Investigation into the circumstances surrounding the death of a man at HMP Brixton in June 2006

Report by the Prisons and Probation Ombudsman for England and Wales

August 2008

This is the report of an investigation into the circumstances surrounding the death of a remand prisoner at HMP Brixton in June 2006. I extend my condolences to his family and friends for their sad loss.

The cause of death recorded by the pathologist was lobar pneumonia. Toxicological examinations were also carried out and a level of 0.55mg/ml of methadone was detected. This is a relatively high level and raised concern on the part of both the man's family and my investigator. The family has asked questions about the issuing, prescribing and administration of methadone at Brixton, as well as prisoners' ability to obtain it illicitly. My investigator explored these and other issues with specialist healthcare professionals.

The investigation was carried out by two of my colleagues. A doctor from the Primary Care Trust carried out a clinical review of the man's medical care and treatment, for which I am most grateful. I also sought advice from a specialist consultant in addictions. She has produced a very comprehensive report that comments on the prescribing of methadone, levels of toxicity, prescribing protocols and the assessment of the man.

I would also like to thank the Governor of Brixton for making the necessary facilities available to my investigator. I am particularly indebted to the prison's liaison officer for his invaluable help and support.

I must apologise for the very lengthy delay in completion of this report. The investigation has been extensive and not without its difficulties. I could not issue my findings until I had seen the final clinical review, and this was not available until January 2007. The revised draft version of my report would have been issued in 2007, rather than April 2008, if the results of the controlled drug audit commissioned by the Primary Care Trust had been received more quickly.

Amongst other things, this report raises serious concern about the administration of methadone at Brixton. I make a total of 14 recommendations, including those from the clinical review. I am concerned that two of these recommendations have been made previously, following the self inflicted death of another prisoner at Brixton in April 2005, and I urge the prison health partnership to address these as a matter of urgency. I consider it vital that all relevant information about a prisoner is passed without delay from the police to the Prison Service. I have also identified two areas of good practice.

Stephen Shaw CBE
Prisons and Probation Ombudsman **August 2008**

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SUMMARY

The man was a young man who had a complex past. He had used and abused drugs for a number of years and told prison staff that he drank heavily. He suffered from asthma and said he had also suffered a recent bout of pneumonia, requiring a spell in hospital.

On 7 June 2006, the man was remanded by the magistrates' court to HMP Brixton. He was in prison for a week before his unexpected death.

It would be usual for a newly received prisoner to be accompanied by any relevant paper work such as Forensic Medical Examiner (FME) reports. There is no definitive way of knowing that these reports did accompany the man. All that can be said for certain is that Brixton did receive these FME reports at some point.

Following his reception into prison, the man was seen by a doctor. The reception doctor did not physically examine him, but remembered him as being talkative and agitated. They discussed his drug dependence and the possibility of commencing a Subutex detoxification. Expert opinion has been given that, even if the reception doctor had examined him, the signs of drug withdrawal may have masked a respiratory problem.

The man was also seen by the head of the substance misuse team. She noted that he was asthmatic and he told her of a recent episode of pneumonia that had resulted in admission to hospital for treatment. During this assessment it appears that he changed his mind about starting Subutex, preferring a methadone maintenance programme.

The man visited the medical hatch once a day from 8 June to 14 June. The last nurse to administer methadone to the man was identified. She said that there was nothing untoward or concerning about him on the afternoon of 14 June.

The man was found not to be breathing in his bed by his cellmate during the early hours of 15 June. The cellmate promptly raised the alarm and staff responded immediately. Sadly, despite the best efforts of all concerned, they were unable to resuscitate him.

A post mortem was carried out and concluded that the man died as a result of lobar pneumonia.

The man's family has expressed a number of concerns about the management of his withdrawal from illicit substances. In addition to a clinical review, I commissioned a specialist review of his care in respect of his substance misuse.

INVESTIGATION PROCESS

1. My practice in apparent deaths from natural causes is to conduct an initial review to determine the extent of the investigation required. My investigator visited Brixton on 22 June 2006 and spoke to a member of the prison's management, who outlined the facts relating to the man's stay in Brixton. Notices to staff and prisoners were issued on 19 June. These invited staff and prisoners to make themselves known to my investigation team if they had any information they felt relevant. My investigator was also given access to the man's records, including his medical record.

2. A family liaison officer from my office contacted the man's family. Both he and my investigator met the family on 30 June and explained the purposes of the investigation and its process. They also listened to the family's concerns. The first family liaison officer has since left my office and the family liaison role has been taken on by another member of my family liaison team.

3. The emerging issues from this investigation required specialist consideration, particularly concerning reception screening, the cell where the man was located, the methadone levels prescribed, the prescribing protocols in a custodial setting, the administering of methadone and whether or not it followed protocol. The question of whether methadone is available illicitly in Brixton was also explored. Other more general considerations were given to the way in which staff responded to finding him, the aftercare available for prisoners and staff, the staffing levels on G wing and the wing's regime and purpose.

4. A general practitioner was appointed by the Primary Care Trust as the clinical reviewer on 13 July. His role was to carry out a review of the management of the man's health needs whilst he was at Brixton. My investigator and the clinical reviewer interviewed several members of staff. These interviews took place over several months with many difficulties encountered such as annual leave, sickness, and union and medical representatives' availability.

5. A general practitioner with a special interest in the management of substance misusers was appointed to undertake a specialist review into the clinical management of the man's substance misuse. In 1991, the general practitioner with a special interest in the management of substance misusers established the Consultancy Liaison Addiction Services in the local area. From 1996 to 2000, she was senior policy advisor to the Department of Health (drugs and alcohol), and amongst other things was responsible for drawing together the national clinical guidelines. Although the general practitioner with a special interest in the management of substance misusers has never worked in a prison, she has helped draw together treatment protocols and guidelines now in use. She has also trained many doctors working in secure settings and has helped to amend the Certificate in Substance Misuse to ensure it is relevant to doctors and nurses working in such an environment. In addition, she has been involved in a number of medico-legal cases. For this investigation she was asked to comment on the prescribing protocols, the treatment and assessments of the man and the appropriateness of

prescribing methadone. She has also explored the difference between Subutex and methadone.

6. My investigator also spoke to a number of prisoners who knew the man.

7. Her Majesty's Coroner was informed of the nature and scope of the investigation. A copy of the post mortem and toxicology report was requested, along with medical reports from the man's GP and an addiction treatment centre. Further information was requested from and provided by the addiction treatment centre. Upon completion of this investigation, my report will be sent to the Coroner to assist with the inquest.

8. A significant amount of additional investigative work was done after I issued my draft report in March 2007. This additional work was undertaken in response to detailed observations made by the PPO Liaison Unit at Safer Custody Group and requests for further clarification and explanation made by the man's family and their solicitors. The new material included in response to these observations and requests can be found in the chapter now inserted immediately prior to the Conclusions section of this report.

HMP BRIXTON

9. Brixton is a local prison holding adult male remand and trial prisoners. It has five residential wings (A, B, C, D and G). The man was located on G wing, which is used as the first night induction centre and detoxification wing.

10. HM Chief Inspector of Prisons commented in an unannounced follow-up inspection report in May 2006 that, "G wing had dedicated counselling, assessment, referral, advice and throughcare services but required further psycho-social provision to support the detoxification programmes. Current mandatory drug testing levels were 15% positive, with a steady downward trend from a peak of 50% in May 2005."

11. A recommendation made by HM Chief Inspector of Prisons in her 2004 full inspection report that, "Primary healthcare staff should receive specialist training in substance misuse" had not been achieved. The report noted: "This recommendation had been rejected by the prison. At the time of their inspection, only two of the three specialist substance misuse nurse posts were filled and only one of these was a permanent position (the other being an agency nurse). The permanent substance misuse nurse did not have specific substance use qualification, although the agency nurse did. There was no generic training in substance misuse for primary healthcare staff. Given that primary healthcare staff would have contact with prisoners experiencing substance related problems, this shortfall diminished the opportunity to encourage prisoners to access treatment."

12. Healthcare is commissioned by the local Primary Care Trust (PCT). The transfer of the responsibility for the delivery of prison healthcare from the Prison Service to local Primary Care Trusts began in April 2004. The PCT became formally responsible for the healthcare provision at HMP Brixton in October 2005. The prison health partnership board has responsibility for monitoring the delivery of services under the clinical governance arrangements.

KEY EVENTS

13. On Tuesday 6 June at 7.55am, the man was arrested, arriving at the police station at 8.05am. When he was arrested, the Police National Computer (PNC) flagged up that he was also wanted on two other warrants. It was for this reason that he was not bailed. Whilst in police custody, he was examined by a Forensic Medical Examiner (FME). The FME first saw the man at 9.51am when he recorded the following: "Asthmatic, recent pneumonia, on amitriptyline 50mgs for depression suicidal attempt two year ago, says not suicidal now. Opiate dependency on methadone 60mls daily diazepam 40mg daily from drugs clinic, not apparently had for 48 hours. Early signs of withdrawal. Given Diazepam 10mg and Dihydrocodeine (DHC) 60mg at 9.50am. Review 4pm if still in custody." The FME judged the man fit to be detained.

14. The FME reassessed the man at 3.56pm that day and made the following observations: "Withdrawal, clear evidence of same. Chest now wheezy. Given Salbutomol inhaler from stock. Given Diazepam 10mg, DHC 90mg and Domperidone 10mg at 3.42pm. Please give Diazepam 10mg and DHC 90mg both at 11pm and at 7am 30 min checks." Again, the FME considered him fit to be detained.

15. The following day (Wednesday 7 June), the man appeared before the magistrates' court where he was remanded into prison custody and taken to HMP Brixton.

16. The man arrived at Brixton about teatime and went through the reception procedures. This included an interview with a healthcare officer. The officer completes a First Night in Custody questionnaire with the prisoner. This document considers the prisoner's current and past health needs.

17. The healthcare officer on reception that evening spoke to the man and completed the First Reception Health Screen Form. The man gave a history of drug dependence, saying that he spent £60 a day on heroin, £40 a day on crack cocaine, and also took benzodiazepines. He also said he was a heavy drinker and would drink six to seven cans of lager a day. When asked about any ideas of self harm, he strongly denied any suicidal or self harm thoughts. He was asked if he had ever received medication for any mental health problems and confirmed he had. The healthcare officer explored this in more detail, asking him about when this was, what medications he had received and at what dose. He said he took benzodiazepines for anxiety and had done so for 15 years. He said that 30mg a day was on prescription and that the other 20mg was un-prescribed.

