

**Investigation into the circumstances surrounding the
death of a man in October 2008,
after his release from HMP Wayland**

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

September 2010

This is the report of an investigation into the death of a man. He was released from HMP Wayland on 6 October 2008 and was found dead, in his home, at about 12.15am the next day after taking drugs. He was 32 years old when he died.

This investigation has been undertaken under the Ombudsman's discretionary powers to investigate deaths which follow release from prison. It was decided to investigate in this case to ensure that the man was given proper care whilst in custody and was fully prepared for his release. I apologise for the delay in issuing the report. This was caused by a delay in the police investigation and in the writing of this report.

I would like to add my personal condolences to the man's family, friends and everyone affected by his death.

This investigation was undertaken by an investigator. I would like to thank the prison's Governor and his staff for their participation in the investigation process. A clinical reviewer was identified by the NHS to undertake a review of the man's clinical care and I am grateful for her contribution to the investigation.

In the main, I believe that the man received a good level of care and understanding from staff. Nevertheless, his death is an important reminder that however well prepared prisoners are for release, for many it remains a difficult and dangerous transition.

I make eight recommendations in this report.

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

September 2010

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SUMMARY

On 16 July 2007, the man was remanded into the custody of HMP Peterborough, charged with burglary. Reception staff noted that he was using heroin, benzodiazepines and crack cocaine, drinking 12-13 cans of lager daily and had tested positive for cannabis. There was no history reported of him being at risk of self harm or having any mental health difficulties. He had completed a previous prison sentence some years before.

The man was sentenced to two years and six months for burglary on 21 August. He was identified as a Prolific and Priority Offender because of the level of his offending behaviour. He moved to HMP Highpoint on 13 September. It was noted that he suffered from epilepsy, which was treated with clonazepam, and depression, treated with mirtazapine.

He was transferred to HMP Wayland at the end of December 2007. Medical staff at Highpoint contacted Wayland beforehand to provide a telephone summary of his medical problems.

The man was released from Wayland on 6 October 2008, and met by a police officer who was on secondment from the police to the Prolific and Priority Offender Scheme, and a drug worker from a Drug Intervention Programme (DIP). He was taken to his home by the police officer, after being allowed to go shopping alone in Peterborough. While shopping, he had bought a can of lager, which he continued to drink on the journey home.

Sometime in the afternoon of 6 October, it seems that he obtained an amount of crack cocaine. He was found dead by his mother at approximately 12.15am.

My report includes eight recommendations, one of which is a repeat of an earlier recommendation from the Ombudsman to the PCT and concerns how prisoners' ability to take responsibility for their medication is assessed.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Wayland on 15 October 2008, by one of the Ombudsman's investigators. He visited the prison and K Wing, where the man lived. All documents relating to him were examined, including his medical records. Notices were later issued informing staff and prisoners of the investigation and inviting anyone with information to come forward. There were no responses to these notices.
2. During the initial visit, the investigator met a number of staff including managers, local branch representatives of the Prison Officers' Association (POA), and the Independent Monitoring Board (IMB). He subsequently visited Wayland on 22 December to speak to the Governor and staff. Four staff were interviewed. These included two officers, the clinical lead and a Counselling Assessment Referral Advice Throughcare (CARATS) worker.
3. The investigator also interviewed several members of the Prolific and Priority Offender Scheme. These included the police officer and the drug worker, who met him on his release from Wayland.
4. Cambridgeshire Constabulary also conducted an investigation into the involvement of some of their officers. This report has been made available to the man's family.
5. A clinical review of the man's health needs and the care he received at Wayland was commissioned from the NHS (formerly the Primary Care Trust). The review was conducted by a clinical reviewer.
6. The investigator and one of the Ombudsman's Family Liaison Officers met the man's family during the investigation. This gave them the opportunity to discuss the purpose of the investigation and to raise any questions or concerns they would like explored and addressed. The family raised a number of concerns regarding his care in and after his release from prison. In particular, they raised the following issues, which I hope this investigation goes some way to address.
 - Whether his medical and prescription history had been transferred to each prison he moved to.
 - He was released from prison with a high volume of prescribed medication. The family asked whether he should have been, particularly as they believed he had been on "suicide watch" at this time. They asked why they were not been informed of the amount of medication he had in his possession.
 - His family questioned whether the decision to allow him to drink alcohol on his way home, at a time when he was accompanied by probation and police staff, was appropriate.

