

**Investigation into the circumstances surrounding
the death of a man,
whilst in the custody of HMP Wandsworth,
in September 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

February 2011

This is the report of an investigation into the circumstances surrounding the death of the man, a prisoner at HMP Wandsworth. He died aged 38 years, in September 2009. He had been in prison for five days. A post mortem stated that his death was caused by Mixed Drug (methadone and benzodiazepine) Toxicity. He had abused drugs and alcohol for many years and was being treated with a routine detoxification programme. After his death, traces of an additional drug were found in his body.

I would like to offer my sincere sympathy and condolences to the man's family for their loss. My report could only be completed once the toxicology tests were completed. I apologise for the delay in issuing my report and any additional distress that this may have caused.

The investigation was carried out on behalf of the Acting Ombudsman by my colleague. I would like to thank the Governor of Wandsworth and all his staff for their co-operation during the course of our enquiries.

The local Primary Care Trust (PCT) was commissioned to conduct a clinical review of the healthcare the man received whilst in custody. I am grateful to the PCT for appointing a clinical reviewer to conduct a specialist independent clinical review. Her review shows that the man received a standard of care which was equitable to what he could have expected in the community. I make one recommendation regarding healthcare records.

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

Jane Webb
Acting Prisons and Probation Ombudsman

February 2011

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SUMMARY

On Saturday 12 September 2009, the man appeared at Magistrates Court. He was remanded into custody until 18 September and taken to HMP Wandsworth where a nurse conducted an initial healthscreen check. He told the nurse about his history of asthma and hypomania, and also said that he abused alcohol and had used drugs. He provided a urine sample that proved positive for opiates. Medication was prescribed.

Later that same evening, he saw a prison doctor who prescribed medication for asthma and hypomania, as well as detoxification medication for opiate and alcohol withdrawal. Two days later a second prison doctor reviewed the detoxification medication and agreed a plan with him to initially increase the level of medication for a two week stabilisation period followed by weekly reductions.

Over the following two days he received his medication in accordance with the plan devised by the prison doctor. He told doctors that he had trouble sleeping and was also prescribed zopiclone (for insomnia).

On a morning in September he was found unconscious in his cell. Urgent medical assistance was requested and nurses responded immediately. The nurses assessed that he had been dead for some time and so they did not commence cardio pulmonary resuscitation.

The paramedics agreed with this assessment and he was pronounced dead by the prison doctor at 9.15am. (temazepam, which had not been prescribed (usually taken for insomnia or anxiousness), was found at the post mortem.)

The prison family liaison officer visited the man's family later that morning to break the news of his death. In the days that followed the prison family liaison officer maintained contact with them. I judge that Wandsworth appropriately followed Prison Service Order (PSO) 2710 "Follow up to death in Custody" and offered financial assistance towards funeral expenses.

Together with the clinical reviewer, I am satisfied that the standard of care he received ensured that his conditions were treated appropriately. However I make one recommendation concerning healthcare record keeping.

THE INVESTIGATION PROCESS

1. On 18 September 2009, I appointed my colleague to investigate the man's death. He was assisted by Assistant Ombudsman. Notices were issued to staff and prisoners, inviting those who wished to submit information relating to his death to make themselves known to the investigator. No prisoners contacted the investigator as a result of these notices.
2. The investigator visited HMP Wandsworth on 29 September to obtain copies of relevant documentation relating to the man. The investigator and Assistant Ombudsman returned to Wandsworth on 10 and 11 November to interview seven members of staff. In addition the investigator asked three prisoners on two separate occasions for information about the death. One prisoner was interviewed, however the other two declined.
3. The investigator wrote twice to the Health Authority for copies of the man's community medical records. Regrettably the health authority has not responded to the requests. The HM Deputy Coroner has had ongoing contact with the investigators and tried to help resolve this matter. The investigators have maintained contact with the Coroner to update her on the progress and findings of the investigation. The investigator requested a copy of the post mortem report. The post mortem was delayed due to the toxicology tests and I suspended my investigation on 12 November 2009, pending the results. The Coroner issued a copy of the post mortem results on 13 April 2010 and I recommenced the investigation.
4. The Chief Executive of the local Primary Care Trust (PCT) initially commissioned a clinical reviewer to carry out a review of the man's clinical care. After the results of the post mortem were received, the investigator and Assistant Ombudsman met the clinical reviewer and discussed the man's treatment and care. It was agreed that an independent substance misuse specialist should conduct the clinical review. The Chief Executive of the local Primary Care Trust (PCT) subsequently commissioned another clinical reviewer to conduct the review.
5. One of my family liaison team contacted the man's family to inform them of the investigation. The family liaison officer and the investigator later met the family who expressed the wish that he should be referred to by his Christian name in the report. The family asked the investigator to consider the care that he received whilst at Wandsworth. The family said that they did not believe that he used opiates but knew that he regularly drank alcohol. The family told them that they were impressed by the sensitivity and professionalism shown by the prison family liaison officer.

