist which would be custom and practice in general practice.

Record keeping

123. There were numerous entries on the man's medical record prior to arriving at Rye Hill. It was clear that there was a lot contact with him on a frequent basis, in some instances daily. However, his records were not clear in identifying problems raised and the actions taken to address these. In particular, it is unclear in the notes made during his stay in Lowdham Grange why some medication was started or, in the case of his methadone prescription, why this was increased. It is important that medical entries provide clear evidence of the care planned for a prisoner in addition to what decisions have been made and actioned. The following recommendation is therefore made to the Head of Healthcare at Lowdham Grange:

    The Head of Healthcare at Lowdham Grange should ensure that all staff provide documented evidence relating to all medication reviews, detailing the rationale for medication usage and dosage changes.

124. The Clinical reviewer found that, upon the man's arrival at Rye Hill, with the exception of one entry which is discussed later in this report, the medical records entries made were factually correct, consistent and accurate and made in a timely manner.

[10] The BNF provides authoritative, independent guidance on best practice with clinically validated drug information, enabling healthcare professionals to select safe and effective medicines for individual patients.

Mental health

125. The man had a history of mental health problems and of suffering from paranoia, insomnia and anxiety. Whilst in Dovegate however, it is noted that there was a delay in his mental healthcare follow up appointment. Whilst the reasoning behind this was staff shortages, the substantial delay would have had an impact on him receiving timely and effective care. The following recommendation is therefore made:

The Head of Healthcare at HMP Dovegate should ensure that all mental health referrals are followed up within a timely manner, to ensure prisoners receive effective care.

Contact with the Integrated Drug Treatment System (IDTS) doctor

126. The man was on the IDTS programme when he arrived at Rye Hill and this was immediately identified and noted. Appropriate referrals were also made to the CARATs and IDTS team. He saw the IDTS doctor on two occasions. No concerns were noted and it was planned that his methadone dosage would steadily decrease, something he (the man) agreed to.

127. On the first occasion that he was seen by the IDTS doctor, the examination took place on a residential prison wing. The investigator was informed that this was due to the non availability of a clinical room on the healthcare wing. The doctor was therefore unable to complete a full examination which would have included a urine test screening for drugs of abuse. It also made it impossible for him to look at the electronic medical records of the patient. Given his documented history of misusing drugs and using drugs “on top”, this would have been an important part of the screening process.

128. While it is appreciated that the availability of clinical rooms can sometimes cause difficulties, it must be considered a priority to ensure that medical assessments are carried out in an appropriate room to fit the purpose of the examination. Failure to do this could jeopardise a full account of an individual’s medical history being obtained and then appropriately shared.

129. In addition, because of the location of the examination, there was no immediate access to the medical computer system, System One. When the medical record was updated, the entry was completed by the IDTS nurse on behalf of the doctor and dated the day after the actual examination took place. The clinical reviewer notes that this is not in keeping with acceptable healthcare governance guidance for accurate and appropriate record keeping. Staff should be reminded to record the name of the clinician who carried out the examination and ensure the correct associated date is used for audit purposes. The following recommendation relates to these two issues:

The Head of Healthcare at Rye Hill should ensure appropriate clinical premises for the assessment and treatment of patients, including testing facilities and computers for access to medical records.

Integrated Drug Treatment System (IDTS) and medication administration

130. The IDTS service is provided by an external provider (at the time NHS Northamptonshire). The doctor and nurse working for this service had received training specifically relating to the field of drug substitution therapy. The administration of methadone is delivered by healthcare staff employed by Rye Hill but working for provider services.

131. At the time of the man's stay in Rye Hill, the nurse providing the methadone had not received any specific training in this field. This also applied to the other two nurses who had contact with him. The investigation found that staff working at the prison do undergo an induction programme which includes induction into prison specific issues. However, there was no evidence that specific induction is provided in relation to substance abuse and the use of substitution medication such as methadone, either for healthcare staff nor the wider prison staff.

132. This investigation has raised concerns that a lack of staff awareness of the risks and side effects of medication and other substances could result in misuse going undetected. From interviews, it transpired that he may have been intoxicated by drugs on a number of occasions. A lack of general staff awareness of issues relating to drug use also increases the risk that clinicians are not made aware of potential misuse issues. This clearly has serious implications, as any drugs taken illicitly may interact adversely with medication prescribed by healthcare professionals.

