Investigation into the circumstances surrounding the death of a man at HMP Bedford in April 2007

Report by the Prisons and Probation Ombudsman for England and Wales

October 2009

This is the report of an investigation into the circumstances of the death of a man in April 2007. At 1.30pm that afternoon, he was found hanging in his cell at HMP Bedford by his cell mate. Cardio pulmonary resuscitation was carried out but at 2.04pm he was pronounced dead.

I would like to offer this public expression of condolences to the man's family and friends on their loss. A key objective of all my investigations is to ensure the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. Initially, his family conveyed their concerns through their solicitor, but, eventually, in November 2007 one of my family liaison officers and the investigator met the man's parents and sister and they raised a number of additional matters. It is regrettable that there was a delay in meeting the family. I hope my investigation begins to offer answers to these questions. I regret the delay in the completion of this report.

The investigation was led by one of my investigators, who was assisted by a former colleague. A clinical review was conducted by the Lead General Practitioner at HMP Chelmsford, and I am grateful for his assistance. I would also like to thank staff at HMP Wormwood Scrubs and HMP Bedford for their co-operation with this investigation.

The man was a long-term drug user who was initially remanded to HMP Wormwood Scrubs where he was placed on a methadone maintenance prescription. Following a routine court appearance, he was "locked out" of HMP Wormwood Scrubs due to population pressures and spent the night in police custody. The next day, he was taken to HMP Bedford where methadone is not prescribed for drug users. Four days later, he hanged himself. Although there can be no certainty in these matters, it is very hard to believe that these facts are not related.

Operation Safeguard came into effect in 2006 and is used by the Prison Service, police, courts and escort contractors to manage the shortage of prison places. I am continuing to monitor its implementation with concern. The man's death, and another to have occurred in April 2008, share similar features in that both had the clinical management of their drug problem disrupted as a result of being unable to return to the discharging prison.

My report contains a number of recommendations concerning clinical care and procedures. One further recommendation, plus significant textual amendments and additions, have been added after consultation on the first draft of this report.

Stephen Shaw CBE

Prisons and Probation Ombudsman **October 2009**

CONTENTS

SUMMARY

Following arrest by the police, the man was remanded to HMP Wormwood Scrubs on 15 March 2007. He was a long-term drug user who had been in Wormwood Scrubs, mainly on remand, on a number of occasions and was known to staff there. He was located on the Conibeere Unit, a dedicated wing for drug users, and started on a methadone maintenance prescription. On 22 March, he returned to court and was further remanded until 12 April. He returned to Wormwood Scrubs and continued on his methadone maintenance.

On 12 April, the man was one of three prisoners to go to court from the Conibeere Unit. He appeared at the magistrates' court and was remanded until 19 April. Population pressures throughout the prison estate meant that he was unable to return to Wormwood Scrubs. (In such circumstances, prisoners are taken by the escort contractors to the nearest available space at a police station. This is known as Operation Safeguard.) He was taken to the police station where he was given medication overnight to help with his withdrawal symptoms.

The following morning, the man was taken to HMP Bedford, the nearest local prison with available space within the jurisdiction of the escorting contractors. He arrived just after 3.00pm. During the reception medical screen, and subsequent appointment with the prison General Practitioner (GP), the man explained that he was a drug user. He was assessed as suitable for a withdrawal programme using lofexidine and other symptomatic relieving medication. This was started the following day. He was also suffering from an ulcer but was not given the medication he had been prescribed in Wormwood Scrubs.

The man was placed in C wing. During the early hours of 16 April, his cell mate pressed the cell bell complaining that he could not cope with being in a cell with the man because he was suffering badly from detoxification symptoms. Staff moved the other prisoner to another cell.

In the morning, after complaining of vomiting, the man again saw the prison GP who changed some of his medication. Later that afternoon, he moved to cell C3-10. His new cell mate told my investigator they stayed awake talking most of the night as the man was unable to sleep due to withdrawing. The following morning (17 April), the man told a member of healthcare that he was feeling better. Over the lunchtime period, the cellmate fell asleep in the cell. He awoke to discover the man slumped on the floor and with a ligature tied around his neck. He immediately cut the ligature before ringing the cell bell and kicking the door to attract urgent attention. Within minutes, staff entered the cell and began cardio pulmonary resuscitation (CPR). At 2.04pm, the man was pronounced dead.

After the man's death, the prison complied with the required procedures. Staff had the opportunity to use the services of the care and welfare team and prisoners subject to Assessment, Care in Custody and Teamwork (ACCT) monitoring (used to support and monitor those thought to be at risk of self harm) were checked**.** After some initial difficulty, the prison managed to contact his family the next day.

I make a number of recommendations relating to clinical care and procedures.

THE INVESTIGATION PROCESS

1. My former colleague conducted a preliminary visit to HMP Bedford on 24 April to open up the investigation. She also visited the cell where the man died. Subsequently, all the relevant documentation was reviewed and a chronology of events established. Feedback about the findings of the investigation was given to the then Governor, on a regular basis.

2. Notices were issued to staff and prisoners telling them of the investigation and offering the opportunity to speak with my colleagues. No one came forward as a result.

3. My investigators met representatives of the local branch of the Prison Officers' Association (POA) and the Independent Monitoring Board (IMB). No specific concerns were expressed. The man's last probation officer and the solicitor who represented him at his final court appearance were also contacted for background information.

4. Given that the man had spent the majority of his time in custody in the Conibeere Unit in HMP Wormwood Scrubs, my colleagues visited the unit and spoke informally with a number of staff. They also visited the Population Management Section (PMS) at Prison Service Headquarters to discuss the daily logistics of Operation Safeguard. (On a daily basis, PMS assess how many prison discharges there were in London and notify the contractor (SERCO). The contractor would fill these spaces and then any number over and above would have to go to other available prisons or available police cells.) Feedback about his death with regard to Operation Safeguard was given to Safer Custody Group over the telephone during the course of the investigation. (Safer Custody Group is the policy unit within Prison Service Headquarters that issues instructions and guidance to prisons on the management and prevention of suicide and self-harm.)

5. Thirteen members of staff, both discipline and healthcare, were interviewed at Bedford by my investigator and former colleague. The man's cellmate at the time of his death was also interviewed. (The cellmate has since been released from custody and my investigator has been unable to make contact with him at his discharge address. Consequently, he has not had sight of the transcript of his interview.) His first cellmate was released from Bedford within days of his death

and did not provide a discharge address so could not be contacted. The prisoner in the neighbouring cell was unable to provide any information for the investigation.