HMP WANDSWORTH

6. HMP Wandsworth is a busy category B local prison in South London. The prison can hold a maximum of 1,665 sentenced or remand adult male prisoners. Since 1989, there has been an extensive refurbishment programme which is still ongoing.
7. There is a dedicated wing within the prison for men who have been identified as having a history of drug use and who require appropriate monitoring and detoxification programmes. This is where the man lived.
8. In addition there is a healthcare unit with an inpatient facility. Health services are commissioned by the local Primary Care Trust (PCT) and were provided by Secure Healthcare from July 2007 to September 2009. From September 2009 the PCT assumed responsibility for healthcare services at the prison.
9. The Independent Monitoring Board (IMB) is made up of representatives from the community. The Board monitors day-to-day prison life to ensure proper standards of care and decency for all prisoners. In the summary of their latest annual report, the Chair of the IMB at Wandsworth said:

“It is very encouraging to be able to report that Wandsworth has continued upwards in performance improvement. There are significant improvements in a number of areas compared with last year and overall it is a better place than it was this time last year. Prisoners tell us that the “old” Wandsworth has almost disappeared and that the “new” Wandsworth provides a much more acceptable regime for prisoners and that this compares very favourably with most other large local prisons.”
10. Her Majesty’s Chief Inspector of Prisons last reported on Wandsworth following an announced inspection in June 2009. In her report, the Chief Inspector concludes that “Patients received a thorough reception screening”.
11. The Ombudsman investigated four other deaths at Wandsworth in 2009 in addition to the man’s death. Two were self inflicted deaths and two by apparent natural causes. There is nothing from the investigations into the previous deaths that is relevant to this investigation.

KEY EVENTS

12. The man was born in January 1971 and lived in the Walthamstow area. He was single and had a close relationship with his family. He had a history of asthma, hypomania (mood state characterised by persistent and pervasive elevated or irritable mood), alcohol abuse and had also used drugs. He received treatment from his community general practitioner.
13. He was arrested by the police on Friday 11 September and held in police custody. He tested positive for opiates, and was prescribed dihydrocodeine (for opiate dependency treatment) and diazepam (for alcohol withdrawal) by the police doctor.
14. The man appeared at Magistrates Court on Saturday 12 September where he was charged with handling stolen goods. He arrived at 8.45am and a prison custody officer (PCO) regularly checked on him. He accepted a drink at 8.50am and was checked a further nine times between 9.00am and 10.00am with no problems being reported.
15. At 10.04am, he told Senior Custody Officer (SCO) A that he felt unwell and was suffering from drug withdrawal. The SCO called for a doctor to examine him. Between 10.09am and 1.00pm his condition was checked by custody staff a further 16 times. He accepted a drink at 11.48am and no problems were reported.
16. The doctor arrived at 1.03pm but the man declined to be examined as he had been remanded into custody until 18 September. He was taken from court to HMP Wandsworth. He had been in prison before.
17. On arrival at Wandsworth, he saw Nurse A who carried out a routine initial healthscreen. He told the nurse about his history of asthma and, before entering custody, said that he had been prescribed a salbutamol inhaler (used for treatment of asthma). He also said that he suffered from hypomania for which he was prescribed sodium valproate (a mood stabiliser for treatment of psychiatric conditions). He told the nurse that he smoked, drank eight to nine cans of strong cider per day, spent £20 to £30 a day on heroin and had previously used cocaine. The nurse tested his urine and the results proved positive for benzodiazepine (used for treatment of alcohol withdrawal) and opiates. The nurse referred him to the detoxification team and the doctor.
18. The nurse explained to the investigator that information taken from prisoners when they arrive at the prison is entered directly onto the computerised medical record system. The nurse said that the man's high daily alcohol intake was a concern and that the positive test for opiates indicated that there was heroin in his system.
19. The man saw Nurse B, a member of the detoxification team, later that afternoon for a further healthscreen. The nurse noted his history of asthma, hypomania, drink and drug misuse. His blood pressure was 114/88 with a pulse of 123. (The normal range for blood pressure is 100/70 to 140/90,