The Director and Head of Healthcare at Rye Hill should ensure appropriate drug specific training for staff at all levels.

133. The administering of methadone at Rye Hill is also of concern. The current prison policy is to administer methadone in the evenings was an issue raised as a concern by HM Inspectorate of Prisons at their most recent inspection. Other prisons give methadone in the morning. The clinical reviewer notes that by administering methadone in the morning, there is a greater window of opportunity to monitor and observe those who have been given methadone for side effects and complications. Prisoners who receive methadone in the evening and are locked into their cells soon after it is administered for the night, as the man was, and not routinely checked upon. The following recommendation is therefore made.

The Head of Healthcare at Rye Hill should implement the administering of methadone in the mornings so that prisoners can be more easily monitored after taking the medication.

Contact with the prison doctor at Rye Hill

134. The man saw the prison doctor on two occasions. At the first consultation he complained of an anxiety attack and said he had family history of epilepsy. He was keen to be prescribed clonazepam. This medication was not prescribed by the doctor on this occasion. On his second consultation with the doctor, he said he had had an epileptic fit and presented with bruises to

his head. On this occasion, the doctor made a diagnosis of epilepsy and medication, clonazepam at a dosage of 2mg three times a day, was initiated. This was a lower dosage than which he said he wanted and he expressed his unhappiness about it.

135. The clinical reviewer comments that, although clonazepam is licensed for use in patients with epilepsy, it was not started at an appropriate dose. It was also not considered to be the first line of treatment for someone suffering from epilepsy. The clinical reviewer also noted that, although the post mortem and toxicology report do not mention clonazepam as being present or contributing to the cause of death, the doctors choice of prescribing clonazepam, which is a potent benzodiazepine and which can give respiratory depression in combination with the high dose of methadone, was a poor choice. In addition, the investigation found that there was no documented evidence to suggest that the doctor had carried out or initiated any test on the man for epilepsy, despite telling the investigator that he intended to do this the following morning, 7 April.

The Head of Healthcare should ensure that adequate training and governance is in place to support locum doctors to provide a robust service

136. The investigation found that there was mixed views from staff and prisoners as to the level of drug abuse on Davies unit. What was quite apparent however, and documented, was his suspected involvement in misusing drugs. What is not clear, as there was no mention of it on his medical record, was whether this information was passed onto healthcare, as suggested on an SIR submitted. Nonetheless, he had a previous and documented long history of misusing drugs so it is a concern that given this, the doctor did not appear to be more cautious in prescribing a drug to him for an illness which had not been fully diagnosed.

137. The doctor was at the time of the man's stay in Rye Hill, employed as a locum. We have no information what the clinical governance arrangements are between the locum, its agency (if applicable) and the Prison.

138. An observation was made that this doctor, despite extensive experience in working in custodial settings, had not undertaken or received any training in dealing with drugs related issues.

Reporting and follow up of Security Incident Reports (SIRs)

139. Although during interviews some prisoners stated that he appeared wobbly and unsteady the evening before he was found dead in his cell, this was not corroborated by any of the staff members. That said, one PCO reported that he always seemed a bit sleepy and wobbly. There did seem to be a general feeling that this was his normal appearance.

140. This investigation found mixed attitudes amongst staff about the reporting of SIRs and about perceived effectiveness of follow up where an SIR has been submitted. One member of staff said that they received no feedback on the

follow up and outcome of SIRs submitted. Another reported that his colleague failed to submit an SIR believing no action would be taken even if it was. Certainly from his prison records, there is evidence that staff submitted SIRs when concerns were raised. It is imperative to the security and safety within prisons that all staff are vigilant and consistently take appropriate action when concerns like this arise. It is also noted that he did not have a mandatory drug test (MDT) as a result of SIRs raised after suspected drug misuse. Whilst this might simply be because of the short period of time between the SIR being submitted and his death, the following recommendation is made:

The Director at Rye Hill should remind staff to submit Security Incident Reports for all suspected concerns relating to the misuse of prescribed and non-prescribed drugs so that appropriate and timely follow up action can be taken, including mandatory drug testing.