6. The Lead GP at HMP and YOI Chelmsford and Prison Service Eastern Area, Clinical Advisor for the Integrated Drug Treatment System, undertook a clinical review of the healthcare provided for the man. The clinical reviewer was given copies of all the medical transcripts. He also visited Bedford and spoke to two members of staff, including the prison GP.

7. Shortly after the man's death, solicitors appointed by his family contacted my office requesting that all contact be made through them rather than directly with the family. My colleagues complied with this request, but a subsequent miscommunication between my office and the solicitor meant that a meeting with the family was unfortunately delayed. This caused the family great distress. I regret and apologise for this. However, this was remedied and the investigators met the man's parents and sister late in November 2007 when they gave an overview of the investigation.

8. The man's family had some additional questions about his medication at HMP Bedford. My investigator relayed these to the clinical reviewer and he subsequently elaborated on these issues in his clinical review.

9. A draft version of this report was sent to the Prison Service. An action plan was provided in response. Paragraph 65 has been elaborated to include further details regarding the discovery of the man.

10. The man's family were sent a copy of the draft version of this report. His mother, father and sister responded separately in writing to the report. Having considered their views, I have added a further recommendation to which the Prison Service have also responded. In addition, his family felt that the commendation of staff involved in attempting to resuscitate the man was insensitive. I have respected their comments and removed it from the report.

11. The Primary Care Trust, through their solicitors, made a number of comments regarding the draft report. No changes were made as a result of their comments.

12. Following the issuing of the revised draft report, in December 2008, a meeting took place between the man's family and their solicitors and my investigator and other staff members including the deputy Ombudsman. Following the meeting my investigator completed a number of additional enquiries. These were:-

    - My investigator wrote to the Governor of Bedford for further details of the drug policy.

- Additional material has been included in the final report regarding the background information about Bedford and drug policy.
- My investigator asked the Clinical substance misuse advisor, Offender Health, to review the man's case and provide a report.
- A statement has been provided by the Deputy Head of the Population Management Section.
- Some changes to the text at the request of the man's mother.

HMP BEDFORD AND HMP WORMWOOD SCRUBS

HMP Bedford

13. HMP Bedford is a small, city centre local prison. In an unannounced short follow-up inspection report in April 2006, the HM Chief Inspector of Prisons, described Bedford as "a fundamentally safe prison". She concluded, "this is a prison that has been able to work sensibly and remarkably effectively given the challenging population and the constraints of its old buildings."

14. However, the HM Chief Inspector of Prisons report went on to say:

> "… we have drawn attention to some shortcomings in the area of drugs detoxification, and arrangements to maintain drug support for those who are not in custody for lengthy periods. Both of these areas are now behind contemporary practice elsewhere."

On page 18, the HM Chief Inspector of Prisons wrote:

> "We found that clinical management of substance users was poor or nonexistent. Neither subutex nor methadone was used. Men who arrived at the prison on a maintenance prescription of methadone were not able to continue with it, but were instead only given symptomatic relief on their first night in custody, and were then offered a fourteen day britlofex detoxification programme."

15. The HM Chief Inspector of Prisons recommended:

> "The clinical management of substance users should be urgently reviewed in conjunction with the national prison health clinical substance use lead. Maintenance prescribing, adequate first-night medications, and appropriate detoxification regimes to meet the needs of prisoners, should all be introduced by the prison."

16. The action plan by Bedford in response to the recommendation stated that by 31 March 2007:

> "A new Head of Healthcare and doctor, who specialises in substance misuse, have been appointed. Six weekly meetings are now held to review our approach to clinical substance misuse policy. Bedford has not received funding for the Integrated Drug Treatment Systems (IDTS), but we are committed to improving provisions within current resources."

17. By letter, my investigator asked the Governor about the policy for prisoners arriving by unplanned transfer from a prison with IDTS. He stated:

> "At the time of the man's death, prisoners who arrived by unplanned transfer, and who were on methadone maintenance, were converted to the local opiates policy, which at the time was the prescription of Lofexidine."

18. The Integrated Drug Treatment Systems is a national mandatory programme for prisons. The National Treatment Agency (NTA) determines the programme for the roll out of the IDTS across the prison estate. IDTS aims to not only increase the volume and quality of treatment available to prisoners, with particular emphasis on early custody, but also to improve integration between clinical and CARAT (Counselling, Assessment Referral Advice and Throughcare) Services and to reinforce continuity of care from the community into prison, between prisons, and on release into the community.

19. HMP Bedford was in the third roll of IDTS and funding made available from April 2009. The criteria used for the selection of the IDTS Third Wave prisons were a combination of:

- Priorities for clinical treatment need in those prison not yet receiving additional funding;
- Those trainer prisons taking prisoners from these newly identified local prisons;
- Those non-IDTS funded local prisons in which suicides have occurred in the last financial years;
- Prisons serving localities with a prevalence of drug-related deaths greater than 7/100,000 population.

(IDTS Announcement letter, April 2008)

20. There have been five apparent self-inflicted deaths at HMP Bedford between December 2004 and this man's death in April 2007. Although the circumstances of these deaths are not similar, this investigation found some common features with two of my previous reports regarding the use of emergency equipment. Although these were not found to have contributed to the deaths, this report makes a number of similar recommendations in this area.

21. A further inspection of HMP Bedford took place in February 2009. The findings of this inspection have not been included in this report since it took place nearly two years after the death of this man.

HMP Wormwood Scrubs

22. HMP Wormwood Scrubs is a category B local prison. It has one dedicated wing, for drug users, Conibeere Unit (CBU), which was

introduced in 2004. The unit is staffed by both clinical and discipline staff and holds a maximum of 46 prisoners. A number of detoxification options are available based on individual need including a methadone maintenance programme.

KEY FINDINGS

23. The man was arrested at 11.06am on 14 March 2007and taken to the police station. A routine risk assessment form was completed by a police officer on the basis of information provided by him. He described himself as suffering from depression, being a heroin addict and having an ulcer. It was recorded that he was taking methadone and "ameprazol" (sic). (There are a number of spelling mistakes of omeprazole throughout his records. Each time, the spelling used by the author has been included in this report). He was offered the chance to see a drug referral worker which he said he was interested in doing. The man was asked if he had ever tried to harm himself to which the officer wrote "no". He told the officer that he had an anti-social personality disorder. According to the officer, he appeared under the influence of drugs and he concluded that he was "a risk".