- When he arrived home, his mother saw that he had an injury on his finger, a cut to his wrist and scarring on his face. She wanted to know how they had occurred.
 - Why the Probation Service had not intervened (given their belief that he was not fit to be interviewed) when he attended their offices on the day of his release
 - The lack of contact with the family from the Probation Service after his death.
7. An Assistant Ombudsman and the Family Liaison Officer visited the man's family on 22 March 2010 to discuss the findings of the draft report. The family remained concerned that he did not receive medication while in the segregation unit. They were also concerned that a wound he sustained was not treated appropriately and that the incidents that led to this and other injuries were not adequately recorded. I have examined the prescription charts for the period he was in the segregation unit and I am content that he was given the appropriate medication while there. Paragraph 73 of my report details the treatment he received for the wound on his wrist which was reopened following a fall during exercise. A nurse explained that the wound was treated and dressed, but it was not appropriate to re-stitch the wound because of the risk of infection and possible scarring. I can also confirm from the records I have seen, the interview transcripts and, above all, the clinical review, it is my opinion that the injuries he sustained were logged and explained appropriately.
 8. The man's family were also concerned that he was released with various types of prescribed medication, given his history of drug misuse, and that the police officer was not made aware of this. The family also questioned why he was issued with his discharge medication on 9 September, nine days prior to his release. In her interview with my investigator, Nurse A explained she would never speak to anyone, other than the patient, about medication for reasons of medical confidentiality. She also explained that she notified the GP when it transpired he had received his discharge medication over a week prior to his release although it is not clear what was done about this.
 9. The man's family remained concerned that the Probation Service failed in its duty of care towards him in ensuring his safe return home following his release from prison. The family further reiterated the distress caused by the way they feel they were treated by probation staff following his death and welcomed the recommendation made to improve practices as a result.
 10. In response to the issuing of the draft report, I have received comments from the NHS on the recommendations which relate to HMP Highpoint, at which they commission healthcare services. I also received feedback from the Director of HMP Peterborough. NOMS identified no factual inaccuracies on the report, and have not commented on the recommendations.

HMP WAYLAND

11. HMP Wayland is a category C closed training prison for adult males, situated near Thetford in Norfolk. It holds a maximum of 1,017 prisoners. The prison was built in 1985, and has been extended three times since. The prison now has 13 living units (known as wings).
12. Since the Ombudsman took responsibility for investigating all deaths in custody in 2004, there have been three previous deaths. In two of these investigations, there have been issues concerning the standard of medical records, and in one of the investigations, a recommendation was made. In the second investigation, another recommendation was made that there should be a formal process established for assessing the suitability for the prisoner to hold "in possession" medication. These issues have been raised again during the course of this investigation.
13. HM Chief Inspector of Prisons carried out an announced inspection of Wayland in June 2006. Provision of healthcare services was praised as being of "high level". A selection of medical records were seen and found to be comprehensive and appropriate. There was, however, a recommendation that the secondary dispensing of medication should cease.
14. Each prison has an Independent Monitoring Board (IMB). The role of the IMB is to ensure that prisoners are treated humanely and that there are appropriate and adequate programmes available to prepare them for their release. They also report any concerns to the Secretary of State, and produce an annual report about the establishment.
15. The most recent IMB report for Wayland, for 2007/8, is critical of the NHS for failing to meet the mental health needs of prisoners. The IMB reported that the healthcare provision did not meet their expectations, particularly in the light of an expanding prison population. They also noted that inadequate funding for the integrated drug treatment system had "condemned prisoners to a dependency on methadone".

Personal Officers

16. The role of the personal officer is to build up and maintain a positive relationship with prisoners. They are first port of call for questions, complaints or advice.

Assessment, Care in Custody and Teamwork (ACCT)

17. ACCT has been introduced at all prisons as a documented process to monitor and support prisoners assessed as at risk of suicide or self harm. Once placed on ACCT, the prisoner is observed at intervals determined by their perceived level of risk.
18. Each prisoner is assessed within 24 hours and then reviewed further at intervals decided on an individual basis. The ACCT guidance says that, to be

effective, the review should involve the people who know the person at risk or are involved in their care.