18. In light of the information given during this assessment, the man should have been referred for further assessment by the mental health team. This did not occur.

19. The man was then allocated to G wing. Once on the wing, he was seen by the reception doctor. He was assessed and asked to provide a urine sample,

which he eventually did after some difficulty. This tested positive for cocaine, opiates and benzodiazepines.

20. The reception doctor made a referral for the man to be seen by the Substance Misuse Team (SMT). The prison doctor wrote in the medical record that he was very agitated, with flu like illness and sweats. He was apparently anxious to get "something" to help him through the night. When asked about drug withdrawal symptoms, he said that he had a runny nose and sweats. The reception doctor made the decision to prescribe a once only dose of dihydrocodeine (DF118) at 90mg to help the man with the symptoms of withdrawal he was experiencing.

21. The FME reports completed at the police station were not available for the healthcare team to refer to during their consultations with the man.

22. The following day (8 June), the man was seen by the head of the substance misuse team. The head of the substance misuse team completed a Substance Misuse Clinical Assessment Form, and explored the man's history of drug abuse including his withdrawal symptoms at that stage. He explained that he was known to two drug addiction centres. She noted that his intention was to start Subutex, but recorded "prefers methadone maintenance PMH [past medical history] Asthma and pneumonia in May admitted." The information gathered during the assessment was summarised within the man's main medical record. The head of the substance misuse team also made a note that the MO [medical officer] should review in two days.

23. Later that day, the head of the substance misuse team consulted a second prison doctor about the man. The prison doctor signed a Methadone Titration Form. The doctor did not see or examine the man before or after signing the prescription.

24. The titration form begins with two doses of 10mg. The prison doctor changed the prescription to a single 20mg dose at the request of the substance misuse nurse. The man's dose was increased by 10mg a day until he reached 40mgs which occurred on day four of the regime. All the man's doses were administered in accordance with the protocol, with two nurses present.

25. According to the note made in the man's medical record by the head of the substance misuse team, he should have been seen again by a doctor two days after her entry of Thursday 8 June. According to the locally agreed protocol, "Treatment Protocols For Patients With Substance Misuse Problems Entering Brixton Prison", there is an on call doctor for Saturdays, Sundays and Bank Holidays. G wing should be visited by the duty doctor to enable patients to be discussed and monitored as appropriate. According to his medical record, the man was not seen; nor was he seen on Monday 12 June. At 12.21pm on 12 June, the EMIS electronic record system appears to show that a second healthcare officer made an appointment for him to be seen at a GP clinic on Tuesday 13 June at 9.05am. However, he did not attend that appointment and it has not been possible to establish why not. (In interview the second healthcare officer's recollection was that the EMIS system had

been in operation for about a year at the time of the man's death and there were only two or three computer terminals for all the medical staff to use. He said:

> ''It would be relatively common practice for people , other members of staff to use that computer because they needed to at the time or they would maybe ask you to do something for them because they weren't able to access it because you yourself were using the computer. So it could have been me [who booked the appointment for the man], I could have been doing it on behalf of somebody else or it could have been someone else.''

The second healthcare officer also explained that an appointment entered on the electronic record at 12.21pm might relate to an application made by a prisoner earlier the same day or even on a previous day.)

26. The following day (Wednesday 14 June), the man's cellmate left the cell early to attend court. He was not expecting to return to Brixton. The man got up to say goodbye to him, they shook hands and had a brief conversation before his cellmate left. There was nothing that struck his cellmate as 'odd' about the man.

27. A prisoner on G wing recalled seeing the man slumped by the medical hatch at around 4.00pm. The prisoner could not recall if this was association time (period of time prisoners are allowed to mix with others out of their cells) or if this was when the man was queuing to receive medication.

28. A second prisoner on G wing said that he visited the man in his cell that afternoon during the association period at about 4.00pm. He said that the man was on his bunk, dressed and lying down. The second prisoner asked him what was wrong and he said words to the effect of: "Nothing, [my cellmate] kept me up all night talking." The second prisoner described the man as looking "out of it". Neither prisoner felt it their business to alert staff to him not being his usual self.

29. The Methadone Titration Form shows that the man attended the medical hatch to receive his methadone that afternoon.

30. The cellmate did in fact return to Brixton and was taken back to the same cell at around 8.00pm that night. On his return, he said that the man was asleep. He always breathed heavily and so again there was nothing at that stage to indicate to his cellmate that anything was amiss with him. The cellmate settled down to watch a televised football match and eventually fell asleep.

31. The cellmate recalls waking up in the early hours and becoming aware that he could not hear any sounds coming from the man. He climbed down from his bunk and checked him. He was cold to touch.

32. The cellmate raised the alarm by pressing his cell bell. This is confirmed by the printout of the cell bell record. The alarm was raised at 1.25.01am. It was

cleared at 1.25.50am when an officer responded to the bell. In order to clear a cell bell the officer must physically attend the cell.

33. The first officer to arrive at the cell said that he became aware there was an emergency at approximately 1.22am. He rushed to the threes landing when he heard a door being banged. When he arrived at cell G3-41, the cellmate was stood by the door shaking and saying "Gov open the door, it's like he is dead. He is not breathing. Open the fucking door." The officer was not in a position to open the door as it is only Oscar 1 (the code for the Orderly Officer – the senior officer in charge of the prison – who is the designated key holder to respond to emergencies at night) who can open the cells during the night. The officer put out a call for emergency assistance. He also called for Hotel 6 (the emergency response nurse). The Hotel 6 nurse that night was located in healthcare. She received the call via telephone by the first officer on scene and not via the UHF radio.

34. When the Hotel 6 nurse arrived at the cell, Oscar 1 was already in attendance and the cell door was open. The first officer on scene and Oscar 1 were inside the cell. Oscar 1 then called a Code 1 emergency over the radio and checked the man for breathing and a pulse, both were absent. The Hotel 6 nurse was soon accompanied by Hotel 3 who arrived with the resuscitation equipment.

35. The first officer on scene and the Hotel 6 nurse placed the man on the floor, positioned him on his back and the Hotel 6 nurse commenced cardio pulmonary resuscitation (CPR). The Hotel 6 nurse noted in the medical record that the man was cyanosed (a blue colouring to the skin), face down, unconscious and his pupils were fixed and dilated.

36. The ambulance arrived at Brixton at 1.44am and at G wing at 1.48am. The ambulance crew took over the resuscitation attempts, but to no avail. The on-call doctor for the prison arrived but despite all efforts the man was pronounced dead at 2.05am. The ambulance crew left the prison at 2.30am.

ISSUES CONSIDERED AS PART OF THE INVESTIGATION

Family concerns

37. The man's family raised a number of questions about the management of his withdrawal from illicit drugs. Due to the complexity of their questions and the emerging issues, two separate clinical reviews were commissioned, one by a specialist in management of drug addiction. I hope that the findings of these reviews and those of my own investigation provide the answers to some of the family's questions.

Was the consultation with the reception doctor thorough and did he recognise signs of pneumonia or take them to mean drug withdrawal?

38. The consultation on 7 June in G wing lasted about 10 minutes. The man wanted some medication for his first night in custody. The reception doctor assessed the man and prescribed a one-off dose of DF118. A urine sample had been taken and tested positive for morphine, diazepam and cocaine.

39. The reception doctor believes he was not in possession of the Forensic Medical Examiner's reports which note that the man's chest was wheezy and that he had recently had a bout of pneumonia. He remembered the man and said that he did not appear unwell in any way. He was not short of breath, but was described by the reception doctor as being talkative and agitated. The reception doctor explained that matters regarding his drug withdrawal would normally be discussed the following day with the substance misuse team. As far as the reception doctor was concerned following the consultation, the man would commence a Subutex detoxification and benzodiazepine detoxification. The reception doctor did note that the man was asthmatic.

40. The specialist in management of drug addiction explains that withdrawal symptoms may mimic symptoms of severe flu, and says that many people describe withdrawal as "the worst case of flu they have ever had". She adds, "it is likely that had the man been suffering from an acute respiratory infection at this time then the symptoms would have been masked by his opiate withdrawal. Only through really careful history taking, together with a high index of suspicion (of the presence of a concomitant physical illness) would a coexisting severe chest infection be identified."

41. The reception doctor did not make a physical examination of the man. However, he said he would have examined him if he had been in possession of the FME reports. These FME reports were detailed and highlighted the fact that the man was an asthmatic and had recently had pneumonia. It was also noted that, whilst he was in police custody, his chest had become wheezy.

42. My report following the self inflicted death of a prisoner at Brixton in April 2005 referred to uncertainty about when an important FME form, indicating concerns about the mental health of a prisoner who had recently been medically examined in a police station, was received at Brixton. The clinical

review commissioned for that report made the following recommendation that has so far not been implemented:

A system should be instituted to record all documents and papers that arrive in Reception with new prisoners.

The system for assessing newly arrived prisoners at HMP Brixton must ensure that all relevant documents, such as FME reports, accompany prisoners as and when they are seen by the GP.

43. The specialist in management of drug addiction considers that, as the man had been identified as an asthmatic and had previously suffered with pneumonia severe enough to warrant a hospital admission, it might have been appropriate to have examined his chest and for the assessing doctor to have enquired about his breathing. However, she also points out it would be difficult to ascertain how much the physical signs would have been masked by the withdrawal and general anxiety around being admitted to prison. The specialist in management of drug addiction explains that, even if the man had been found to have a rapid heart rate, high respiratory rate, and moderately raised temperature, it is likely that these would have been attributed to withdrawal and anxiety.

Should the prison doctor have seen and examined the man before signing him up for methadone maintenance?

44. The prison doctor signed the man up for a methadone maintenance programme that commenced on 8 June. Initially, he was started on 20mls (according to the titration chart, this is made up of two 10mls doses). However, the lead of the substance misuse team asked the prison doctor to change this to one dose of 20mls, which he did. Before the doctor signed the man up for methadone maintenance, he was informed of his background and drug use issues by the lead of the substance misuse team. After interviewing the man, she recorded this information on the substance misuse care plan. The prison doctor did not see him or any of the clinical entries or documents relating to him. He relied solely on the information provided to him by the lead of the substance misuse team. The prison doctor said that he would have wanted to see the man before issuing the prescription for methadone maintenance if he had been aware of the contents of the FME reports. Whilst it was not wrong for the prison doctor to sign the man up for methadone titration, I believe that the doctors should review all available medical documents, thus making a more informed decision.