24. At 2.12pm, the man was seen by the Forensic Medical Examiner (FME), a doctor who provides services to the police service. At that time the FME concluded that hel was fit to be detained but not fit for interview. He wrote:

> "heroin addict (IV) use, PH peptic ulcer, depression and self-harm, appeared co-operative and orientated, no recent self-harm, ½ hour observation, will be fit for interview at 6pm, given LOSEC 40mg x 1 and DHC [dihydrocodeine] 30mg x 2."

25. The same FME saw the man at 6.00pm, identified him as fit for interview, and again prescribed 60mg DHC. In addition, the FME recorded that the man was Hepatitis C positive and a self-harmer, and that the half hourly observations should be continued. At 9.29pm, he was charged with burglary of a non-dwelling property between 7/8 February 2007.

26. In the early hours of 15 March, at 1.30am, the man saw another FME who observed that he was withdrawing from opiates. He prescribed 60mg DHC and 7.5mg of zopiclone (usually prescribed for insomnia in withdrawing drug users). There was no mention of self-harm.

27. The man was taken to the magistrates' court later that morning and was remanded into custody until 22 March. The Prisoner Escort Form (PER), designed to communicate important information between the various criminal justice agencies, indicated that his risk categories were "medical condition, escape risk and drugs/alcohol". In a further section concerning risk issues, it stated "heroin addict, hep c, has escaped lawful custody". The form mentions that it "took 6 policeman to put him on the van at the police station, violent and mouthy."

28. The PER recorded that the man left the court at 5.55pm. Neither the escort staff nor receiving prison staff completed the PER to show that he was handed over to staff at Wormwood Scrubs or at what time.

Upon his arrival, he went through the reception process. This included staff completing the core record (form F2050) which asks basic questions about age, religion and other such information. The form also requires the prisoner to provide the name and address of his next of kin but he did not do so and gave his solicitors as the contact for an emergency.

29. A cell sharing risk assessment (CSRA) was completed. The man was noted to be dependent on drugs. In response to the question as to whether the prisoner has an open 2052SH (a system of monitoring those at risk of self-harm or suicide), the author wrote "no" but ticked "yes" to the question asking if there is evidence of the prisoner having a previous 2052SH. All the answers, bar the last, indicate that he was the source of this information. (It is not known if this was a mistake on the author's part and if the final answer was also provided by the man. Staff would not routinely have known if a new prisoner had previously been on suicide support and monitoring arrangements. When he had previously been in Wormwood Scrubs in December 2006, he had not been on any suicide monitoring.)

30. In response to further questions, the man said he did not have any concerns about sharing a cell but described himself as someone who gets "angry/frustrated quickly". The assessor concluded that the man was of low risk of harm to others and was suitable for multi-cell location. Section 3 of the CSRA was completed by a nurse who concluded that he was of medium risk to others. This indicated that there was "no immediate risk but situation will need to be reviewed regularly". In response to the question "following the self-harm assessment have any concerns been raised?" the nurse ticked "no".

31. These answers would have been informed by the First Reception Health Screen (FRHS) that was completed by the same nurse. The man said that he had seen a doctor recently for a perforated ulcer and was taking omeprazole 20mg daily and methadone. He went on to give details of his drug use and took a urine test that proved positive for heroin, methadone, benzodiazepines, cocaine/crack and cannabis.

32. Question 10 of the FRHS asked, "Have you ever tried to harm yourself?" to which the author wrote "yes (in prison) DHS (sic) (Dec 2006)." (During a visit to Wormwood Scrubs my investigators checked the man's old records from 1-7 December 2006. There was no record of an incident of self-harm during this time. This suggests that any attempt by him to harm himself was not known by staff at the time, hence not recorded.) Question 11 asked, "For some people coming into prison can be difficult, and a few find it so hard that they may consider harming themselves. Do you feel like that?" Neither "yes" nor "no" was ticked. The author was then asked to "record your impression of the prisoner's behaviour and mental state" and wrote "appears stable at present". It was concluded that he needed to see a doctor due to his physical health and substance abuse.

33. The man's prescription chart indicates that at 10.20pm he received a once only dose of zoplicone (7.5mg), buscopan (20mg), loperamide (2mg) and metoclopromide (10mg). There is a reference number for Primecare and the nurse's signature. This suggests that the nurse contacted the out of hours doctor and, following an assessment, was granted permission to prescribe these drugs which are routinely given at Wormwood Scrubs for the difficulties associated with withdrawal from drugs (insomnia, abdominal cramps, diarrhoea and vomiting).

34. In the man's medical records there are three separate entries on 16 March. It is not possible to decipher the corresponding signatures. The first one indicates that he was seen in the First Night Centre and gives brief details regarding his ulcer which at that point was described as asymptomatic. The second is an in-depth history of his medical needs and his 15 year drug history. It recorded that he had had no overdoses, but six fits during withdrawal from substances in the past. It went on to say that there have been no suicide attempts and no thoughts about self-harm or suicide. However, the author has then recorded: "then said he tried to hang himself and harm himself when withdrawing – last time in December." The author has concluded: "methadone titration and maintenance, symptomatic relief and carbamazepine in view of previous seizures." (Carbamazepine is routinely provided for prisoners undergoing a detoxification at Wormwood Scrubs, for 14 days initially. However, there is no corresponding prescription chart in the man's records and therefore it is not known if he was actually prescribed carbamazepine at Wormwood Scrubs.)

35. The man was located in the Conibeere Unit, Wormwood Scrubs' drug wing and started on a methadone regime. A 'Current Admission and Research Form' was completed and he was asked about suicide indicators. He answered yes to previous attempts, by "hanging [and something illegible] but is not expressing suicidal ideation at that time or does he have a plan made." Under history of self-harm a tick was placed against 'no' (when it should be 'yes' given his previous answer).

36. After seven days, the man went onto a methadone maintenance programme of 50mg a day. In his medical records, there are almost daily notes by the nurses who administer methadone in which they indicated no concerns and that he appeared stable.

37. On 22 March, the man returned to the magistrates' court for a routine court appearance. He was remanded until 12 April and returned to Wormwood Scrubs.

38. My investigators visited Wormwood Scrubs and spoke with the Substance Misuse Service Team Leader. The man was known to staff there because of previous remands. The team leader described him as usually polite and quiet and that he liked to be by himself. She said

that he could be difficult when he first came in but would calm down once he began his medication. This was supported by prison records from December 2006 which showed that he spent two days (during a stay of seven days at Wormwood Scrubs) in the segregation unit after throwing water at a nurse.

39. On 12 April 2007, the man returned to the magistrates' court. His PER indicated that he had a problem with drugs and in the section "further information about risk" was written: "not to be given opiate based medication on methadone maintenance." He appeared in court and was further remanded until 19 April.