Counselling Assessment Referral Advice Throughcare (CARATS)

19. Prisoners with a history of drug or alcohol abuse can be referred to CARATS workers. Following a full assessment, the worker has a range of options to help meet the individual's needs. These include arranging for drug treatment, and counselling work to take place to help them reduce their drug intake or prevent them starting to take drugs in the future. The 2006 HMCIP inspection report described the CARATS team as being well integrated, with input into sentence and release plans.

End of Custody Licence (ECL)

20. In June 2007, the Secretary of State for Justice introduced a new early release scheme, to ease the population pressures on prisons. Prisoners eligible for ECL are released up to 18 days earlier than they would normally have been released. Prisoners released on ECL are required to observe the same licence conditions as would have been applied had they been released normally. (Prisoners released early on licence have to comply with the conditions or they will be returned to prison to complete their sentence)

Distribution of medication

21. Medication is issued to prisoners in two ways. "In possession" medication is held by the prisoner in their cell, and they are encouraged to take responsibility for it. "In sight" medication is distributed on a dose by dose basis and must be consumed immediately in the presence of healthcare staff.

Prison Addressing Substance Related Offending (PASRO)

22. This is an accredited cognitive behavioural group work programme designed to address drug and alcohol dependence and related offending.

Prolific and Priority Offender Scheme (PPO)

23. This is a Government-led initiative which was launched in September 2004 to target the most prolific and persistent offenders in local communities. The scheme is managed by multi-agency partnerships, including the police and probation services. The PPO scheme has three strands – to prevent and deter potential offenders from committing crime, to tackle the offending behaviour of those individuals locally identified as committing most crime and causing most harm to their communities, and to help rehabilitate and resettle offenders.

KEY FINDINGS

The man's arrival at HMP Peterborough

24. On 16 July 2007, the man was received on remand at HMP Peterborough, charged with burglary. He went through the normal reception procedure where it was noted that he had been using heroin, benzodiazepines (tranquilisers) and crack cocaine, and was drinking 12-13 cans of lager daily. A urine test confirmed this. No medication was prescribed for his withdrawal from opiates or alcohol and no clinical observations were recorded. There is no record that he reported any history of harming himself or of having any mental health issues. He completed a local Peterborough form, 'Contacting Your GP', and registered himself as being of no fixed abode.
25. The next day, the man told the prison doctor (who is not named in the clinical records), that he was taking clonazepam (a drug used to treat seizures), and admitted to being dependent on alcohol. Again, no treatment for the withdrawal of alcohol was documented and there was no record of why he was taking clonazepam.
26. The man claimed to have had a seizure on the evening of 21 July, although this was not reported to healthcare staff. Later that night, he was seen by a Nursing Sister as he was suffering from a headache. He informed her of the seizure and that he should be taking 2mg of clonazepam per day, and not 1mg (as he had done since arriving at Peterborough). She told him that she would ensure that the day staff were aware of his concerns.
27. The man's father had died on 5 July, and he was not allowed to attend his funeral. He was distressed about this, and saw a doctor on 23 July. He was prescribed 30mg of mirtazapine (used to treat major depressive disorders) and 7.5mg of zopiclone (used for short term treatment of insomnia) daily.
28. On 25 July, the man complained of earache and was prescribed an antibiotic, azithromycin (this was later changed to amoxicillin).
29. A night nurse reported that the man had a seizure on 2 August. It is not clear if the nurse took any action, aside from telling the day staff. The following morning (3 August), Nurse B saw him in his cell. He was awake but feeling weak. She advised him to see the doctor, which he did later that afternoon. Although 6mg of clonazepam was prescribed to be taken daily, the doctor noted that "it is still to be confirmed of the reality of fits".
30. The man cut his left forearm with a razor blade on 22 August. An ACCT document was opened as he was still feeling upset about his father's death. The ACCT was closed on 29 August as he felt better and had no more thoughts of harming himself.
31. On 12 September, a prison doctor made an entry in the man's medical record that he had been discovered hiding the clonazepam and amitriptyllin in his cell.

It had still not been confirmed that he was suffering from fits and so it was decided to stop prescribing clonazepam from the end of that week.