Emergency response

141. The emergency response when he was discovered was professional, with healthcare staff arriving extremely quickly after the alarm was raised. The investigation team found that the appropriate actions were taken and no other actions could have been carried out. However, three issues did come to light.

142. There appeared to be a slight delay in opening his cell door as staff were hesitant to open their sealed pouches or enter the cell until more staff had arrived. It is vital that staff are clear on the local procedures for opening cells during night state, which includes the following:

> "….Where there appears to be, immediate danger to life, cells may be unlocked without the authority of the NOO (Night Orderly Officer/Night Manager) and in individual member of staff may enter the cell on their own. Staff have a duty of care to prisoners and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger."

143. In the case of the man this made no difference to the outcome. However, the following recommendation reflects the need to ensure staff are aware of procedures for future emergencies:

The Director of Rye Hill should ensure that staff are aware of the content of their local procedures for entering cells during night patrol duty.

144. As in many prisons, Rye Hill has an emergency code system that should be used to inform and alert staff to emergencies. The Rye Hill emergency Code 1 or Code 2 was not used by staff when he was found. An emergency code system gives staff an indication of the type of incident they are responding to and can help to prepare them for what they might expect to see when they arrive. Although this did not in any way impact upon the timeliness of staff arriving at his cell, the following recommendation refers to the need for staff to adhere to their local procedures:

The Director of Rye Hill should remind staff of the appropriate use of the code system in emergency situations

145. When staff examined him, rigor mortis was present and so any attempt to resuscitate him would have been futile. Indeed it would have been undignified for him and distressing for the staff to have attempted resuscitation when there were clearly no signs of life. The response by staff was in line with the guidance given by the National Offender Management Service.

146. However, the first two members of staff who initially discovered him had not received any recent first aid or resuscitation training. It is essential that an adequate number of uniformed prison officer staff, who are usually the first responders to medical emergencies, have up to date first aid training which enables them to start CPR. Although this was not appropriate in his case, we refer to a letter written by the Chief Executive of NOMS, and dated 29 October 2010, to all prison governors. The letter highlights the need for each establishment to review their first aid arrangements for prisoner-related incidents and, where inadequacies are identified, action plans must be put in place with timescales to remedy the situation.

The Director of Rye Hill should, as per Chief Executive of NOMS **'s letter, ensure that sufficient numbers of frontline staff are appropriately trained in first aid or basic life support training, including refresher training.**

Critical debrief

147. A critical debrief takes place normally after about two weeks after a serious incident. It gives the staff the opportunity to understand the incident in greater detail, identify any learning points, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment. Although a critical debrief was arranged, no staff attended and the investigator was unable to ascertain the reasons for this. The care and support offered to staff in the aftermath of such an incident is extremely important, as is reflected by the following recommendation:

The Director of Rye Hill should ensure that following a serious incident, staff are reminded and allowed the time to attend the critical debrief meeting.

CONCLUSION

148. The man had a long history of drug abuse, both in the community and while in prison. He was placed onto the IDTS programme once in custody with the aim of assisting him to safely detoxify from heroin. However, he also appeared to misuse other drugs and medication he obtained illicitly on the wings. This investigation has found a number of areas in need of improvement in respect of how his detoxification was managed, specifically relating to the amount of methadone he was prescribed.

149. The investigation also found a number of missed opportunities for staff at Rye Hill to share information about his alleged misuse of drugs on the wing and makes recommendations on steps needed to improve practice in this area.

RECOMMENDATIONS

1. The Head of Healthcare at Lowdham Grange should ensure that all staff provide documented evidence relating to all medication reviews, detailing the rationale for medication usage and dosage changes.

   The National Offender Management Service accepted this recommendation, writing:

   Direct dissemination of HM Coroner findings to lead prescribing clinicians (GP Primary Care Lead & GP Secondary Mental Health Services, Nottinghamshire NHS Trust). All clinical records at HMP Lowdham Grange are now on System One, electronic patient care records. All prescribers informed of requirement to document rational for change in medication and dosage as part of the clinical assessment. Confirmation replies have been received from lead clinicians

2. The Head of Healthcare at HMP Dovegate should ensure that all mental health referrals are followed up within a timely manner, to ensure prisoners receive effective care.