40. The man had expected to returned to Wormwood Scrubs, but during the afternoon that prison and a number of others had to "lock out" prisoners due to the swelling prison population. He was one of three prisoners who had left Wormwood Scrubs that morning to go to court who was locked out and was subject to Operation Safeguard. (Operation Safeguard came into effect on 12 October 2006. Under these procedures, police cells are used to hold prisoners from court who cannot be placed in prison accommodation because of overcrowding. In these circumstances, a prisoner is taken to the nearest police station with available space. This may mean travelling outside the contracted area of the escorting service. Under these measures, where prisoners are placed in police cells, it is intended that they should spend only one night there and be returned to their discharging prison the next day. The procedures are set out in Prison Service Instruction 30/2006.)

41. The man was taken to the local police station where he spent the night. The police custody risk assessment sheet indicates that he told staff he had a stomach ulcer and was a heroin addict for which he was receiving methadone and "amerpail x tablets – evening" (sic). In response to the question, "Have you ever tried to harm yourself?" the assessor ticked "no". He was assessed as a risk. No further explanation or details were given.

42. The PER for 13 April outlines drugs, escape risk and medical condition as risk categories. Under the section "Further information about risk" the author wrote: "D/P states he suffers from a stomach ulcer and on methadone. Prescribed and given 2 x 30mg Dihydrocodeine and 1 x 5mg Diazepam @ 06.35 hrs 13/4/07." Part B of the PER, which gives a record of events, indicates that the man was given further medication at 12.30 pm. The PER suggests that the intended journey was for him to go from the police station back to Wormwood Scrubs. However, he left the police station at 2.47 pm and arrived at HMP Bedford at 3.09 pm.

43. The police station comes under the jurisdiction of the GSL East escort service. Although the man was taken to the police station by Serco, who operate the escort service between Wormwood Scrubs and the

magistrates' Court, he could only have been transferred from there to a prison within the responsibility of GSL East. In addition, due to the demand on prison spaces within the London area, once prisoners had been transferred out of the area it was not desirable to return a prisoner back into the area with high demand during Operation Safeguard.

44. The man was one of 26 new receptions who arrived at Bedford on 13 April, making it a very busy day. All new arrivals have to be inducted by discipline staff and see both a nurse and a doctor. The First Night Centre, on the lower floor of C wing, holds only 16 prisoners and so some prisoners are located directly onto the upper landings.

45. Upon his reception at Bedford, a Cell Sharing Risk Assessment (CSRA) was completed. The man said that he had abused drugs, but in response to being asked if he was currently dependent told the assessor "no". When asked if he was on an open F2052SH or if there was any evidence of a previous F2052SH, he also responded "no". He also said he had no concerns about sharing a cell and described himself as someone who did not get angry/frustrated quickly. The assessor concluded that he was at low risk of harm to others and suitable for multi-cell location. He was located in cell C3-007 which he shared with another prisoner.

46. The same officer conducted a first night interview with the man. He asked him whether it was his first time in custody and if he had any concerns about being in prison. He also asked if he had ever committed an act of self-harm/attempted suicide and if he felt at risk of self-harm. He answered "no" to all four questions.

47. A nurse completed section 3 of the CSRA. The only box she ticked was that the man was a medium risk, which is described as "no immediate risk but situation will need to be reviewed regularly". In interview, the nurse said she had identified him as a medium risk because he was withdrawing from drugs.

48. Bedford operates a computerised healthcare system and entries are completed electronically at the time of seeing the patient. A second nurse, who completed the records at 4.12pm was very new in post, and in interview she could not recall the man. She said that she was still being supervised in reception because she was so new. Although her colleague was there, the second nurse carried out the interview. She recorded that the man was "quiet and calm and his skin appearance was healthy". He said he was concerned about detoxing and was receiving omeptrzole (sic) 20mg daily and methadone 50mgs daily. The second nurse recorded that health information had been received from an outside source indicating that his medical records would have been with him. In response to being asked if he "had harmed himself inside or outside of prison?" he had answered "no". He said he had received treatment from a psychiatrist outside prison and that he had

been diagnosed with an anti-social personality disorder. It was recorded that he "said that he was anxious about giving up methadone," and had been referred to the doctor.

49. The man was seen by the prison GP who prescribed a "standard 14 day opiate detoxification regime using Lofexidine". The prescription chart for that day indicates that the prison GP prescribed a once only prescription of diclofenac, buscopan and Nitol. This is in line with Bedford's policy and would have been given to him by one of the reception nurses that evening until the lofexidine programme started the day after.

50. In interview, the prison GP described the consultation with the man:

> "He was very upset and aggressive then because he was told he couldn't have his methadone and was anticipating cold turkey. That made for the consultation starting off on a confrontational basis because I was having to tell him he could not have what he was expecting to have. The problem we've got here is that identifying those people who have underlying strong suicidal ideation is rendered much more difficult under such circumstances. All that one can see is expressed anger. And in fact, when I saw him on the Monday before he killed himself, he was still very angry. I told him I was sorry I could not prescribe him what he was asking for.
>
> "I had the IMR from Wormwood Scrubs so I knew the situation there. He had been on 120mls of methadone outside, it had been reduced to 50ml and then he'd gone to court, then been locked out of Wormwood Scrubs. He'd stayed overnight in police custody. Now in police [custody] the forensic medical examiners, generally speaking, hand out dihydrocodeine and diazepam as apparent standard practice to people who are opiate dependent. They use dihydrocodeine because it's a short-acting drug, not even a controlled drug but it does blunt withdrawal, and they give diazepam, and that's quite helpful. But there again, he comes here and he says: 'Why can't you give me dihydrocodeine? They could in the police station!' and I have to say: 'I can't because the protocol says I can't, this is the way we're supposed to do things here.' So the issue here is a man who has a very reasonable expectation, and I am really struggling to answer the questions that he has.
>
> "It was fairly tense but it was basically me trying to sell detoxification to him. Unfortunately we have to focus on this issue of the opiate dependent person going to have a detox whether he likes it or not, and having to persuade him that it will be okay, even though it might not be."