Was it appropriate to prescribe methadone to the man?

45. The specialist in management of drug addiction says that it was entirely appropriate to provide the man with methadone substitution treatment. She explains that methadone is the most researched treatment for opiate addiction in the world.

Was the amount of methadone prescribed the correct dosage?

46. A report produced for the Coroner by a Consultant Forensic Toxicologist suggests that the level prescribed (40mgs) was not a particularly high dose. The maintenance dose for methadone can be from 20mg up to 200mg per day. The dosage prescribed depends on the individual's tolerance. The specialist in management of drug addiction concludes that both the initial dose and the process of dose induction was in keeping with HMP Brixton, Prison Health Care Services, National Health Service (NHS) clinical guidelines, and international guidelines. It is also the specialist's view that the prescribing of benzodiazepines alongside methadone was appropriate, given the man's addiction history.

Did the man have a methadone intolerance?

47. The report from the man's GP makes no reference to methadone. A report obtained by the Coroner from the treatment clinic refers to him having been prescribed 45mg of methadone mixture by the Maudsley Hospital in January 2006. A month later when he was seen at the treatment clinic, he told them that he had successfully completed a Drug Treatment Testing Order (DTTO), but had been unable to come off methadone. The man expressed a wish to try Subutex. (Subutex is used as an alternative to methadone for detoxification purposes.) Initially he did very well, but over the next two months he apparently relapsed and began using heroin on occasions. Evidence therefore suggests strongly that he was able to tolerate methadone.

48. Had someone unused to opiates taken the 20mgs dose that the man was prescribed on day one of his methadone maintenance, they would have been drowsy. Most methadone associated deaths have been reported in individuals with little or no tolerance to opiates. There are a couple of discrepancies in the history that he gave to the prison. There is one about when he last used heroin and methadone, and the other about his reported use of heroin and methadone. However, it is sadly not unusual for prisoners to falsify their drug habits in order to obtain more medication. The specialist's report (pages 24 and 25) details in depth the clinical examinations, with attention to signs and symptoms of dependence and biological investigations (such as urine tests) to ascertain the true physical dependence on illicit substances.

Were there signs of methadone intoxication before the man's death?

49. The two prisoners on G wing make reference to "[the man] looking out of it". One prisoner talked about the afternoon of 14 June, when he apparently saw "[the man] slumped outside the medical hatch", possibly waiting for his methadone. Neither prisoner raised their concerns with staff, as they thought it was none of their business. Both prisoners mention the fact that he breathed heavily and was an asthmatic. They apparently never discussed the issue of illicit drugs.

50. The man's cellmate was at court for most of the day on 14 June. When he left that morning, the man got up and shook his hand. They said their goodbyes as the cellmate was not expecting to return to prison. On his return to the cell that evening, the man who later died was asleep and the cellmate recalled him breathing heavily. The cellmate eventually fell asleep but then later woke up. He was aware that something was wrong as there was no noise coming from him. The cellmate knew that the man was an asthmatic and that he had previously suffered with pneumonia. He had filled out an application for the man to see a doctor a few days prior to his death, although on questioning he could not remember the reason he put down for his needing to see a doctor. The cellmate said that although the man who is the subject of this report was an asthmatic, he smoked heavily and managed the stairs without any difficulty. The cellmate said it was usual for his inhalers to be left in their cell and he did not recall the man having to use these on a regular basis.

51. Despite the notices announcing the investigation into the man's death, no other prisoners asked to see my investigator. However, my investigator identified any prisoners who were still in Brixton and had been on G wing on the threes landing at the time of his death. Twenty other prisoners were identified. My investigator spoke to them individually. The majority were unable to add any further information. A couple knew him and spoke about his general appearance. They said that he did not appear 100 per cent. One described him as looking yellow and sweating. They also said that they thought he was recovering from a recent bout of pneumonia and that he still appeared to have ''fluid on his lung''.

Were staff aware of the man being unwell in the hours preceding his death?

52. The two prisoners on G wing both said that they did not feel it their place to alert staff to the man's condition. Neither did they ask him if he had taken any illegal drugs.

53. The staff identified to my investigator as working on 14 June were either interviewed by my investigator or spoken to with interview notes taken.

54. The officer on duty from 12.30pm until 9.45pm on 14 June remembers the man being a quiet man, one who kept himself to himself. When asked to explain what he meant by quiet, he said "he was not a demanding prisoner". He had no recollection of anything significant in relation to him. The officer on duty was under the impression that procedures for prisoners receiving methadone have changed recently. He was unclear of the procedures, but was certain that prisoners were given methadone in a medical room rather than out on the landing. On being asked about what would happen if a prisoner was sitting slumped outside the medical hatch, he said "it would be challenged by a member of staff". Things can apparently get chaotic by the medical hatch and for that reason a member of staff is usually in the vicinity to help maintain order.

55. Another officer had no knowledge of the man, and did not believe that he met him. In light of what the officer on duty said about the methadone procedure,

the second officer was asked if the methadone procedure had changed recently. He said it had not. He has been on G wing for a year. He explained that prisoners are taken into a consultation room with two nurses and given a bottle with methadone in it to drink. He confirmed that it was not acceptable for a prisoner to be sitting on the floor and it would be challenged. However, he also said that G wing was chaotic and sometimes the men could be waiting for an hour or more to receive their medication.

56. A third officer had no recollection of the man at all, and said this was due to the high turnover of prisoners on G wing. He had no knowledge of methadone being available illicitly on the wing. My investigator asked if he had ever been present at a meeting where a Senior Officer had suggested officers keep an eye out for this. He was vaguely aware that something along those lines had been mentioned.

57. A fourth officer was working a late shift, mid-day until 9.45pm. He had worked on G wing for about 18 months. He did not remember the man at all. He was also asked about prisoners sitting in the medicine queue. His view was that it would not really be a problem, as the men do have to wait for long periods of time to receive their medication. He said that ideally the queue would be more controlled, but there are not enough staff to accommodate this at present. When asked about the availability of illicit methadone on the wing, he was not aware that this was or had recently been a problem. However, he did add that if it was, he would not be surprised. He did not recall attending any meeting where the subject of methadone and "spit back" was mentioned.

Are staff sufficiently trained in the management of substance misuse and detoxification?

58. The training records for the healthcare staff at Brixton were obtained and particular attention was paid to the records of those involved in the man's care.

59. The head of substance misuse at the time of the man's death had received training in CPR (twice), HIV and Hepatitis C, breakaway training and control and restraint training. The nurse who administered the last dose of methadone to the man had been trained in diabetic management three times, CPR, a further diabetic management course, ACCT (for prisoners on suicide watch), EMIS (the electronic version of medical record keeping) a further ACCT course, a diabetic management exam and a course on anaphylaxis. The Hotel 6 nurse who attempted to resuscitate the man had received training in EMIS, anaphylaxis, CPR, outreach, ACCT and SMN (substance misuse nursing).

60. I am rather surprised that more courses are not undertaken with regard to drug dependence, poly substance misuse, signs of intoxication and withdrawal. This concern was also raised by HM Chief Inspector of Prisons in her 2004 inspection report. As noted above, HM Chief Inspector of Prisons recommended that: "Primary healthcare staff should receive specialist training in substance misuse."

61. The clinical review identifies that the nurses require more training and evaluation of their knowledge. I was pleased to hear of the advances in staff training that had taken place by the time my investigator interviewed a third doctor in November 2007. I am certain, however, that the potential gains to be realised from the Integrated Drug Treatment System will only be put in practice if the relevant managers ensure that staff who deliver the system receive appropriate initial and refresher training.

The training needs of all the nursing members of the Substance Misuse Team as well as the primary care nurses on G wing should be reassessed to ensure that they are all able to assess and monitor the health needs and clinical problems of prisoners who are drug addicts. They need to understand fully what they are assessing and monitoring and the reasons why they are doing this. They also need to be clear about what to do if any cause for concern arises, including new information.

What is the relevance of Subutex (buprenorphine)?

62. It appears that the man did consider taking Subutex prior to his imprisonment and may well have been receiving it. (His family have informed my investigator that he had been taking Subutex daily since February 2006.) It was certainly prescribed on 5 June by a doctor from the treatment clinic, as evidenced on the prescription found by my investigator in the man's belongings.

The Substance Misuse Team (SMT) should always attempt to contact outside drug agencies and GPs to establish the pattern of treatment of prisoners who are drug addicts or are being considered for treatment by the SMT. These contacts should be made as soon as possible, and there may be a need for a standard system for making these contacts and obtaining the relevant clinical information.

63. The specialist in the management of drug addiction explains in her report that buprenorphine is a safe, effective medication for use in the treatment of opiate dependence, and is a valuable addition to the formulary of medications for treating heroin addiction. It is a partial opiate agonist which appears to be safer in overdose than methadone. She says that, in her view, even if the man had been taking Subutex at the time of his admission to prison, this would not have altered his management plan.

64. Brixton offers both methadone and Subutex to prisoners. During the consultation between the man and the reception doctor on 7 June, the plan was for him to commence on a Subutex programme. This is evidenced in his medical record. However, when he saw the substance misuse nurse the following day, it appears that he changed his mind. The comment documented by the nurse is: "Prefers methadone maintenance."

Was it appropriate to locate an asthmatic on the threes?

65. It does not appear from information available that the man suffered too badly with his asthma. According to his medical records and information provided by other prisoners, he did not have any problems managing the stairs. In fact, his cellmate said that the man often left his inhalers in the cell. Prisoners commented on the fact that he breathed heavily, but at no time did it appear to be a problem for him. There are no entries within his medical records to suggest that his asthma was severe or was causing him distress.

When a prisoner with a clinical condition that may affect their physical abilities is received in prison, they must be individually assessed to ensure that they are given accommodation suitable to meet their health and social care needs. This assessment must be documented in their medical record and their wing history sheet to ensure continuity of care.

Is methadone available illicitly on G wing?