   The National Offender Management Service partially accepted this recommendation, writing:

   The Head of Healthcare agrees with the recommendation, however, processes are already in place and have been since 2008.

   I am pleased to say that Dovegate reports GREEN in an independent Mental Health Audit and can provide you with the following information as evidence.

   - *The PHPQI GREEN Indicator as audited and agreed by the Strategic Health Authority*
   - *TAG Referral form which scores the urgency of the referral (Dovegate led the regions 10 prisons in rolling this out as good practice)*

   Assessments completed within Community Target times (5 Weeks) from referral to assessment

3. The Head of Healthcare at Rye Hill should ensure appropriate clinical premises for the assessment and treatment of patients, including testing facilities and computers for access to medical records.

   The National Offender Management Service accepted in principal this recommendation, writing:

   The Doctors surgery and the treatment room to be reviewed in line with current medical standards, a process of upgrade to be identified for the refurbishment of the facilities, funding is not at this time in place and needs to be sought.

We will seek funding from the PCT in line with the prison ITFit programme to provide access to System One computer system in Treatment hatches in both house blocks.

4. The Director and Head of Healthcare at Rye Hill should ensure appropriate drug specific training for staff at all levels.

   The National Offender Management Service accepted this recommendation, writing:

   All staff are provided with training to the required standard for their specific Job Roles.

   Nursing staff will receive drug specific training as part of their Preceptorship, the training will be provided by the current Pharmacy practitioner with regard to the administration of medications.

   In partnership with the NHS commissioned substance misuse service provider we will ensure that both new and existing staff receive substance misuse awareness training at least annually.

5. The Head of Healthcare at Rye Hill should implement the administering of methadone in the mornings so that prisoners can be more easily monitored after taking the medication.

   The National Offender Management Service accepted this recommendation, writing:

   An operational review will be conducted to ascertain a suitable time for the administering of Methadone, with consideration given to continuity of care, impact on the regime and the secure management of the process.

6. The Head of Healthcare should ensure that adequate training and governance is in place to support locum doctors to provide a robust service

   The National Offender Management Service accepted this recommendation, writing:

   G4S Healthcare will develop a formulary for any locum doctor to follow and will provide the doctors access to current G4S and DOH guidance to enable the doctor to fulfil the requirements of patient care effectively. Locum doctors will be advised of the content of the formulary and how to access other guidance before they are able to practice at HMP Rye Hill.

7. The Director at Rye Hill should remind staff to submit Security Incident Reports for all suspected concerns relating to the misuse of prescribed and non-prescribed drugs so that appropriate and timely follow up action can be taken, including mandatory drug testing.

The National Offender Management Service accepted this recommendation, writing:

Directors notice to staff to be written and circulated to all staff, reminding them to submit Security Intelligence Reports for all suspected concerns relating to the misuse of prescribed and non-prescribed drugs and prompt reporting back to healthcare of any SIR's relating to substance misuse or misappropriation of prescribed medication, including updating the information on the patient's medical record.

8. The Director of Rye Hill should ensure that staff are aware of the content of their local procedures for entering cells during night patrol duty.

   The National Offender Management Service accepted this recommendation, writing:

   Directors notice to staff to be written and circulated to all staff to ensure they are aware of the content of their local procedures for entering cells during night patrol duty.

9. The Director of Rye Hill should remind staff of the appropriate use of the code system in emergency situations

   The National Offender Management Service accepted this recommendation, writing:

   Directors notice to staff to be written and circulated to all staff to ensure they are aware of the appropriate use of the code system in emergency situations.

10. The Director of Rye Hill should, as per Michael Spurr's letter, ensure that sufficient numbers of frontline staff are appropriately trained in first aid or basic life support training, including refresher training.

    The National Offender Management Service accepted this recommendation.

11. The Director of Rye Hill should ensure that following a serious incident, staff are reminded and allowed the time to attend the critical debrief meeting.

    The National Offender Management Service accepted this recommendation, writing:

    Following a serious incident, staff are invited and allowed the time to attend the critical debrief meeting.