51. In addition, the prison GP was asked whether he spoke specifically about self-harm and suicide with the man:

> "The problem is that when they kick-off, and get angry, if you then ask them whether they are going to kill themselves, they'll likely say 'Well, I don't know what I'll do!' and it's then very difficult to differentiate those people that you genuinely need to watch from those people who are just angry because they have been thwarted, but do not intend to kill themselves. We cannot open an ACCT document on every single person who comes in with substance misuse and is going through opiate withdrawal. It would be very difficult to maintain that level of surveillance on that number of prisoners. So yes, in retrospect an ACCT document wasn't opened on this man, the question of suicidal potential I don't think was addressed as well it should have been, and I look at myself and blame myself. I mean, I generally tend to have a conversation around suicidal ideation if I possibly can. It wasn't documented in this case, and I can't recall absolutely whether we did touch on it in consultation on Friday night … On the Friday we may have touched upon it, as my usual practice is to ask about self-harm and I usually record that in notes. On this occasion it wasn't recorded, so I might not have asked the question. Alternatively I might have asked it and not actually recorded it, I can't recall, whether I did or not, in this particular circumstance."

52. The prison GP was asked about the added complication of the man's stomach ulcer:

> "I have to say that was a concern to me because this boxed me into a corner. One of the drugs you have available to give him, to stop pain in the muscles, you can't give because he's got this history of a bleeding stomach ulcer. So you are in effect saying: 'We'll punish you even more now, by saying you can't have this drug, because you've got a history of bleeding stomach ulcer.' So I actually prescribed him diclofenac which is not something I'd really like to have done. Then he came to see me on Monday and said that he was vomiting and there were streaks of blood in it, so I had to stop the Diclofenac. So that meant I was then reducing even what he was getting."

53. In line with Bedford's policy, the detoxification prescription was written up to start the following day, Saturday 14 April. The routine prescription was for diclofenac, buscopan, diphenhydramine hydrochloride, all for seven days, and lofexidine for 14 days. On that Saturday, the man's blood pressure was taken twice although the times were not recorded. (The protocol states that this must first be before, and then half an hour after, the first dosage of lofexidine.) No specialist detoxification nurses worked at Bedford during weekends, although all nursing staff are trained to work with prisoners undergoing a

detoxification and are familiar with the protocol. On the first day, lofexidine has to be seen to be taken by the prisoner and then given daily in possession.

54. In interview, a pharmaceutical technician recalled speaking with the man on 15 April as she was giving out medication that day. She said that he had asked her about methadone. She had explained that no detoxification nurses were available at the weekends and that he should ask to see the doctor.

55. The observation book on 16 April shows: ”during the night [the man’s cellmate] pushed his cell bell stating that his cell mate was detoxing and doing his head in. He requested to move cells before he done something stupid. He has now been located in cell C1-2 overnight.” In interview, an officer recalled answering the cell bell and speaking with the cellmate who said that the man was keeping him awake with his detoxification symptoms. Unable to recall the exact time, he thought it was in the early hours of the morning. The cellmate was then located to another cell. The officer said that the man seemed fine and had no concerns about him. (My investigators were unable to speak to the cellmate because he had been released from custody.)

56. As part of the induction process, the man was visited by a Counselling Advice Referral and Throughcare (CARAT) drug service worker on 16 April. Engaging with the CARAT team is entirely voluntary. He wrote: ”declined induction – seen in cell.” Investigators spoke to the CARAT’s worker who was unable to recall anything specific about the man. He explained that it was not unusual for prisoners to decline to see a CARAT worker.

57. On 16 April, the man asked to see the doctor during morning medication and an appointment was booked at 8.17am. He saw the prison GP at 3.27pm and the notes read: “c/o vomiting and has brought up streaks of blood. Stop diclofenac, start omeprazole 20mg nocte and paracetamol. Not happy at having britlofex detox. Adv we have no choice in the matter.” The prescription chart indicates that he was given a five day dose of prochlorperazine and seven days paracetamol. In interview, the prison GP said about this consultation that it “was even more confrontational (than Friday’s) about medication, and at the end he left abruptly before I had a chance to do anything more.”

58. At 3.30 pm, the man moved into a cell with another cellmate. A number of documents should be completed when a prisoner moves cells but none was done so in this man’s case. Part of the process is to check the risk assessment of each prisoner to see if they are suitable to share but there is no evidence to indicate that this was done. Although the man and the new cellmate were deemed suitable to share, my investigators were unable to find out which officer had sanctioned the move.

59. At interview, the new cellmate said he was aware that the previous cellmate was finding it difficult being in a cell with the man while he was detoxing. The new cellmate said that he was willing to share with the man because he was not worried about losing sleep as he had been through the same experience himself at Bedford a few months earlier.

60. Given the man's withdrawal symptoms and insomnia, the new cellmate said that he and the man were awake much of the night talking. He said the man told him about his long standing drug addiction and all the associated problems of homelessness and prison. The man had said he had felt quite at home at Wormwood Scrubs and that coming to Bedford was the worse thing that could have happened to him. He complained about the prison GP and the lofedixine programme.

61. The new cellmate said they spoke about suicide and the man had admitted to experimenting with ligatures. He said he had described tying a noose around his neck and then stopping at the last minute. From the new cellmates' account, he had said that if he could face doing that, then he could cope with anything that life threw at him. The new cellmate shared his own experiences with him and said he was very candid about how he had previously felt suicidal as well. He said the man told him that he had found it very positive speaking with him and was encouraged that the new cellmate had become drug-free.

62. The following morning, the pharmaceutical technician saw the man again while giving out medication. He told her he had seen the doctor the day before and had been given some anti-nausea medication and was feeling much better. The prescription chart shows he was issued with in-possession omeprazole 20mg on 17 April, having been prescribed it by the prison GP on 16 April. The pharmaceutical technician was asked in interview how the man had presented during her encounters with him. She said that he was polite and never gave her any indication he would harm himself. She commented that he did not look especially ill and could walk and talk without difficulty.

63. The substance misuse nurse specialist, and one of two specific detoxification nurses at Bedford, spoke with my investigators. She explained that there are two part-time detoxification nurses who between them provide full-time cover during weekdays. In addition, they have to carry out other duties. The week beginning 16 April was unusual in that both the substance misuse nurse specialist and her colleague were not working that Monday. One of their usual duties on Mondays is to see all the prisoners who have started their detoxification over the weekend (the man would have been on their list). This consultation would have included a questionnaire from which a care plan would have been drawn up. Instead, they had scheduled to see all the prisoners on Tuesday afternoon. In their absence, he would have been able to request to see a nurse or doctor if required.

64. During the morning of 17 April, the man's cellmate went to the gym, leaving him alone in the cell. They then went to the exercise yard together where the man spent the time sitting on a bench. Later that morning, they collected their lunch and returned to the cell. The cellmate said in interview that, after having lunch, he was extremely tired having stayed awake all night talking with the man. He recalled the man asking him if he minded the television being turned off and then falling into a very deep sleep. When he awoke he saw him sitting on the floor underneath the window. Initially, he did not notice anything unusual and started to speak to the man. He then noticed that he had a ligature round his neck and attached to the bars of the window. The cellmate used his plastic knife from lunch to cut the ligature. The man fell to the side and he tried to find a pulse but was unable to do so. He said that he was very cold to touch. At this point, he rang the cell bell.