The man's transfer to HMP Highpoint

32. The man was transferred to Highpoint on 13 September. The reception screening noted that he had epilepsy (treated with clonazepam) and depression (treated with mirtazapine). From the Prescription and Administration Record Card, it would appear that he continued to receive medication. It was also noted that he had made attempts to harm himself at HMP Bedford in 2003 and HMP Peterborough in 2007. He did not report having any current thoughts of harming himself.
33. The man's ongoing ear problems were also noted. However, he did not attend any appointments until 5 December. A week later, he was prescribed antibiotic ear drops.
34. On 10 December, a prison drug dog (trained to detect the presence of drugs) indicated that a parcel sent to the man might contain drugs. The parcel was searched and found to contain herbal cannabis. There is no suggestion on his adjudication record that any action was taken following the incident.
35. Five days later, during an altercation with another prisoner, the man injured the little finger on his right hand. However, he told staff that the injury was caused when his finger was "trapped in a door". In contrast, an entry in the Continuous Clinical Record says that he injured his finger after a seizure. It is not clear whether there is any connection between the incidents, and there is no entry on his medical records that he had had a seizure.
36. On the morning of 21 December, the man suffered another suspected epileptic fit, which was reported to healthcare staff by other prisoners. It was noted in the Continuous Medical Record that he was already receiving clonazepam for the condition. No further action was taken.
37. At approximately 11.05am that day (and after the seizure), the man and another prisoner climbed on to the roof of one of the prison buildings and demanded an immediate transfer. They climbed down at about 5.20pm. As a result of their behaviour they were taken to the segregation unit.
38. The following day, the man commenced a "dirty protest" at 6.00pm, after demanding to have hot water every two hours. The protest ended at 7.00am the following morning (23 December). It was noted on the Prison Incident Report that he may have been under the influence of drugs as his speech was slurred. He was seen by healthcare staff on 22 and 23 December who did not report any concerns.
39. On 24 December, and while still in the segregation unit, the man harmed himself by making five superficial cuts to his left wrist, which did not require stitches. As a result, an ACCT form was opened. The ACCT form was reviewed three days later, when he said he was in debt and wanted to be

transferred to another jail. It was also noted that the injury to his finger was getting worse.

40. The man threatened to kill himself four days later, after his request for tobacco was refused. He said that he was concerned about his mother who, he said, had cancer. An ACCT review later that day concluded that his behaviour was manipulative. He threatened to hang himself “before 6.00am” and said that he had attempted to hang himself before. He also threatened to stop taking his medication. He told the healthcare staff that in the past year, both his father and 13 year old brother had died.
41. A further episode of self harm occurred on 29 December at 3.50pm when he cut his left forearm. Initially, the man did not cooperate with the healthcare staff who wanted to treat him saying that “he was going to a better place in the near future” and had twice attempted suicide. He finally allowed healthcare staff to attend to his injury at 5.35pm.
42. A little later (the time was not recorded), the man again threatened to kill himself and the ACCT observations were increased to five times per hour. He harmed himself again by cutting his right cheek after asking for the evening meal, which he had earlier refused. These injuries were sufficiently severe for him to be taken to hospital where they could be stitched.
43. As a consequence of the roof climb and his request for a transfer, the man moved to Wayland on 31 December. An entry on his Continuous Clinical Record said “Fit for transfer, has issues with his medication, states not strong enough”. Staff at Highpoint telephoned their counterparts at Wayland and updated them on his medical history.

The man’s transfer to Wayland

44. The man arrived at Wayland and went through the normal prison reception process. During the reception interview with the nurse, he asked for co-codamol (a pain killer) and said he was allergic to paracetamol. The reason for the request was not recorded and it does not appear that he was given either medication. It was noted that he suffered from epilepsy and had a fractured right little finger. His current prescriptions of 2mg clonazepam and 30mg of mirtazepine daily were noted. The ACCT document remained open.
45. The man’s ACCT document was closed on 3 January 2008. He was considered to be “now settled at Wayland”.
46. On 24 January, the man was assessed by a CARATS worker. He told her that (and in contrast to his reception interview at Peterborough) he never drank alcohol because of his epilepsy, was employed as a delivery driver and had been drug free for two and a half to three years. She also recorded on the Comprehensive Substance Misuse Statement that he last used drugs almost three years earlier when he smoked heroin, was now substance free and that he “had never deliberately hurt himself”. He also said that he had a lot of contact with his children.