although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low. A high pulse rate, such as 123, is a clinical indicator of opiate withdrawal for an individual with a history of drug misuse.)

20. He told the nurse that he had used drink and drugs for the previous 25 years since he was in his early teenage years. In response to routine questions, he said that he had no thoughts of self harm and gave details of his doctor in the community. He had tested positive for opiates and benzodiazepine and the nurse recorded that his average alcohol consumption was 252 units per week. (The NHS recommended daily limit for alcohol for a man is three to four units per day.) The nurse referred him to the doctor and the detoxification doctor and recommended that he be placed on the substance misuse unit.
21. Prison Doctor A saw the man the same evening. He told the doctor about his drink and drug use and that he had been in prison about 15 times before. The doctor recorded that he was prescribed medication for asthma and hypomania by his community doctor. The doctor prescribed a range of medications, which included the standard level of detoxification medication:
 - sodium valproate
 - salbutamol inhaler
 - thiamine hydrochloride (vitamin supplement during alcohol withdrawal)
 - vitamin B tablets (vitamin supplement during alcohol withdrawal)
 - methadone 20ml (used for treatment of opiate dependence) for an initial three days
 - chlordiazepoxide (used for treatment of alcohol withdrawal).

The doctor referred him to the detoxification team and completed both the Methadone Maintenance Chart and the Chlordiazepoxide Detoxification Chart.

22. A cell sharing risk assessment (to assess the risk of harm to others) was completed. The man had no concerns about sharing a cell, did not get angry or frustrated easily, and was a smoker. There was no evidence of risk from sharing a cell. He and his co-defendant were allocated to share a cell. At interview the co-defendant said that he had been friends with the man for 18 years. The co-defendant knew that the man had a drink problem and was nervous about being in prison. He told the investigator that the man did not look ill and, if he had done, he would have told him and mentioned it to a nurse or another member of staff.
23. The next day Nurse C saw the man for his second healthscreen check. The nurse recorded his blood pressure as 111/83 with a pulse of 109. He told the nurse that he had started smoking at the age of 15 and had tried to give up. He said that he avoided doing any form of exercise and the nurse gave advice on exercise and referred him to the Stop Smoking clinic.