65. An officer was passing through C wing at approx 1.30 pm. He saw the red emergency light on above the door of cell C3-10 and heard someone kicking the door. He immediately went to the door and opened the flap. In interview, the officer said he saw the cellmate first at the flap and only saw the man slumped on the floor in a sitting position when the cellmate said that his 'pad mate had tried to kill himself'. Upon seeing the man, the officer called for medical attendance and opened the door.

66. Over the radio, there had been some misunderstanding of the officer's location and initially staff made their way to A wing. Another officer was working in the control room (COMMS) and responded to the first officer on scene's call over the radio. He explained in interview that the first officer on scene was carrying a radio, identified as Alpha Two. When an officer triggers the transmit button, they are trained to wait a second before talking. In his haste, it would seem that the first officer on scene began to talk immediately, thus the message that staff heard in COMMS was "medical assistance, alpha two" and as a consequence directed staff to A wing rather than C wing. The first officer on scene then radioed again to correct the location relayed to staff. The layout of the wings is such that officers were able to get to C wing very quickly.

67. The first officer on scene laid the man out on the floor and cut the ligature from around his neck using the anti-ligature knife that is carried by all officers. He could not see any movement in the man's chest to indicate breathing. After putting on his mask, he started to give breaths. By this time other staff arrived. Another officer began chest compressions.

68. A nurse was coming back from lunch and heard the emergency call on the radio of a colleague with whom she was walking. As with the other staff, she initially attended A wing before setting off for C wing. In interview, she said that when she arrived at the cell one officer was doing mouth to mouth and the other was performing chest compressions. The nurse checked with staff that an ambulance had

been called and then took over the compressions. The man was clammy to touch and from his colour she believed him to be dead.

69. Hotel 2 is the emergency medical response radio and it is the responsibility of the nurse carrying it to respond to any emergency call. At Bedford it seems that the radio is sometimes switched off for an hour at lunchtime and any emergency calls are put through to the healthcare centre. On this occasion, the radio was turned off but the Hotel 2 nurse was in the prison and heard the call coming through a colleague's radio. The message came over as "medical assistance to A wing". The Hotel 2 nurse did not take any medical equipment with her. She arrived at the cell at the same time as the nurse coming back from lunch. She then went to get the emergency bag from the main wing office, returned to the cell and then left again to collect the defibrillator from healthcare. Once back at the cell, the Hotel 2 nurse was unable to attach the plugs into the machine. In interview with my investigators, she said she felt this was because she was panicking. The nurse coming back from lunch said that she did not try the lead herself but did have a quick look with the Hotel 2 nurse.

70. Nurses and discipline staff continued cardio pulmonary resuscitation until the paramedics arrived at 1.50pm and took over. Sadly, the man was pronounced dead at 2.05pm by the prison GP.

71. The cellmate had been taken to the Listeners' suite by another officer. (Listeners are prisoners trained by the Samaritans to provide confidential support to other prisoners.) The officer took a statement from the cellmate who was later interviewed by the police. He felt that the prison dealt with him well. All staff involved were offered the services of the care and welfare team and all prisoners on ACCT documents were checked in line with guidelines.

Contacting the man's family

72. Given that the man had not given any next of kin details, staff at Bedford initially contacted Wormwood Scrubs. He had given his grandmother's phone number as a number on the PIN phone system (in which each prisoner is given a unique number to access the telephone system). Unsure of her age and state of health, staff did not want to contact her without other information. The man had spoken to his cellmate about previously staying with a vicar in the London area. It would seem that the prison chaplain then worked her way through the telephone book until she traced the vicar who was able to tell her a little bit more about his grandmother.

73. The prison's family liaison officer and the chaplain then went to see the man's grandmother the next morning and telephoned his parents from his grandmother's house. The family are not convinced that this delay was necessary. Their view is that, despite being elderly, the man's grandmother should have been informed on the day regardless of any

other factors. Whilst respecting the family's opinion, I am not minded to criticise staff for this decision. The prison staff made their judgement without the benefit of knowing his grandmother and, in my view, the care that they took was appropriate.

74. When my colleagues met the man's family they were very complimentary about the leaflet given to them by the prison when they were notified of his death. However, in general, his family feel that the quality of the liaison with them was very poor. They spoke negatively about obstacles raised by the prison service regarding practical arrangements for the man's grandmother to visit with the rest of the family due to her restricted mobility. Subsequently, perfectly acceptable arrangements were made for the family to meet the Governor on the ground floor but they felt there had previously been a degree of insensitivity. They also commented that they had been told by the police that the cellmate had said he would talk to them but thought that they were put off doing this by prison staff.

ISSUES

Operation Safeguard

75. When the man left Wormwood Scrubs to attend court on 12 April 2007, he expected to return there later that day. However, given the high prison population some prisons became full and were "locking out" under Operation Safeguard, and this meant prisoners were being accommodated overnight in police cells. Depending on which police stations had cells available, prisoners were being taken outside the area of the escort contractors. This made it impossible for them to be returned to the originating establishment the next day if a space became available as a different contractor was involved. Another factor was that there was a disinclination to return prisoners to areas of high demand once they had been transferred out of area.

76. Unexpected transfers and moves at short notice are far from ideal and recognised as unsettling for prisoners. Under normal circumstances, staff try to avoid them. However, pressures on the prison population have made this unavoidable. Operation Safeguard allows for exceptions for certain categories of prisoners.

77. Section 5.3 of the Prison Service Instruction governing Operation Safeguard (PSI 30/2006) states:

"Every effort must be made avoid the use of police cells for the following groups of prisoners. In every case, when a prisoner from one of these groups is discharged from prison to court, his/her PER form must be endorsed 'return to discharging establishment'.

- Juvenile prisoners;
- Female prisoners;
- Those at risk of self-harm on open ACCT or F2052SH;
- Those with significant health care issues, including:
  - Prisoners undergoing assessment for, or due transfer, under the MHA 1983
  - Any prisoner identified by the prison health team as unsuitable on clinical grounds (This must be clearly identified on the PER)
  - Any other prisoner with a significant physical or mental health problem that the health care provider to the Police station feels is clinically unsuitable for their locally available service eg clinically unstable substance misuse problem or a patient undergoing complicated treatment;
- Vulnerable prisoners
- Prisoners with a Crown Court trial in progress (including those from the Court of Appeal (Criminal Division) – COACD;
- All category A prisoners including potential category A prisoners;
- Escape list prisoners or prisoners with a documented history of disruptive behaviour;

- Prisoners with mobility problems;
- Prisoners with language difficulties."