47. The CARATS worker noted in her assessment that the man was currently suffering from epilepsy and taking clonazepam. At interview with my investigator, she said however that she was unaware that he was taking prescribed medication. She said that, generally speaking, there would be a heightened risk of overdose if he mixed alcohol and/or prescribed medication with an illegal drug. A careplan was subsequently drawn up for him to address the links between his substance use and offending.
48. Over the next few months, the man came into contact with medical staff on several occasions. On 4 February, his ongoing problem with an ear infection was noted. His injured finger was reviewed on 17 March, and he was prescribed 500mg of naproxen (an anti inflammatory drug). On 23 April, a discussion took place with him concerning the possibility of amputating the tip of his right little finger.
49. On 26 April, the man was taken to outside hospital after telling prison staff that he had taken 50 paracetamol tablets. He refused to wait for the Accident and Emergency clinician and was returned to Wayland without treatment. There is no record of how he, who had said that he was allergic to paracetamol, obtained these tablets. An ACCT document was opened on 27 April but was closed the same day, after he admitted lying about the incident in order to obtain other medication. An ACCT post closure review took place on 4 May with no further issues or concerns noted.
50. Despite being taken to outside hospital and the incident being reported to healthcare, there is no evidence that a Security Information Report (SIR) was raised or his medication reviewed. The man refused to be examined or screened by healthcare staff on his return to prison.
51. Surgery on the man's finger was carried out without any complications on 2 May. The dressing was reviewed the following day, and there was no sign of infection and he could move it easily. Another appointment was made for 15 May for sutures to be removed, but he did not attend.
52. The man did go to a healthcare appointment on 17 May. He had removed the stitches from his finger by himself. The wound did not require a dressing and he was asked to report any deterioration to staff.
53. On 3 July, the man went to an appointment with an Ear, Nose and Throat (ENT) consultant for treatment of his ear infection. Cotton wool was removed from one ear and microsuction was performed on the other and ointment applied. Another appointment was to be arranged for a review.
54. The man started the PASRO course five days later, as arranged by the CARATS worker. This course attempts to address the links between substance use and offending, and he was also keen to obtain support whilst in custody and after release to help him stop using drugs.

55. The man reported having a *grand mal* seizure at 10.30pm on 14 July, which he said was the second in six months. (*Grand mal* seizures feature loss of consciousness and violent muscle contractions and, while they can be caused by low blood sugars or a stroke, most are caused by epilepsy.) It was not witnessed by anyone else. He reported to healthcare feeling well, except for a small cut to the bridge of his nose. Although he was told to make an application to see the doctor, there is no record that he did.
56. On 17 July, the man again reported having a seizure. He was seen by a prison doctor, who noted that he had been seen in the past by a neurologist and treated with tegretol and epilim but that they had not stopped the seizures. His misuse of medication was noted and the clonazepam was increased to 2mg three times per day. The doctor suggested that he should see his community doctor on release from prison, which was expected on 18 September.
57. Nurse A noted in the Patient Record on 26 July, that the man appeared to be drowsy with slurred speech when he went to collect his medication that afternoon. The information was passed to the Security Department using an SIR. The Security Manager recommended that staff on his unit monitor and search him. The Security Governor also recommended that a Mandatory Drug Test should be carried out but there is nothing on his records to suggest that any of these actions were carried out.
58. Also on 26 July, the man visited healthcare suffering from further pain in his left ear. He was found to be suffering from a chronic inflammation with a creamy discharge and was given co-codamol to relieve the pain.
59. On 29 July, Nurse A informed Security that the man had not swallowed his medication and was being bullied to bring it back to the wing for other prisoners. Another SIR was raised and brought to the attention of wing staff but again, no action appears to have been taken.
60. The man was visited on 12 August by two Offender Managers with the Probation Service. The purpose of their visit was to prepare him for his release from prison. As he was registered as a priority and prolific offender, it was necessary to ensure that a coordinated approach to his release was taken by all agencies. He was notified subsequently in a letter dated 15 August, that he would be released under ECL terms on 18 September.
61. On 28 August, the man received his PASRO report. He had missed four of the 20 sessions, one due to illness and three whilst in the Segregation Unit. The report was otherwise positive. He took an active role in group discussions, his assignments were completed to a high standard and he appeared to work well in a group environment.
62. The next day, as part of his ongoing contact with the CARATs worker, the man completed his release plan and discussed overdose and tolerance issues with her. He signed the 'Overdose & Tolerance Information Form' to confirm this. The CARATs worker later confirmed to my investigator that he had been given

verbal information that tolerance to drugs diminishes the longer the period when they are not used.