24. The handwritten Chlordiazepoxide Detoxification Chart record shows that 100mg was administered on 13 September, as authorised by Prison Doctor A. He was given 35 mg at 8.30am, 30mg at 12 00pm and 35mg at 5.00pm.
25. On Monday 14 September, Prison Doctor B, saw the man in the detoxification clinic. The doctor assessed that he was withdrawing mildly from opiates and noted that he had been prescribed 20ml of methadone. The doctor prescribed an increase to 30ml from the next day, to continue for two weeks, followed by weekly reductions. The doctor recorded that he agreed with this plan. He set a review in seven days and amended the methadone maintenance chart accordingly. There is no entry made by the doctor in the computerised record regarding the chlordiazepoxide or the other medications.
26. The doctor told the investigator that the rationale for dealing with patients undergoing opiate withdrawal was to stabilise them over a number of days. This is because urine testing only confirms whether an individual has taken opiates, and does not indicate the quantity or quality of the drug. Therefore it is important to avoid over prescribing withdrawal medication, which could have serious implications to how an individual reacts to the medication. He explained that as the man was also withdrawing from alcohol, care had to be taken over the level of his prescribed medication.
27. Later the same day healthcare administration staff attempted to telephone the man's community doctor but got no reply. (This was the first opportunity that contact could have been made, as he had arrived at Wandsworth over the weekend.) An entry was made on the medical record that a further call would be made later although there is no evidence that a further attempt was made.
28. The same day the man moved to a cell in the wing for prisoners on detoxification programmes. He shared the cell with a cellmate. At the same time the cellmate moved to another wing which was the last time he saw the man. He told the investigator that the man was in good spirits. During the time that they shared a cell, he was not aware of him obtaining or being offered illicit drugs from other prisoners.
29. The handwritten Chlordiazepoxide Detoxification Chart record shows that 90mg was administered on 14 September, authorised by Prison Doctor A. He was given 30 mg at 9.35 am, 30mg at 11.40am and 30mg at 3.45pm. In addition on the Prescription and Administration Record Chart, Prison Doctor B added zopiclone to the man's list of prescribed medication to be given at night. The drug is not mentioned on the computerised medical record, either as a consultation having taken place or on the list of medication.
30. When interviewed, Prison Doctor B confirmed that he prescribed the zopiclone for the man but said that he had not seen him. The doctor said that one of the nurses would have asked him to prescribe it. He said that zopiclone was a short acting drug to address sleeplessness, which is a side effect of opiate and alcohol withdrawal. It was given for just two to three days.

31. There are no entries in the computerised medical record for the next day, 15 September. From the handwritten Chlordiazepoxide Detoxification Chart, the man was to have 80mg that day, as authorised by Prison Doctor A. He was given 30 mg at 9.00am, did not attend later to receive 20mg and had 30mg at 5.05pm. He also took the zopiclone at night as prescribed.
32. Again the following day, 16 September, no entries were made in the computerised medical record. From the handwritten Chlordiazepoxide Detoxification Chart, he had 70mg during the day, as authorised by Prison Doctor A. He was given 25 mg at 8.55am, 20mg at 12.05pm and a further 25mg at 5.05pm. He also had the zopiclone at night as prescribed.
33. In a statement given to the police, the man's cellmate said that he knew that he took his "sleeping pill" and he seemed to be in good spirits. The cellmate said that he turned the cell light off at about 8.15pm, when the man was lying down on the top bunk. He watched a film on television until about 11.30pm and remembered hearing him snore before going to sleep himself. He said that he was not disturbed until the following morning when an officer opened the cell door.
34. The investigator has confirmed from prison records that the man's cell bell was not pressed at any time during the evening of 16 September or early hours of 17 September.

Events of 17 September

35. In the previous 24 hours there had been an outbreak of sickness and diarrhoea that had affected some 300 prisoners. As a result movement for prisoners was temporarily restricted in an attempt to prevent the spread of the infection. On the morning of 17 September, staff were asked to obtain signed statements from prisoners to confirm that they were not experiencing diarrhoea, sickness or flu like symptoms.
36. Officer A went into the man's cell at approximately 8.20am. The officer told the investigator that it was dark. He recalled that he was lying on the top bunk bed, beneath the covers which were pulled up to his face. His head was on his pillow and he appeared to be asleep. His cellmate had just woken up. The officer asked him if he was ill or had any sickness symptoms, to which he replied that he had not and signed the declaration form.
37. The officer then called to the man by name to wake him and repeat the questions. He did not respond and his cellmate shook the bed but there was no response. The officer noticed that there was blue mottling around the man's lips and neck. He felt his neck for a pulse but was unable to find one and immediately called for urgent medical assistance.
38. Nurse D was already on the landing below and responded to the emergency call. The nurse found him lying on his bed, under the covers with his lower right arm protruding through the bed rails. The nurse checked for a pulse but was unable to find one and immediately requested an ambulance. She told

the investigator that, from her experience, there were no signs of life, rigor mortis was present which indicated that he had been dead for some time.