78. With the exception of those "identified by the prison health team as unsuitable on clinical grounds", prisoners falling into any of the other categories are easily identifiable. It is not clear, however, whether a prisoner being stabilised on a methadone maintenance programme in one establishment would fall into this category. In these circumstances, it is the transfer to another establishment with limited detoxification programmes that would render them "unsuitable".

The Prison Service should undertake a review of the criteria of those deemed suitable for Operation Safeguard giving specific consideration to prisoners on drug maintenance programmes. Clear guidance should be given to all prison staff following the review.

79. For the man to have been returned to Wormwood Scrubs, staff would have had to have marked his PER with "return to discharging establishment". Although staff at Wormwood Scrubs expected him back and told my investigators that they had held his cell, they did not recognise that they needed to identify him as being required to come back. They believed that this decision was a matter for the Population Management Section (PMS).

80. The man was one of three prisoners from Conibeere Unit who went to court on 12 April. The other two were returned and their PERs were examined by my investigators. They also did not have "return to discharging establishment" written on them. One went to Crown Court so may have been returned for that reason. It is also possible that they returned simply because it was earlier in the day and before Wormwood Scrubs reached its operational capacity.

The Governor of Wormwood Scrubs should ensure his staff are aware that the provisions of Operation Safeguard permit them to make representations concerning prisoners who should return to their establishment.

The man's ulcer

81. When the prison GP saw the man at his reception interview, he was aware of his history of a bleeding stomach ulcer both from his account and his records. The prison GP prescribed diclofenac. The clinical review suggests this was not appropriate. The clinical reviewer comments that diclofenac is a drug that is contra-indicated in patients with previous or active peptic ulceration. The prison GP, in interview, said that he was conscious of this incompatibility but prescribed diclofenac regardless. Following their second consultation, when the man reported the presence of blood when vomiting, the prison GP changed the medication. Additionally, the prison GP did not continue

with the omeprazole medication that the man had been prescribed at Wormwood Scrubs until after his second consultation with him.

82. I am not a clinician and it would not be right for me to criticise the prison GP given the pressured circumstances under which he found himself that evening, and the obviously difficult consultation with the man. However, it is of concern that little consideration appears to have been given to his pre-existing medication, or his presenting clinical conditions.

The healthcare manager at HMP Bedford should ensure that the care of substance users is planned taking account of the individual needs of the patient as well as clinical needs which may contraindicate the prescribing and issue of certain medications.

Substance misuse treatment

83. The only option offered to opiate drug users at Bedford is lofexidine along with other medication to ease the withdrawal symptoms. The clinical reviewer has expressed concern about the low dose of lofexidine used at Bedford: "the use of low dose lofexidine to manage symptoms of opiate withdrawal does not conform to national guidelines and needs to be modernised in line with current thinking".

84. As noted earlier in this report, the Chief Inspector of Prisons has highlighted the need for the clinical management of substance users at Bedford to be urgently reviewed. At the time of the man's death a year later, the options available for opiate users remained limited. The clinical reviewer makes the following recommendation in his clinical review which I strongly endorse:

The Governor and Chief Executive of the PCT should give urgent consideration to the overall planning of a sound and comparative substance misuse service for prisoners.

The cell move

85. The man moved into cell C3-10 on the afternoon of 16 April. My investigators were unable to identify the member of staff who sanctioned this move as none of the correct documentation had been completed. This included the cell location review which asks a number of questions regarding the reason for the move and the risk assessments of both the prisoner moving cells and the occupant of the cell to which he is moving. To answer these questions the cell sharing risk assessment forms of both prisoners would have had to have been checked. The move should then have been added to a list of 'cell changes' and the roll board in the office updated.

86. In this case, there was nothing of significance on either the man's or his cellmates cell sharing risk assessment. This is very disappointing

as the use of cell sharing risk assessments is an essential part of the safer custody agenda. Other cell moves that day were documented and the man's move was recorded on the local computer system.

The Governor of Bedford must remind all staff of the importance of completing all the relevant documentation with regard to cell moves.

The response by medical staff on 17 April

87. The clinical reviewer has written extensively about the response of healthcare staff on 17 April. I repeat his comments here and endorse all his conclusions and recommendations.

On-call radio, Hotel 2

88. It is accepted practice within the prison that the Hotel 2 radio is switched off at lunchtime for one hour every day and any emergency or other calls are directed by telephone to healthcare from COMMS.

89. On the day, Hotel 2 did have the radio switched off but heard the call on another person's radio and attended despite being on lunch break. Neither nurse who responded actually heard the call on a radio which they had on their possession. There is no note of any other person from healthcare responding other than the prison GP when he was called on his radio some time afterwards.

90. The current system of switching off the on-call nurses' radio (Hotel 2) for one hour at lunchtime is a practice that is less than safe. Relying on the use of telephone calls to pass on emergency calls to healthcare during this time is hazardous for obvious reasons.

The PCT must remind staff that the on-call radio should not be switched off at lunchtime but passed between members of healthcare to ensure appropriate cover for emergencies is seamless and guaranteed.

The scene of the incident and resuscitation

91. The initial delay in reaching the man's cell due to the incorrect identification of the location as A wing, rather than C wing as it should have been, resulted in a loss of between two to three minutes.

92. No resuscitation or other equipment was immediately taken to the scene by any of those responding. The healthcare manager said she would expect such equipment to be taken at all times an emergency

call is attended by a nurse. One of the nurses who did attend had to leave the cell on two occasions to get resuscitation equipment, once to the wing to fetch the resuscitation bag and then to healthcare to get the defibrillator. The Hotel 2 nurse was then unable to attach the defibrillator to the leads which would enable the defibrillator itself to be connected to the chest pads. She described "panicking" as the reason for this failure. No defibrillator was therefore available when it was needed.

93. I also note that no ambubag was used during resuscitation. One of the nurses says in her statement that mouth to mouth is as effective as an ambubag. However, ambubags, when available and used proficiently, are widely regarded as the safest and best way of both securing effective respiration and allowing oxygen to be attached and administered. There is no note of any airway being used during the resuscitation process nor any oxygen being used.

94. The first nurse to attend to the man ensured the ambulance had been called. The prison GP was called by a radio message some time afterwards and arrived at the cell at the same time as the ambulance crew. This was apparently 15 minutes (or more) later.