66. My investigator explored with a number of prisoners the possibility of methadone being illicitly available on G wing. The majority of prisoners were not of the opinion that it was generally available. However, a few did say that it was possible to obtain methadone illicitly via a method known as “spit back”. (This is where a prisoner is able to hold the methadone in their throat, spit it back after leaving the consultation room and then possibly sell it on.)

67. From this investigation, it seems that illicit methadone may sometimes be available but there is no compelling evidence either way. There was a rumour that it was available, but the majority of prisoners said that it was not. The second G wing officer recalled that G wing had had a problem a few months earlier with “spit back” and the Senior Officer (SO) had told his staff to be aware and vigilant. This was also recalled by the third officer.

Is there any way of improving the system for issuing methadone?

68. At present, methadone is given by two nurses. The prisoners arrive at the medical hatch and their identity is confirmed by photograph. Once this has been done, the prisoner is taken into a side room. One of the nurses completes the paper work (controlled drugs book and Methadone Titration Form), while the other talks to the prisoner. If the prisoner is able to communicate and appears to have no problems, the prescribed methadone is given. Methadone is a liquid and is given to the patient in a sealed individually named medicine bottle. The prisoner is required to drink the methadone whilst in front of a nurse.

69. The lead of the substance misuse team said that, after the methadone has been drunk, the bottle is filled with water and the prisoner is asked to drink that too. This is then followed by a short conversation. The process lasts about two or three minutes. The lead of the substance misuse team was also asked about the process. She said much the same except she did not mention any water being given.

70. The nurses were questioned about the Methadone Titration Form. On the form there is a column headed “symptoms assessed by”. Both nurses were of the opinion that this was not to be filled in unless there was something significant to record which would indicate that the dose of methadone was to be withheld. On the man’s form there are no entries recorded, no dose of methadone was withheld and there was nothing significant to record about him or his well being. On 14 June, it appears that he received methadone. The last dose of methadone was administered by the nurse at the medical hatch. She said that had there been anything untoward with the man she would have withheld his methadone dose. The nurse at the medical hatch was asked if she had ever withheld a dose of methadone to which she replied “not in this prison”. The nurse at the medical hatch was asked what signs and symptoms she would be looking out for in a prisoner, and what would determine a dose being withheld. She said: “I would look for smells, speech, dry mouth, things like sweatiness, him complaining maybe of headache …” The clinical reviewer further questioned the nurse at the medical hatch about how confident she would be of noticing if the man had had breathing difficulties or been short of breath. The nurse at the medical hatch said: “I would be able to spot it.” Had she done so, she would have explored this further with him and would have made an entry in his medical record. As no entry exists in his record, one can assume that she did not have any cause for concern regarding him receiving his methadone on that afternoon.

71. My investigator asked the nurses and the head of healthcare about the column headed “symptoms assessed”. My investigator suggested its meaning is that symptoms are assessed before the methadone is given. She also suggested that a signature should then appear to indicate that this has been done. The specialist in the management of drug addiction is of the same opinion and this is reflected in her report. The clinical reviewer comments that he is concerned that this practice meant that prisoners, such as the man who is the subject of this report, were not as fully assessed as perhaps they should have been.

72. My investigator and the clinical reviewer visited Brixton on 19 September to observe the administration of methadone. The first two prisoners seen were managed according to the local policy. Everything was satisfactory: their identity was checked and the prisoner confirmed his prison number, the methadone was taken, the bottle was then refilled with water and drunk, a short conversation was held with the prisoner, and finally the blood pressure was taken and recorded. This process lasted about three or four minutes.

73. As the morning went on the process changed. The prisoner’s identity was checked, but some prisoners were unable to confirm their prison number. The methadone was given to the prisoner and taken in front of the nurses. Some prisoners then refilled their bottles with water, but the majority did not. Blood pressures were not taken and little or no conversation was held after drinking the methadone. The process took as little as 30 to 45 seconds. Prisoners questioned at random on G wing that morning said that they had

never had their blood pressure taken. Some said that they drank water after methadone, but others did not.

74. The nurses administering methadone that morning were asked by my investigator and the clinical reviewer if they had ever withheld a dose of methadone. Both said they had done so. Asked when this was, the reply was three and five years ago. The "symptoms assessed" column on the Methadone Titration Form was noted now to contain signatures.

75. The clinical reviewer says in his report: "the experience of observing the dispensing of drugs such as methadone on G wing caused me significant concern. Prisoners were sometimes in and out the room so quickly that I would say it was not possible to assess them adequately in order to identify significant ill health."

The administrative systems related to the monitoring of the treatment of drug addiction need to be reviewed and changed in several ways. Prisoners who fail to attend for important appointments, such as reviews of their drug treatment, must be followed up. Important clinical information about prisoners must be rapidly passed on to members of the SMT and G wing nurses. Assessment and decision-making must occur rapidly for prisoners who do not adhere to their agreed programme.

76. The document "Drug Dependence In The Adult Prison Setting" dictates that methadone should be administered by a registered nurse or pharmacist. Before the administration of methadone, the following should be checked: (a) identity of patient; (b) ensure patient is fully alert, responding appropriately and there are no signs of drowsiness/collapse, slurred speech, droopy eyelids or lowering of blood pressure; and (c) consider whether there are any other reasons to suspect illicit drug use.

The prison health partnership should remind healthcare staff of the correct procedure for administration of methadone as dictated in the Drug Dependence guidance.

77. Despite the photographic identity that prisoners carry and the requirement to verbally check prisoners' numbers, my investigator was alarmed to hear that the previous day a man had been admitted to an outside hospital for receiving the methadone from the nurses on duty that was meant for his brother. This was confirmed by a manager. Thankfully, after treatment he was well enough to be returned to the prison. This issue was dealt with at local level.

78. I believe that it would be appropriate to add a further column to the Methadone Titration Form, requiring the prisoner to sign and print his name, confirming that he has received his methadone. This process would alert staff to possible physical impairment, by observing daily consistency in writing. It would also help with identification of possible fraudulent activity.

I recommend that the prison health partnership reviews the existing systems in place for administering controlled medications, such as methadone. The new system should make safeguards for the following:

(i) Ensuring prisoners are fit and well prior to receiving medication;

(ii) Ensuring as far as practically possibly that impostors are prevented from receiving medication.

Did the man die of pneumonia?

79. A Home Office pathologist carried out the post mortem on the man. On examination, he noted consolidation of most of the left lung with features of lobar pneumonia. There were also a number of centrally situated abscesses. The pathologist was made aware of the level of methadone found in the man's post mortem blood sample. He agrees that it appears relatively high. However, he is of the opinion that this does not necessarily mean that the man was being given an excessive quantity or that he took more than was prescribed. The pathologist explains that relating methadone levels to the amount prescribed is not a straightforward exercise and it is beyond his competence to comment further. He believes the pneumonia and formation of abscesses was so severe that he is convinced that this was the cause of death.

80. The man's family feel he was unwell prior to 14 June, and attach particular significance to his appearance when he was visited by his niece on 12 June. During that visit he coughed a lot and, according to his niece, sounded quite wheezy at times. The clinical reviewer's report contains his conclusions about the failure to identify the pneumonia in the man. The clinical reviewer suggests that the man was probably not unwell until 14 June when he received his last dose of methadone. The information from prisoners about his well being suggests it was around this time that he was becoming acutely ill with lobar pneumonia. Lobar pneumonia is a condition that can develop extremely rapidly, over a matter of hours or days. The clinical reviewer goes on to say "A man such as [this one], who was relatively debilitated as a result of alcohol and drug misuse, would be more likely to succumb to such an infection, compared to the average person." The clinical reviewer further researched lobar pneumonia with two professors of chest medicine who both concurred with this view.

The reliability of methadone levels at post mortem?

81. The clinical reviewer and the specialist in management of drug addiction are both aware that there is much debate about the reliability of post mortem samples. A paper written by Professor Forrest at the Forensic Pathology Services in Sheffield states that results "should only be truly relied on if three samples of post mortem blood are taken and from different parts of the body, this proving that all three results are subsequently consistent."

82. The specialist in management of drug addiction says that: “It may be that any concomitant severe respiratory disease altered the metabolism of methadone resulting in higher plasma methadone levels. It may also have been that if the man was suffering from severe respiratory problems that methadone and benzodiazepines (both respiratory depressants) further compromised his respiratory function. It may also be the case that his plasma methadone level was within normal range as single post mortem results are notoriously inaccurate.”

83. The clinical reviewer notes: “Although it is the case that a relatively high amount of methadone was found in the post mortem sample, this does not necessarily reflect the level of methadone in his blood before death. It is therefore not possible to know whether [the man’s] methadone consumption while in Brixton contributed to his death in any way.”

84. The Coroner’s Officer asked staff in the toxicology unit at Imperial College, London about the concentration found in the man. A doctor at Imperial College replied: “After death, drug is released from tissue bound stores and it then diffuses into adjacent blood vessels. This phenomenon is know as post mortem redistribution and it means the amount of drug present in post mortem blood may be higher that the amount of drug present in blood at the time of death. Because of this, it is not possible to calculate the dose ingested from the concentration of drug present in post mortem blood.”

Clinical review

85. The clinical reviewer has provided an extremely detailed clinical review. The aim of his enquiries was to ascertain if the level of care that the man received in Brixton was comparable to what he would have received in the community. In doing so, it is important to point out that the prison population is very different to the general population. These differences, such as challenging behaviour, drug and alcohol abuse and mental health problems, are part of a day to day challenge for healthcare professionals working in prisons.

86. The First Reception Health Screen was not completed fully and in accordance with the local protocol. The man’s answers to the mental health questions meant that he should have been referred for a mental health assessment, but it would appear that this did not happen so an opportunity for a further assessment of his health was missed.

Steps should be taken by healthcare management to ensure that staff carrying out a First Reception Health Screen do so correctly and fully in line with the protocol.

87. The clinical reviewer has reached a number of conclusions in relation to the drug treatment programmes at Brixton. His review covers staff training which he feels needs to be addressed urgently, given the fact that G wing is the location for most new arrivals with a drug problem. The clinical reviewer discusses the possible lack of clarity amongst nurses and doctors about who

holds the clinical responsibility for assessing patients prior to decisions being made on treatment for substance misuse.