39. Nurse E arrived seconds after Nurse D. On examining him, Nurse E also assessed that he had been dead for a considerable amount of time. The nurse considered that to commence cardio pulmonary resuscitation (CPR) would have been undignified and disrespectful.
40. The paramedics arrived at the man's side at 8.40am and also considered that he had died. Prison Doctor B confirmed death at 9.15am.
41. Wandsworth followed Prison Service Order (PSO) 2710 "Follow-up to Deaths in Custody" and appointed Governor Perry Cain who broke the news to the man's family in person later that same morning. A governor maintained contact with the family and the prison offered financial assistance towards the funeral costs.
42. At approximately 11.00am a hot debrief was held for staff involved in the incident. (Hot debriefs are held as soon as possible on the same day after a death in custody to ensure that staff involved have an opportunity to discuss any issues arising.) Support was available to staff from the Post Incident Care Team and the chaplaincy. Support was also made available to prisoners from the chaplaincy and Listeners (who are trained for this role by the Samaritans).

ISSUES

Clinical care

43. Given the post mortem findings, the investigator asked the clinical reviewer to consider the man's assessment and medications, particularly how the different medications could interact with one another. The clinical reviewer made the following comments:

"This gentleman was reported as having a 25 year history of heroin and alcohol use. He reported consuming in excess of 200 units of alcohol per week although there is no note of the length of time he had been consuming alcohol in this quantity. He was noted to have a tremor and complained of night sweats, both signs of alcohol withdrawal on arrival in reception and was given 35mg of chlordiazepoxide. He was then prescribed a reducing regime of chlordiazepoxide in line with the degree of dependency he was showing and prison policy. This regime concurs with the NICE [National Institute for Health and Clinical Excellence] Guidelines, June 2010.

"He also reported smoking heroin £20-30 worth daily it is noted that this was for the previous month. Again there is no exact history of how long he had had a problem with opiates. His urine drug screen was positive for opiates although this could be as a result of taking a number of different opiate painkillers.

"The starting dose of methadone 20mg daily is a safe and reasonable dose in line with Drug Misuse and Dependence, UK Guidelines on Clinical Management, Department of Health 2007, in a man of normal weight and build (BMI=20.11.). On review three days later he was said to be mildly withdrawing from opiates, although symptoms were not recorded.

"He was also noted to be asthmatic and was prescribed a salbutamol inhaler, which he had in his possession. It should be noted that use of this inhaler can cause fine tremor, palpitation, tachycardia and arrhythmias.

"The man reported that he was taking sodium valproate prescribed by his General Practitioner for hypomania. He gave a history of psychiatric treatment and in order to prevent a relapse of his mental health problem it was reasonable to continue this on admission to the prison.

"In summary, I think this gentleman's treatment was satisfactory within the confines of HMP Wandsworth prison and in line with their substance misuse policy."

44. The investigator specifically asked the clinical reviewer to consider the combination effects of the medication that were prescribed and whether, in the doctor's opinion, they might have had any bearing on the man's death. She made the following comments:

“It is very unlikely that the combination of medications this man was prescribed would lead to his death. The main mechanism of death from opiates and benzodiazepines is the cumulative respiratory depressant effect of both drugs. In this case he had been taking chlordiazepoxide in a reducing dose for 4 days and his methadone dosage was gradually increased and was still at a relatively low level.

“The addition of zopiclone 7.5mg is extremely unlikely to have caused any respiratory depression or other adverse effects. It is said to cause respiratory depression but in my clinical experience rarely causes any problem.

“There is nothing that causes me concern in terms of the medication prescribed and administered to him or that is likely to have directly led to his death.”

Healthcare records

45. At the time that the man entered custody at Wandsworth the healthcare records were computerised, with the exception of medication and drug charts. This investigation has shown that there were healthcare interventions with him which were recorded manually but were not entered on to the computerised record. This means that there is no complete continuous medical record of all the interventions between the healthcare staff and the man.

46. The clinical reviewer highlights the following issues regarding healthcare notes:

“In my opinion, there should be continuous monitoring (observation of symptoms and signs, Blood Pressure and Pulse) of patients undergoing alcohol detoxification. The NICE Guidelines 2010 emphasise early assessment by an experienced clinician to identify clients at risk of alcohol withdrawals and administration of medication if necessary. Alcohol withdrawals can lead to serious medical conditions and death, yet there is no mention in the notes of the progress of his detoxification.