The Chief Executive of the PCT should urgently consider the training needs of all staff who may find themselves dealing with emergencies and plan for any necessary training to be given. Staff need to be familiar with the location of all emergency equipment and proficient in its use. They should also be both familiar and proficient in all other aspects of the processes necessary in dealing with emergency medical situations (eg CPR, mouth to mouth, ambubag use).

Emergency Coding System

95. It has been established that there was no existing coding system within the Bedford prison for highlighting the potential nature, severity and actions needed for emergency incidents.

96. In her statement, the healthcare manager felt that the introduction of an emergency coding system was unnecessary due to the imminent introduction of permanently carried emergency rucksacks by Hotel 2. However, this system has yet to be introduced and it is my understanding that there is still no emergency coding system in place.

I recommend that the Chief Executive of the PCT urgently considers introducing a coded radio call system to ensure that healthcare staff attending an emergency are able to take the necessary equipment to the incident and thereby manage it effectively.

Emergency Bags

97. The clinical reviewer could not establish exactly how many emergency bags are currently in the prison, where these may be located and what they actually contain.

98. Emergency bags should be readily and easily available throughout the prison so that they can be speedily accessed whenever they are needed. Their contents should be consistent and checked on a daily basis. The formal arrangements surrounding both the placement, contents and use of emergency bags and regular/refreshing of resuscitation training for all staff should be reviewed to ensure proper governance is in place and evidence-based best practice is followed.

The Governor should consider the immediate introduction and use of strategically placed emergency bags that can easily be moved to the scene of an incident and contain the necessary equipment to manage incidents effectively until the arrival of medical or other paramedic support. Urgent consideration should also be given to placing suitable portable Automated External Defibrillators strategically within the prison with easy access in the event of an emergency.

Conclusion

99. Prisoners detoxifying from drugs are especially at risk of suicide or self-harm. The man was on a maintenance prescription of methadone before being relocated under Operation Safeguard and ending up in a prison where methadone is not in use. The evidence of his cellmate is that he suffered pains of opiate withdrawal, and four days after arriving at the new prison he took his own life.

100. The man left no note to explain his actions and there can be no certainty as to what was in his mind when he tied the ligature around his neck. However, it is difficult to conclude other than that his transfer and change in medication were relevant factors in his death.

RECOMMENDATIONS

The Governor of Wormwood Scrubs should ensure his staff are aware that the provisions of Operation Safeguard permit them to make representations concerning prisoners who should return to their establishment.

The Prison Service accepted this recommendation, and said:

"The Governor has reminded staff but due to population pressures compliance is not always possible."

The healthcare manager at HMP Bedford should ensure that the care of substance users is planned taking account of the individual needs of the patient as well as clinical needs which may contraindicate the prescribing and issue of certain medications.

The Prison Service accepted this recommendation, and said:

***"**All prisoners who use the substance misuse service undergo a full assessment. Prisoners are given a health screen by a substance misuse nurse and then are either maintained or detoxified as required, including Methadone maintenance."*

The Prison Service updated their action plan response six months after the recommendations were made and said:

"*Completed. A new protocol is awaiting ratification by the PCT and partnership board."*

The Governor and Chief Executive of the PCT should give urgent consideration to the overall planning of a sound and comparative substance misuse service for prisoners.

The Prison Service accepted this recommendation, as above. The Prison Service updated their action plan response six months after the recommendations were made and said:

"Completed, we are currently in the process of becoming a third wave IDTS site, due for commencement April 2009"

The Governor of Bedford must remind all staff of the importance of completing all the relevant documentation with regard to cell moves.

The Prison Service accepted this recommendation, and said:

"The Governor will remind all staff of the importance of completing all relevant documentation with regards to cell moves."

The Prison Service updated their action plan response six months after the recommendations were made and said:

"Completed, Governors Order issued April 2008."

The PCT must remind staff that the on-call radio should not be switched off at lunchtime but passed between members of healthcare to ensure appropriate cover for emergencies is seamless and guaranteed.

The Prison Service accepted this recommendation, and said:

"A system has been implemented ensuring that the on-call radio is not switched off and is covered by a qualified nurse 24 hours a day."

The Prison Service updated their action plan response six months after the recommendations were made and said the action from this recommendation had been completed.

The Chief Executive of the PCT should urgently consider the training needs of all staff who may find themselves dealing with emergencies and plan for any necessary training to be given. Staff need to be familiar with the location of all emergency equipment and proficient in its use. They should also be both familiar and proficient in all other aspects of the processes necessary in dealing with emergency medical situations (eg CPR, mouth to mouth, ambubag use).

The Prison Service accepted this recommendation, and said:

"A training review has been completed for all clinical staff, this has resulted in all staff now being compliant with the PCT's training matrix. Clinical staff are also subject to twice yearly updates in CPR and Anaphylaxis."

The Prison Service updated their action plan response six months after the recommendations were made and said the action from this recommendation had been completed.

I recommend that the Chief Executive of the PCT urgently considers introducing a coded radio call system to ensure that healthcare staff attending an emergency are able to take the necessary equipment to the incident and thereby manage it effectively.

The Prison Service accepted this recommendation, and said:

"The emergency clinical response procedure was reviewed, with consideration given to introducing a coded radio system. As a result of that review, all emergency calls are treated as urgent and an emergency bag is taken to every call."

The Prison Service updated their action plan response six months after the recommendations were made and said:

"Completed. A draft document is now with the integrated governance group of the PCT for comments and to ascertain risk."

The Governor should consider the immediate introduction and use of strategically placed emergency bags that can easily be moved to the scene of an incident and contain the necessary equipment to manage incidents effectively until the arrival of medical or other paramedic support. Urgent consideration should also be given to placing suitable portable Automated External Defibrillators strategically within the prison with easy access in the event of an emergency.

The Prison Service accepted this recommendation, and said:

"Four Automated External Defibrillators (AED's) and two fully equipped resuscitation bags have been strategically positioned around the establishment, with a further two resuscitation bags planned in the very near future. The emergency response nurse also carries a fully equipped resuscitation bag to all incidents."

The Prison Service updated their action plan response six months after the recommendations were made and said:

"Completed. There is 5 AED's situated around the prison and an emergency bag on all wings. Two nurses respond to emergencies during the day and one at night."

Additional recommendation

The Prison Service should undertake a review of the criteria of those deemed suitable for Operation Safeguard giving specific consideration to prisoners on drug maintenance programmes. Clear guidance should be given to all prison staff following the review.

The Prison Service accepted this recommendation, and said:

"NOMs agency will review the criteria within a wider already planned review of Operation Safeguard."