88. The clinical reviewer could not reach a conclusion as to why prisoners are not adequately assessed by nurses on G wing prior to being given medication such as methadone. Several possible reasons were considered such as high workload, with a large number of prisoners to receive medication in a short period of time. Another possible reason may be lack of training and/or management supervision.

Staffing levels must be modified to ensure that the drug treatment protocols can be implemented, if that is a reason for it not happening. It is not acceptable for there to be insufficient nursing staff to ensure that the twice daily regime for the initiation of methadone on day 1 cannot take place.

89. The clinical reviewer identified a number of areas of good practice as well as a number of shortcomings. He argues: "It is not possible to know for certain whether the death of the man could have been prevented if these shortcomings had not occurred."

90. The clinical reviewer was satisfied that staff attempting to resuscitate the man did their best and carried out CPR adequately. However, he noted that the staff were not using the current guidelines of 30 chest compressions to two rescue breaths, but rather a ratio of 15 to two. He is sure that this variation would have made no significant difference to the outcome, but felt that staff would benefit from updating their CPR skills.

Healthcare management at HMP Brixton should ensure that all relevant nursing and discipline staff receive training so that they carry out cardiopulmonary resuscitation (CPR) in accord with the current recommendations.

91. The clinical reviewer noted that there were delays in emergency equipment arriving at the man's cell. Staff only collected the equipment when requested to do so by the Hotel 6 nurse, despite the local protocol making it the responsibility of the officers to collect the locally available equipment before the arrival of Hotel 6. The clinical reviewer repeats a recommendation that has been made in relation to previous clinical enquiries at HMP Brixton. It is a matter of regret that there still appears to be no reliable system in place.

Healthcare management must look at how to ensure that all the elements of the response to Code 1 emergencies take place. This includes ensuring that the wing-based emergency equipment, the Ambu-Bag equipment, is always brought to the site of the emergency by the wing staff before the arrival of the nurse on duty.

92. The clinical reviewer was also concerned that there was no systematic review of the management of events after the man was found. Reviews following major events are routinely carried out in the primary care setting. They offer

the opportunity for all staff to review their practice, identify learning needs, consider any further training that may be required, and examine systems in place for emergencies so that if necessary they can be improved. In addition, it is also an important source of support for staff who have been through a distressing experience. The following recommendation has been made in relation to previous clinical enquiries at HMP Brixton, and it is again a matter of regret that no reliable system is in place.

A process of significant event analysis (SEA) must be introduced for all major incidents such as deaths or attempted resuscitation. The SEA process should also be used for all other major medical incidents. The SEA should help to identify the learning needs of individual members of staff, as well as the need to develop and refine systems and protocols of care.

93. The clinical reviewer makes a number of recommendations, each of which I fully endorse. It is of concern that some of these recommendations have been made in previous investigations, but do not appear to have been actioned. I urge the prison health partnership to consider these and previous recommendations as part of their clinical governance responsibilities and ensure that an appropriate action plan is developed to address them.

94. The clinical reviewer says that senior members of healthcare management at Brixton should hold discussions with the GPs who hold clinical responsibility for the medical follow up of First Reception Health Screens, as well as with the nurses and healthcare officers who carry out the screening, to clarify what responsibilities can be appropriately delegated in terms of identifying important clinical issues and passing them on to the GP. In a similar way, discussions need to take place between healthcare management, the GPs and the nurses of the Substance Misuse Team (SMT), about how much clinical responsibility for assessing the health of prisoners can be appropriately delegated from the doctors to the nurses on the SMT. The outcome of these discussions must be absolutely clear, and should be set out in a formal written policy so that all the staff understand their own level of clinical responsibility and accountability.

Liaison with the man's family after his death

95. Liaison with the family in the aftermath of the man's death was undertaken by a Reverend. The family and their solicitor were extremely unhappy with the way in which the Reverend conducted his liaison responsibilities. I have seen correspondence between the Governor at Brixton, and the man's mother and solicitor about the way in which the Reverend performed his duties. My investigator has not interviewed the Reverend, who no longer works at Brixton, so I do not comment in detail on these matters. I note that the Governor has done his very utmost to engage with a range of concerns expressed by the family and to apologise for some shortcomings, which he acknowledges. In a letter to the man's mother, dated 10 August 2006, the Governor wrote compassionately, non-defensively and apologetically:

‘’I would like to take this opportunity to make a further apology to you. It is clear to me that through this incredibly difficult time for you and your family and despite our best intentions, we have not managed to satisfy all your concerns , nor have we supported you as well as I would have liked. I am very genuinely sorry for that. ‘’

FURTHER INVESTIGATIVE WORK DONE AFTER THE ISSUE OF MY DRAFT REPORT

96. I issued my draft report on the man's death in March 2007. The following month I received a response to the draft from the solicitors representing the man's family. In May 2007 I received a response to my draft report from the PPO liaison unit in Safer Custody Group. My investigator began a period of maternity leave on the day that the Safer Custody response arrived. One of my Assistant Ombudsmen took over the investigation from my investigator at that time and he has been responsible for producing this revised draft report.

97. The family's April 2007 response to my draft report requested that the clinical reviewer in this case should reach a conclusion as to the reception doctor's practice in prescribing inhalers to the man without examining his chest. The clinical reviewer responded to the request by saying that it was medically appropriate that the reception doctor did not examine the man's chest. The first reason given by the clinical reviewer for his opinion was that the man did not present any symptoms suggestive of a chest problem to the reception doctor or to the Healthcare Officer who carried out the first reception health screen. The clinical reviewer recalled that in interview the reception doctor had stated, "He (the man) wasn't complaining of any signs or symptoms, he wasn't short of breath, he had no cough, he had been asked constantly about any other health issues."

98. The second reason for the clinical reviewer's opinion was that the reception doctor clearly remembered seeing the man on the evening of 7 June 2006. In interview he was able to tell the clinical reviewer that the man had no observable features to suggest a chest problem requiring examination of his chest.

99. The third reason advanced by the clinical reviewer in support of his opinion was that patients with asthma should always have inhalers with them. The clinical reviewer explained that it is best practice for asthmatics to use an inhaler on a regular basis, even if they have no symptoms at all. He added that "this type of inhaled drug is used when the patient is well, to prevent the development of any symptoms or an acute asthma attack. Therefore, if a new prisoner inmate with a history of asthma, such as the man, has no inhalers, it would be good practice to prescribe these inhalers, even if they were asymptomatic (i.e. well). The prescription of the inhalers is not a reason to carry out a chest examination."

100. The fourth reason for the clinical reviewer's opinion was that although the FME reports did mention a recent past history of pneumonia, and of asthma causing wheeziness, the reception doctor was clear that these reports were not available to him when he saw the man. The clinical reviewer concluded, therefore, that the reception doctor was not in a position to be guided by the FME reports in any way.

101. In their response to my draft report, the man's family supplied a witness statement made by the man's niece for HM Coroner. In her witness

statement to the coroner the man's niece described visiting her uncle on 12 June, just three days before his death. In her statement she said that when the man came into the visits room at Brixton he did not look very well. She had not seen him for a couple of weeks but now he seemed to her very small and hunched and his skin looked noticeably yellow. She described his face as "the colour of a yellowing bruise."

102. In the eighth paragraph of her witness statement the man's niece said she could not remember whether her uncle had been particularly sweaty but he was coughing a lot, although that was not unusual because he smoked. She recalled that her uncle had sounded quite wheezy at times during the visit, both when it first began and after he had had a coughing fit. She said it was difficult to tell whether her uncle's coughing sounded any different from normal. She added that "he sounded phlegmy at times, as if he was trying to clear his throat."

103. In the light of the witness statement, the family asked that the clinical reviewer be requested to review, clarify and if necessary expand upon his view concerning the man's likely presentation from the date of his meeting with his niece.

104. The clinical reviewer responded that he did not think it was possible to provide a clear answer to the family's questions. He referred to the possibility that when the man's niece saw her uncle on 12 June, he was beginning to become unwell with what developed into fulminating lobar pneumonia over the course of the subsequent two days. The clinical reviewer accepted that it is not at all uncommon for relatives of a person to be able to detect early changes in their health before this is apparent to a clinician such as a nurse or a doctor.

105. The clinical reviewer considered the possibility that the man was suffering from jaundice when visited by his niece on 12 June. The clinical reviewer would have expected a trained clinician to be able to detect this. He would have expected jaundice to be detected in the post-mortem examination carried out by the pathologist, on 15 June. He observed that the post-mortem examination report referred to "no abnormalities of the colouration of the skin or, more importantly, no abnormalities of the liver."

106. The clinical reviewer concluded that the man was probably not suffering from jaundice on 12 June but that he looked sallow and unwell for other reasons. The clinical reviewer could not know what those reasons were but it was certainly a possibility "that they were due to the early stages of the lobar pneumonia that eventually resulted in the death of the man on 15 June 2006." He considered it would be pure speculation as to how those features might have developed over the next few days and whether they would have been detectable to personnel who did not really know the man.

107. In response to my draft report the man's family made one further request, that the clinical reviewer be asked to perform an audit of the pharmacy records at Brixton to establish whether methadone stocks were properly controlled and if

the entire stock was properly accounted for. The man's family were very concerned by the reference in the post-mortem report to a "potentially fatal dosage" of methadone in the man's blood after his death. The family speculated on the seriously deleterious effect on his health that would have been caused by any over-prescription of methadone.

108. In July 2007, the PCT agreed to an audit of the methadone dispensed around the time of the man's death. The PCT informed my investigator that an independent pharmacy technician would undertake the work with its aims being

- To attempt to ascertain whether there was any methadone which was not accounted for around the time of the man's death.

- To outline the processes, systems and legislative framework which govern the management and dispensing of controlled drugs (including methadone) at HMP Brixton.

109. The work commissioned by the PCT was undertaken by a woman who was the Chief Pharmacist for the PCT for approximately nine months to March 2007 and is now Chief Pharmacist at another PCT.

110. Despite assurances that the work would be completed by October 2007 my investigator did not receive a copy of the audit report until March 2008.

111. A response to my draft report was sent to me from the PPO Liaison Unit at Safer Custody Group in May 2007. My investigator and my then Deputy Ombudsman discussed this response at a meeting at the PCT Headquarters in September 2007 attended by senior PCT colleagues and the then Head of Healthcare at Brixton.