“The medication chart has a dose of chlordiazepoxide available to be given in the evening if required, yet there is no mention that this patient was observed in the evening to see if he required a further dose.

“Despite a mention in the interviews conducted by the Ombudsman that the patient had been noted to be drowsy, there is no mention of this in the medical notes, nor is there any evidence that he sought medical help on 16 September 2009.

“I recognise that recording clinical notes on a computerised system is a relatively new requirement for most clinical staff, however it is important that this does not lead to inadequate recording of clinical encounters, particularly failing to mention negative findings.”

I therefore make the following recommendation:

The Governor and Healthcare Manager should ensure that healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Family liaison

47. I believe that Wandsworth appropriately followed PSO 2710 "Follow up to death in custody" by breaking the news of the man's death in person and offering financial assistance towards funeral costs. The family told the family liaison officer and the investigator that they were impressed with sensitivity and professionalism of the prison family liaison officer.

Toxicology findings

48. The findings of the post mortem toxicology report conducted by Forensic Pathology Services concluded that the cause of the man's death was "Mixed drug (methadone and benzodiazepine) Toxicity". The pathologist stated that no features of significant natural disease were found at autopsy, which could have directly caused or contributed to his death and there were no pathological findings to indicate liver failure. He also concludes that analysis of the man's hair sample indicates that he took cocaine, heroin and methadone regularly in the months leading up to his death.
49. The toxicology results also show that he had temazepam in his blood. As this was not one of his prescribed medications, the pathologist concludes that it was possible that he had obtained drugs from an illicit source. In witness evidence given to HM Coroner for the Inquest into the death a professor of bioanalytics said as follows:

"A number of drugs and their breakdown products (metabolites) were detected in the blood sample and their concentrations measured.

"The drugs and metabolites measured in blood were chlordiazepoxide, chlordiazepoxide lactam, diazepam, desmethyldiazepam, temazepam, methadone, EDDP and zopilclone. None of the concentrations of the drugs or metabolites was consistent with a fatal overdose of the parent drug.

"Desmethyldiazepam and temazepam are metabolites of chlordiazepoxide, but diazepam is not. The presence of the low concentration of diazepam, 0.03 milligrams per litre, is probably the result of the diazepam given during police custody. The remaining compounds detected are all consistent with the therapy prescribed to the man whilst in prison. Thus, chlordiazepoxide lactam is also a metabolite of chlordiazepoxide and EDDP is a metabolite of methadone."

50. Given the post mortem results and the detail in the clinical review this investigation is unable to provide any further answers into the circumstances leading up to the man's death.

CONCLUSION

51. The man had been in prison many times before and had abused drugs and alcohol for many years. He was prescribed a routine detoxification programme, placed in Wandsworth's detoxification wing where he was monitored by staff. I judge that attention was paid to his health needs and appropriate treatment was provided in the very short time that he was in custody.
52. I accept the specialist clinical reviewer's judgment that the standard of care ensured that his conditions were adequately managed. His death was caused by Mixed Drug Toxicity.
53. Although the healthcare records were incomplete, and I recommend improvements in practice, I do not believe that the omissions had any bearing on his death.
54. The fact that he died whilst undergoing treatment for alcohol and drug dependence is a matter of great concern. The expert reviewer judged that the care he received was adequate.

The man's family, via their legal representative, having had the opportunity of reading the report at the consultation stage of the process, and after HM Coroner's Inquest, wish to make the following comments:

- *The detoxification medication was increased.*
- *The interview transcripts contained inaudible entries.*
- *The number of interviews conducted was insufficient and insufficient attention was given to his last day in custody.*
- *The standard of interviewing used badly phrased questions and was not sufficiently robust and challenging.*
- *The family does not agree with the conclusion of the report as they are concerned regarding the level of monitoring he received whilst being prescribed a number of medications.*

RECOMMENDATION

1. The Governor and Healthcare Manager should ensure that all healthcare staff comply fully with the requirements for accurate and contemporaneous record keeping in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

Accepted