112. The man's family asked for a further meeting with my investigator, which was held at the solicitor's office in October 2007. At this meeting the man's family requested that additional investigative work be undertaken. Later that month, my investigator met with the then Deputy Governor at Brixton. In November, he returned to Brixton to interview the third doctor and to re-interview the prison doctor, as the man's family had requested. My investigator duly provided documents which had been sought by the solicitor at the October meeting.

113. The May 2007 response from Brixton, channelled through Safer Custody Group, to my draft report challenged many of the recommendations made in that report. The Safer Custody response noted that the bulk of the recommendations referred to prison specific processes and questioned "whether the clinical reviewer had the necessary experience of prisons to adequately comment.'' The Safer Custody response also referred to significant factual inaccuracy and "apparent confusion regarding the process for review of patients on opioid replacement." The response suggested that this confusion could have been cleared up with a call to the third doctor.

114. After my investigator's meeting with the deputy governor, he was sent a note explaining that the third doctor had written a lengthy response to the clinical review conducted by the clinical reviewer. "This was intended as a discussion document for the senior clinicians at HMP Brixton who would later edit and refine the response.'' It appeared that the response had left the prison before the anticipated editing and refining had taken place.

115. In response to my revised draft report, issued in April 2008, I received an explanatory note on 4 July from the Casework and Learning Section of Safer Custody and Offender Policy Group (SCOP). Safer Custody was merged with Offender Policy in April 2008. The note indicated that part of the Safer Custody response to the draft report I published in March 2007 was based on a document entitled ''Response from Senior Clinicians HMP Brixton to the Draft Report into the Investigation into the Circumstances surrounding the death of the man at HMP Brixton on 15th June 2006''. That document was emailed to Safer Custody Group on 4 May 2007 by the then deputy governor at Brixton. Its purpose, according to the July 2008 note from SCOP, was to ''contribute to the Safer Custody reply to the Ombudsman's draft report and it was presented as a response from all the senior clinicians, not just the third doctor.'' The wording of the senior clinicians' response is indeed almost identical to that of the last four pages of the response to my draft report issued by Safer Custody Group on 10 May 2007.

116. My investigator interviewed the third doctor at Brixton on 15 November 2007 so that any factual inaccuracies could be reduced to a minimum and so that he could comment, if he wished, on the recommendations mainly made by the clinical reviewer and endorsed in my draft report.

117. In interview the third doctor explained that he and four GP colleagues from a family practice have, since 2005, held the contract for the delivery of primary healthcare and substance misuse services at Brixton. He explained that the senior clinicians at Brixton had come together in the past in order to review ways of working together to improve the safety of healthcare in the prison. They had set up a committee which would review all critical incidents and design appropriate policy. The doctors responded to any reports as a group and he wrote an e-mail to his colleagues on the committee about the draft report on the man as he was about to go on holiday. He added that his e-mail was for internal purposes only and for consideration by his fellow doctors at Brixton. In response to a question, the third doctor confirmed that his e-mail was written for discussion with his clinical peers alone and "it was not even intended to go to the PPO Liaison Unit." During the interview the third doctor spoke of his determination to help improve the clinical service at Brixton and to make the major changes which he and his colleagues felt were necessary. He commented on most of the recommendations in the draft report and also spoke about a number of clinical developments at Brixton in the 18 months which had elapsed since the man's death.

118. The first two recommendations in the draft report were that a system should be instituted to record all documents and papers that arrive in reception and that all relevant documents, such as FME reports (reports by the Forensic

Medical Examiner/police doctor), must accompany prisoners as and when they are seen by the GP. In response, the third doctor said that recording all the documents as they arrive would not guarantee that "the proper person" sees them and he observed that GPs must receive as much of the information accompanying a new prisoner as possible. In a later response he added that it is essential for such information to be available to the doctor on the first night because "the second day is too late." He was aware that quite often prisoners go straight out to court on the following day and the doctors need to know as much about them as possible to make an assessment of safety and risk on the first night.

119. The third doctor was asked about the route followed by documents (such as FME reports or concerns about possible suicide risk, raised by the escort company) when a prisoner arrives at Brixton. He referred to a deficit in information getting to the GP, depending on how chaotic the reception is, how late the vans arrive and whatever else might be going on in the prison. His experience was that the PER (Prisoner Escort Records) and IMRs (clinical records) did not arrive together and "we are still frequently seeing patients without the PERs." My investigator asked the third doctor how the information deficit might be closed and he spoke of the enormous pressure on nurses who screen new receptions at Brixton. He feared that some errors were bound to occur "when 30 or 40 people are arriving within an hour and we expect them all to be fully screened and all documentation read." He suggested that an alternative might be to do the necessary screening at court but I suspect that proposal would be even more costly and resource intensive than the existing arrangements at Brixton.

120. The third recommendation in my draft report was for a reassessment of training needs. In a detailed response the third doctor explained that the Substance Misuse Team were not highly trained in November 2005. They were not trained specifically in how to assess patients with substance misuse problems but by June 2006 two dedicated nurses were undergoing training. He recalled that the treatment for people at Brixton with drug problems prior to his arrival was hydrocodeine and valium, which were completely against the national guidelines. He and his colleagues introduced substitute prescribing with methadone in March 2006. Brixton received funding, through the Integrated Drug Treatment System (IDTS), to establish a more comprehensive substance misuse team, which by November 2007 was being built up to a team of five. The third doctor spoke of the difficulty of moving a prisoner from Brixton, which has IDTS, to another prison which does not.

121. The Ministry of Justice issued a Prison Policy Update Briefing Paper in January 2008 which announced that by April 2008 29 prisons would have introduced IDTS "and with the Department of Health we would be extending the scheme to a further 20 prisons over the next 12 months." The briefing paper explains that IDTS provides better clinical services funded by the Department of Health, such as improved detoxification programmes and greater continuity of care between the community and prisons, between prisons, and on release into the community, as well as helping offenders to address some of the deeper roots of their drug abuse. The third doctor told

my investigator that by November 2007 most of the staff on the Substance Misuse Team at Brixton had been employed already trained. An extensive programme of training had been provided to the previous staff and, as a result, at the time when he was speaking, all prisoners at Brixton were assessed on the morning following their arrival by a well-trained substance misuse nurse. The lead of the substance misuse team had become a nurse prescriber who is able to prescribe methadone and systematic relief in her own right.

122. In response to the fourth recommendation, that the Substance Misuse Team should always attempt to contact outside drug agencies and GPs, the third doctor agreed and said, "That is something that we are always trying to do."

123. As to recommendation number five, the third doctor thought that any expectation to locate people with asthma on the ground floor would meet a lot of opposition from the prison authorities. He referred to Brixton having a lot of people with significant physical infirmities who need the ground floor accommodation.

124. In relation to the sixth recommendation, about prisoners who fail to attend follow-up appointments, the third doctor recalled that under the previous system "people would be put onto a nine day detox and would never be seen again unless they were requesting it, unless they actually requested themselves to see a GP." He explained that the current system is that one of the two GPs particularly trained in substance misuse (himself or his colleague) will see any substance misuser within a week of arrival and being put on methadone or Subutex. He recalled that there was no formal system to "go after" (follow-up) prisoners who failed to attend follow-up appointments at the time of the man's death. The system now, as explained by the third doctor, is much more proactive because all the prisoners on methadone or Subutex are held on G wing "and I now go to the wing after my morning surgery, if there is a problem with any of them I would see them. [My colleague] on a Tuesday afternoon at 4 o'clock will go to the wing as well so that he can assess anybody who might have been missed and we are shortly hoping that we will have an observation unit opened."

125. In relation to the seventh recommendation (correct procedure for the administration of methadone) the third doctor said that all staff dispensing methadone at Brixton are trained in the correct procedures "and we are constantly updating them and the pharmacy is heavily involved as well in monitoring and knows what goes on and we believe that we have very robust systems in place."

126. The eighth recommendation was that a review should take place of systems for administering controlled medications such as methadone. The report from the PCT following such an audit was still awaited at the time of my investigator's interview with the third doctor.

127. In relation to the ninth recommendation, that staff carrying out a First Reception Health Screen should do so correctly, the third doctor accepted

that the screening process should be completed in the way that is intended although he expressed a view that tasks in prisons are liable to be completed for themselves rather than for the outcome that is expected from that task.

128. In response to the tenth recommendation, about the possibility of two separate methadone doses on a prisoner's first day of treatment, the third doctor referred to the long period of time that a prisoner would have to spend queuing on his first day if methadone was administered in two separate doses. He said that such prisoners would miss being involved in other activities such as making phone calls or taking showers and he was confident that "20mls of methadone is still a very low dose and we believe that it is safe at that dose." (the man was given a 20mls dose of methadone on 8 June 2006, his first day of treatment at Brixton.) The specialist's report confirms at paragraph 110 that "[the man was provided with a dose induction regime (at Brixton) that was in keeping with prison and national policy and congruent with most other relevant countries' regimes."

129. In relation to recommendations 11 and 12, the third doctor said they were not within his remit and he added that within the healthcare team there is a significant amount of analysis that is used internally for all incidents.

130. The prison doctor was re-interviewed in November 2007. He explained that he usually works at Brixton on Thursdays but is on-call every sixth weekend. For six to eight days each year he supplies cover for colleagues who are on holiday. On Tuesday 13 June 2006, he supplied cover for a clinic that would normally have been undertaken by his colleague. The prison doctor was asked about the current system (in November 2007) for reviewing prisoners who are receiving opiate replacement medication. He replied that the current system was that the third doctor and his colleague are responsible for the policy of substance misuse and drug dependency work. He added that they also do the vast majority of reviewing patients and sorting out their requirements. The Assistant Ombudsman asked the prison doctor about arrangements, both in June 2006 and November 2007, for following up prisoners who did not attend at clinic but a much more detailed discussion of that issue is contained in the remarks made by the third doctor in his response to the sixth recommendation ("prisoners who fail to attend for important appointments, such as reviews of their drug treatment, must be followed up") in my draft report.

131. On 10 March 2008, the Assistant Director of Service Strategy and Adult Commissioning at the PCT wrote to my investigator. He enclosed a report on the methadone audit undertaken by the Chief Pharmacist and apologised for the delay in supplying the report. He referred to a number of factors, including the fact that the Healthcare Service at Brixton had recently been tendered through a competitive process which had been very resource intensive. He added that although the report outlined a number of issues regarding the management of controlled drugs at Brixton, these had been or were in the process of being dealt with through the Drugs and Therapeutic Committee. The Assistant Director of Service Strategy and Adult Commissioning wrote that progress was being monitored by the Prison and PCT Partnership Board.

132. When the Assistant Ombudsman first wrote to the Assistant Director of Service Strategy and Adult Commissioning, he relayed the request by the family solicitors that an audit of the pharmacy records at Brixton be performed to establish whether methadone stocks were properly controlled and if the entire stock was properly accounted for.

133. The introduction to the Chief Pharmacist's report, received on 10 March, states that the Primary Care Trust commissioned an independent review by a pharmaceutical adviser of the governance arrangements relating to controlled drugs at Brixton in order to address the following three questions asked by the solicitors for the man's family:

- Was any methadone reported lost/missing during the time of the man's death?
- Would it be possible for methadone to be diverted in the prison?
- Did an error in the recording in the controlled drugs register occur?

134. In response to a number of questions posed by the Assistant Ombudsman after receiving her report, the Chief Pharmacist set out as follows the ten methods constituting her methodology:

1. Consultation of the literature: Using the search criteria of "prison pharmacy", "controlled drugs" and "controlled drugs in prisons" A selection was made from these searches.
2. Reference to legal framework for controlled drugs (references sourced from the RPSGB, HealthCare Commission, Department of Health)
3. I contacted the East & South East England Specialist Pharmacy Services, which were known to have given the processes some thought and requested documentation of their audit tools, policies and processes
4. I adapted the controlled drugs audit tool produced by the East & South East England Specialist Pharmacy Services to answer the questions posed by the solicitors.
5. I met and discussed the issues/ concerns and the processes utilised by various stakeholders (lead nurse, principal pharmacist, prison pharmacist, specialist nurse for substance misuse, Chief Pharmacist the PCT, Commissioner)
6. I observed the substance misuse clinic on the wing
7. I reviewed controlled drugs registers (wing & pharmacy), including the one for the man, drug charts and SOPs
8. I observed and examined clinic locations/ consultation areas. I questioned a variety of staff as to the procedures used in those areas.
9. Consultation with the leading UK academic on the subject of NHS rationing, resources and ethics and consulted his books.
10. Analysis of the research, procedures/ charts collected and recommendations followed.

135. The stated aims of the report are to provide responses to the questions raised by the solicitors and to assess the governance arrangements relating to the

management of controlled drugs at Brixton that may have contributed to any system failures.

136. The Chief Pharmacist's report indicates that over the 18 months to February 2008 there were significant changes in legislation and good practice arrangements regarding the management of controlled drugs. She refers to a review of the current management of controlled drugs (CDs) instigated by the Department of Health following a previous inquiry. She indicates that several pieces of legislation and guidance have been issued to further strengthen the governance arrangements around the prescribing and use of controlled drugs. The statutory framework now requires all health and social care organisations to be accountable for ensuring the safe management of CDs. Primary care trusts 'must ensure robust monitoring arrangements are in place for the use and management of CDs by all healthcare providers who they employ or contract with'.

137. The Chief Pharmacist's report then turns to the questions raised by the family solicitors. In response to the question about whether any methadone was reported lost or missing at the time of the man's death, she says:

> *"On questioning, the lead nurse and Principal Pharmacist (who were both working at Brixton at the time of the death) reported that there was no methadone that was reported lost or missing. Adverse incident forms did not highlight that any methadone was missing."*

138. In response to the question about whether it would be possible for methadone to be diverted in the prison, the Chief Pharmacist's report reveals that the system of supplying methadone on a named prisoner basis made it difficult to reconcile the contents of the register with the cupboard with ease. The report continues:

> *"This system is no longer in use. The use of a variety of drug charts in a variety of locations, poor implementation of processes (observed during the audit) relating to the supervised consumption of medication and the workload and working environment issues means that it may be possible for methadone to be diverted in the prison."*

139. In response to the question about whether an error occurred in the recording in the controlled drugs register, the Chief Pharmacist's report says the following:

> *"On checking the controlled drugs register for the wing where [the man] was an inmate there were no discrepancies or miscalculations relating to entries for methadone in the controlled drugs register for [him]. The remainder of this register was checked and assessed for quality or recording. In June 2006, methadone was supplied on a named prisoner basis with a maximum of one week. This made it exceptionally difficult to track the stock and correlate it with the entry in the registers, as more than one register could have been in use. The recording of methadone in the CD register was noted to have many errors and was generally poor.*

Where it was possible to check the pages of the CD register there were no discrepancies in calculations noted. It should be noted on assessment of current CD registers on the wings there has NOT been a significant improvement in the recording of controlled drugs."

140. In the section of her report entitled 'Key Findings' the Chief Pharmacist lists 12 issues identified in the assessment which are relevant to the questions posed by the solicitors. I reproduce verbatim the 12 bullet points made at this section of her report:

a. Development of appropriate governance processes needs to occur to ensure that prisoners receiving opiates are clinically assessed regularly by nursing/healthcare staff
b. Review of the workflow during the supervised consumption within clinical areas should be carried out
c. Appropriate performance management structures for staff that consistently poorly perform relating to CDs is needed
d. Capacity assessment of nurses to undertake supervised consumption for the number of clients within HMP Brixton
e. Development of a consistent single record for prescribing and monitoring healthcare, including rationalisation of drug charts, is needed
f. Development/review of clinical guidelines relating to substance misuse is needed
g. Better records management needed and management of controlled drugs stationery needs to be tightened. Consistency and cross referencing between EMIS prescribing and written drug charts is needed.
h. Completion of Standard Operating Procedures within an appropriate timescale
i. Checking anaphylaxis drugs and naloxone are available in clinical areas as appropriate
j. Rapid escalation of medicines related errors and issues to the governor, healthcare manager and chief pharmacist
k. Education and training programme for all staff (CDs, anaphylaxis, medicines management, incident reporting etc) needed
l. Monthly audits of all CD registers in all locations needed

141. The last section of the Chief Pharmacist's report is entitled 'Summary of Findings' and announces that the governance processes related to the management of controlled drugs have been strengthened in Brixton over the last 12 months as a result of the implementation of a previous review and under the leadership of the principal pharmacist. She writes that her report identifies areas where there may have been factors that affected optimal safe systems of managing controlled drugs. Her belief, however, is that 'it is not possible to make inferences or relate any of the suggestions as contributing directly to the death of the man'.

142. The Chief Pharmacist's opinion is that a matrix approach to the management of controlled drugs and medicines would benefit processes. She recommends that professional and managerial accountability needs to be more tightly managed and a focused plan should be developed by the Head

of Medicines Management, the Healthcare Manager and the principal pharmacist to deliver the identified changes required within (appropriate) timescales.

143. Her final observation is that ‘the accountability arrangements for controlled drugs and all medicines need to be better understood by all healthcare staff and managers within HMP Brixton’.

CONCLUSIONS

144. The opinion of the clinical reviewer and the pathologist is that the man died as a result of lobar pneumonia. This condition is quite rare and is described by the clinical reviewer as a very rapidly developing illness. The illness can come on over a period of one to two days or as little as 24 hours. The abscesses found in the man's lungs suggest that he had an extremely aggressive form of bacteria which rapidly damaged the lung tissue.

145. The specialist in the management of drug addiction has concluded that the man was appropriately assessed as a substance misuser over a long period of time and in recent days prior to his incarceration. How much he used, and when he last did so, is open to question but unlikely to be of great significance. The specialist concludes it was entirely appropriate to prescribe and administer methadone treatment. She says that it may have been that severe respiratory problems were also present, but she is of the opinion that these would have been largely masked by withdrawal symptoms. She adds: "It is unlikely that the man was acutely respiratory compromised, with rapid respiratory rate, cyanosis, shortness of breath and so forth as these clinical signs would (should) have been identified by the large number of clinical and non clinical staff that he came into contact with over the course of the nine days he was in prison and police custody." It is also of significance that she says: "it may also have been that if the man was suffering from severe respiratory problems that methadone and benziodiazepines (both respiratory depressants) further compromised his respiratory function."

146. The man was seen by the reception doctor, who did not physically examine him. They did discuss his drug dependence and the possibility of commencing a Subutex detoxification. Expert opinion has been given that, even if the reception doctor had examined him, the signs of drug withdrawal may have masked a respiratory problem. Be that as it may, it would be far more satisfactory if the reception doctor were to give new arrivals a physical examination. I am fully aware of the constraints, time available, and the numbers of prisoners arriving through reception. But even if this physical examination were to take place within 48 hours of arrival, it would be better than none at all.

147. The man was also seen by the lead of the substance misuse team. She noted that he was asthmatic and he told her of a recent episode of pneumonia when he was admitted to hospital. During this assessment, it appears that he changed his mind about starting Subutex. She wrote that the man preferred methadone maintenance. The lead of the substance misuse team discussed the man and the possibility of methadone maintenance with the prison doctor. He signed the man up for methadone maintenance, but he did not see or talk to him about this. Apparently this is the norm. However, it is noteworthy that the prison doctor said that had he been aware of the man's history he would have wanted to see him. This is an area of concern and I suggest it would be beneficial for a prescribing doctor to at least read the papers in a prisoner's medical record before signing a methadone maintenance. That is not to say

that this would have altered the outcome in the case of this man, but doctors need to be fully aware of all the medical information available to them.

148. The man visited the medical hatch once a day from 8 June to 14 June. Each time, there would have been two nurses involved in giving him his methadone. In effect, this means that during this period there would have been 14 separate nursing observations of him, although it is likely that some nurses may have seen him more than once.

149. The nurse at the medical hatch on 14 June was identified as being the last nurse to administer methadone to the man. She said that there was nothing untoward or concerning about him that afternoon. She was asked about this and said that if she had any concerns about a prisoner she would withhold medication and refer to the doctor.

150. The man was found dead in his cell by his cellmate who promptly raised the alarm. Staff responded immediately as evidenced by all of the official logs (prison, police and London Ambulance Service). The Hotel 6 nurse attempted CPR despite the indications that the man was already dead. I do not believe it is respectful if staff are required to commence CPR on those who are clearly beyond resuscitation. However, in the particular circumstances, I believe the actions of the nurse reflect very well and have drawn attention to them as an example of good practice.

151. A good deal of further investigative work has been undertaken by the Assistant Ombudsman in response to a number of questions raised by the man's family and their solicitors. The family asked that the clinical reviewer should reach a conclusion as to the reception doctor's practice in prescribing inhalers to the man without examining his chest. His response to this question was that it was medically appropriate that the reception doctor did not examine the man's chest. Reasons cited by the clinical reviewer were that the man did not present any symptoms suggestive of a chest problem to the doctor, that the doctor clearly remembered seeing him on the evening of 7 June and that (in the clinical reviewer's opinion) patients with asthma should always have inhalers with them. The clinical reviewer acknowledged that the reports from the Forensic Medical Examiner, who saw the man in police custody before his arrival at Brixton, did mention a recent past history of pneumonia and of asthma causing wheeziness. The reception doctor was not in a position to be guided by the FME reports as they were not available to him when he saw the man who is the subject of this report.

152. The man's family supplied a witness statement made by his niece for HM Coroner. She visited him at Brixton on 12 June, just three days before his death. The clinical reviewer was asked by the family to review, clarify and if necessary expand upon his view concerning the man's likely presentation from the date of his meeting with his niece. The clinical reviewer has responded that it is not possible for him to provide a clear answer to the family's question. He has referred to the possibility that when his niece saw her uncle on 12 June, he was beginning to become unwell with what developed into fulminating lobar pneumonia over the course of the

subsequent two days. The clinical reviewer considered the possibility that the man was suffering from jaundice when his niece visited. The clinical reviewer would have expected jaundice to be detected in the post mortem examination carried out by the pathologist, on 15 June. The pathologist's post mortem examination report referred to no abnormalities of the liver and the clinical reviewer therefore concluded that the man was probably not suffering from jaundice on 12 June.

153. The May 2007 response from Safer Custody Group to my draft report challenged many of the recommendations made in that report. The response was particularly critical of the clinical reviewer's role, questioning whether he had the necessary experience or training to make recommendations referring to prison specific processes. I have little doubt that he will be able to defend his reputation robustly but I wish to place on record my thanks to him for supplying a detailed, wide ranging and impressively evidenced report on the circumstances of the man's death.

154. The Safer Custody Group response referred to apparent confusion regarding the process for review of patients on opioid replacement and suggested that this confusion could have been cleared up with a call to the third doctor.

155. After the Assistant Ombudsman met in October 2007 with the then deputy governor of Brixton, he was sent a note explaining that the third doctor had written a lengthy response to the clinical review. He referred in his note (to the healthcare manager at Brixton) to the 'unfortunate distribution of my previous comments'. They were intended as a 'discussion document for the senior clinicians at Brixton who would later edit and refine the response. My comments therefore were taken out of context'.

156. The wording of the last four pages of the response I received from Safer Custody Group on 10 May 2007 is almost identical to the Response from Senior Clinicians at HMP Brixton which was sent to Safer Custody Group six days before. In view of his remarks in the previous paragraph, I judge that the third doctor contributed significantly to the Response from Senior Clinicians document. My investigator gave him an opportunity to comment in detail, almost 18 months after the man's death, on all the recommendations contained in the previous version of this report. I fully accept the third doctor's assertion that he and his GP colleagues at Brixton 'are all trying to ensure that the service we provide is not just equivalent but superior to that received in the community'.

157. In his interview with the Assistant Ombudsman, the third doctor explained that he and his colleagues had introduced substitute prescribing with methadone as recently as March 2006. I note with pleasure the increasing sophistication of the treatment available for substance misusers at Brixton. The recent introduction of the Integrated Drug Treatment System (IDTS) has enabled the substance misuse team to build up to a strength of five staff members. I observe in passing that IDTS has not yet been introduced to many other prisons, with the inevitable consequence that the sophisticated treatment

already available to a prisoner at the likes of Brixton is not yet reproduced throughout the prison estate.

158. In interview, the third doctor confirmed that at the time of the man's death there was no formal system to "go after" (follow up) prisoners who failed to attend their medical appointments. The current system is that one of the two GPs particularly trained in substance misuse will see any substance misuser within a week of him arriving at Brixton and being put on methadone or subutex. Now, but not at the time of the man's death, the system is much more pro-active because all the prisoners on methadone or subutex are held on G wing and the third doctor is able to see them on that wing after his morning surgery.

159. I am grateful to the PCT for supplying the document headed "HMP Brixton – Findings from a Review of Controlled Drugs" though my investigator was informed that the report would be available several months before it eventually materialised. The Chief Pharmacist's report says, according to information supplied by the lead nurse and Principal Pharmacist, that no methadone was reported lost or missing at the time of the man's death. The report concedes that it might have been possible for methadone to be diverted within the prison because the system of supplying methadone on a named prisoner basis made it difficult to reconcile the contents of the (controlled drug) register with the cupboard.

160. The Chief Pharmacist reports that the controlled drug register was scrutinised to establish whether there were any discrepancies or miscalculations relating to the man. None were found but the Chief Pharmacist adds that the system for supplying methadone in June 2006 made it "exceptionally difficult to track the stock and correlate it with the entry in the registers". She highlights her worrying finding that "there has NOT (capital letters in her report) been a significant improvement in the recording of controlled drugs in current CD registers on the wings".

161. The Chief Pharmacist says that her report identifies areas where there may have been factors that affected optimal safe systems of managing controlled drugs. She argues that "it is not possible to make inferences or relate any of the suggestions as contributing directly to the death of the man".

162. I am well aware that the opinion of both the clinical reviewer and the pathologist is that the man died as a result of lobar pneumonia. Nevertheless I believe that the Chief Pharmacist's findings in relation to the management of controlled drugs at Brixton are important and timely. In the concluding paragraphs of her report the Chief Pharmacist suggests that a number of changes are required. She observes that a matrix approach to the management of controlled drugs (and medicines) would benefit processes. Her opinion is that dual accountability (professional and managerial) needs to be more tightly managed. The Chief Pharmacist's last paragraph refers to the need for accountability arrangements for controlled drugs (and all medicines) to be better understood by all healthcare staff and managers within Brixton. I

therefore endorse the following recommendation made by the Chief Pharmacist and include a suggested timescale.

Working in conjunction with the Governor and the PCT, a focused plan should be developed to deliver the changes to the management of controlled drugs at Brixton identified as being required in the Chief Pharmacist's report of February 2008. The Head of Medicines Management, Healthcare Manager and Principal Pharmacist should devise a focused plan, with timescales, within 3 months of receiving my revised draft report.

RECOMMENDATIONS

I make the following recommendations. The majority of these arise from the clinical reviewer's clinical review. Recommendations 5, 7 and 8 are my own.

1. **A system should be instituted to record all documents and papers that arrive in Reception with new prisoners.**

2. **The system for assessing newly arrived prisoners at HMP Brixton must ensure that all relevant documents, such as FME reports, accompany prisoners as and when they are seen by the GP.**

3. **The training needs of all the nursing members of the Substance Misuse Team as well as the primary care nurses on G wing should be reassessed to ensure that they are all able to assess and monitor the health needs and clinical problems of prisoners who are drug addicts. They need to understand fully what they are assessing and monitoring and the reasons why they are doing this. They also need to be clear about what to do if any cause for concern arises, including new information**

4. **The Substance Misuse Team (SMT) should always attempt to contact outside drug agencies and GPs to establish the pattern of treatment of prisoners who are drug addicts or are being considered for treatment by the SMT. These contacts should be made as soon as possible, and there may be a need for a standard system for making these contacts and obtaining the relevant clinical information.**

5. **When a prisoner with a clinical condition that may affect their physical abilities is received in prison, they must be individually assessed to ensure that they are given accommodation suitable to meet their health and social care needs. This assessment must be documented in their medical record and their wing history sheet to ensure continuity of care.**

6. **The administrative systems related to the monitoring of the treatment of drug addiction need to be reviewed and changed in several ways. Prisoners who fail to attend for important appointments, such as reviews of their drug treatment, must be followed up. Important clinical information about prisoners must be rapidly passed on to members of the SMT and G wing nurses. Assessment and decision-making must occur rapidly for prisoners who do not adhere to their agreed programme.**

7. **The prison health partnership should remind healthcare staff of the correct procedure for administration of methadone as dictated in the Drug Dependence guidance.**

8. **I recommend that the prison health partnership reviews the existing systems in place for administering controlled medications such as methadone. The new system should make safeguards for the following:**

(i) **Ensuring prisoners are fit and well prior to receiving medication;**
(ii) **Ensuring as far as practically possibly that impostors are prevented from receiving medication.**

9. **Steps should be taken by healthcare management to ensure that staff carrying out a First Reception Health Screen (FRHS) do so correctly and fully in line with the protocol on the FRHS form.**

10. **Staffing levels must be modified to ensure that the drug treatment protocols can be implemented, if that is a reason for it not happening. It is not acceptable for there to be insufficient nursing staff to ensure that the twice daily regime for the initiation of methadone on day 1 can take place.**

11. **Working in conjunction with the Governor and the PCT, a focused plan should be developed to deliver the changes to the management of controlled drugs at Brixton identified as being required in the Chief Pharmacist's report of February 2008. The Head of Medicines Management, Healthcare Manager and Principal Pharmacist should devise a focused plan, with timescales, within 3 months of receiving my revised draft report.**

12. **Healthcare management at HMP Brixton should ensure that all relevant nursing and discipline staff receive training so that they carry out cardiopulmonary resuscitation (CPR) in accord with the current recommendations.**

13. **Healthcare management must look at how to ensure that all the elements of the response to Code 1 emergencies takes place. This includes ensuring that the wing-based emergency equipment, the Ambu-Bag equipment, is always brought to the site of the emergency by the wing staff before the arrival of the nurse on duty.**

14. **A process of significant event analysis (SEA) must be introduced for all major incidents such as deaths or attempted resuscitation. The SEA process should also be used for all other major medical incidents. The SEA should help to identify the learning needs of individual members of staff, as well as the need to develop and refine systems and protocols of care.**

GOOD PRACTICE

- **I commend the actions of the Hotel 6 nurse in attempting resuscitation despite the fact that the man displayed physical signs of death.**

- **I note that since my investigator expressed concern about the "symptom assessed" column on the Methadone Titration Form, it is now being completed and I urge the prison health partnership to ensure this continues.**