63. Following SIRs that the man “was selling his sleepers [sleeping pills]” to another prisoner, the Security Department recommended that his medication was reviewed and that wing staff should be notified how many tablets he had, so that they could check him regularly. There is no record of whether this was carried out.
64. The man was issued with his discharge medication, clonazepam, on 9 September. However, at 4.30pm, he asked for a repeat prescription as he said he had lost the original allocation. His request was refused. There is no record to explain why the medication was given on 9 September, nine days before his expected release date. There is also no record of whether he was given any other medication, or whether Security had been informed or a cell search carried out.
65. Eight days later, on 17 September, the man was notified that he had been refused ECL. This was because he had escaped from lawful custody in 2004 and run away from police officers while handcuffed. The incident automatically precluded him from ECL, and had only been identified on the statutory check made two days before release.
66. In response to being refused early release, the man harmed himself at about 8.10pm by cutting his left wrist. Paramedics were called, arriving at 9.00pm, and he was taken to hospital. He returned to Wayland at 1.00am and an ACCT form was immediately opened.
67. A prison doctor reviewed the man’s medication on 19 September. He recommended that the co-codamol (which was not working) be changed to dihydrocodeine. Paracetamol was also issued, despite him previously saying that he was allergic to it. He was also prescribed enough mirtazapine to last until his new release date of 6 October.
68. On 21 September, the man was seen again by nursing staff trying to secrete his clonazepam as it was being administered. There is no record, either within the ACCT or his security documentation, that the information was communicated to other departments. The ACCT form was closed the next day after he said that he was looking forward to going home and caring for his mother. The closure meeting was attended by three staff, including healthcare, and the man. An ACCT post closure review took place on 29 September and no issues were raised.
69. Healthcare staff reported that, on 25 September, the man had passed the clonazepam to another prisoner and, so, the doctor had stopped his prescription.
70. The next day, the man fell during the exercise period. He re-opened the wound on his left wrist, which was later dressed by a nurse. Nurse A explained to the investigator that his wound was dressed with an inadine dressing (which

contains the antibacterial agent iodine). It was not appropriate to re-stitch the wound because of the risks of infection and possible scarring. The Accident Form records that “there does not appear to have been any reason or cause for him to fall and he has not stated that he slipped or tripped over anything”. It was also noted that his medication should be reviewed because he had passed it to another prisoner, but there is no record of what action was taken or whether he saw a doctor.

71. The man reported that he had had a seizure on 28 September. Wing staff did not consider it to be ‘real’, and there were no witnesses who could describe the length and type of episode. The next day, 29 September, Nurse A recorded in the Patient Record that he was threatening to sue because his clonazepam had been stopped.

Events of 6 - 7 October

72. A Principal Officer (PO), who was the discharging officer, told the investigator that the man’s discharge through reception on the morning of 6 October took place as normal. He was identified as the correct prisoner for discharge, his discharge licence was checked and the conditions were explained. He signed the licence and was given a copy. He was given his property, his personal money and discharge grant. He signed Section 21 of the Firearms Certificate which prohibited him from possession of a firearm for five years. Staff checked whether he had any complaints or there were any outstanding issues before giving him his discharge medication in a sealed bag.
73. A doctor at Wayland was asked by the Coroner’s Officer to confirm what medication the man was prescribed before his release. In a letter, dated 29 October 2008, he confirmed that he was prescribed: mirtazapine (30 mg once a day), dihydrocodeine modified release tablets (120 mg twice a day), paracetamol tablets (500 mg one or two four times a day) and clonazepam (two mg tablets one in the morning and two in the evening). His medication was given to him by prison staff, which is not normal practice.
74. Nurse A told my investigator that the doctor had prescribed a month’s supply of medication. This is normal practice at Wayland, as there is no guarantee when a prisoner will contact his doctor. However, because of the man’s history of misuse and the nature of the medication he was prescribed, Nurse A decided to discharge him with just one week’s supply.
75. On leaving the prison, the man was met by a police officer seconded to work with the PPO scheme and a Case Manager with the Drug Intervention Programme (DIP) Team. He was taken to the DIP team office to begin his induction and take a urine test. He was unable to produce a urine sample.
76. After leaving the DIP office, the man asked the police officer to take him into town as he wanted to buy a new pair of trainers. He was taken to the town centre and allowed to shop on his own. About 15 minutes later, he returned to the police officer with some shoes and a hooded top. He was drinking from a can of lager. (His mother later told police officers that, during the visit to the

shops, her son committed a shoplifting offence and stole the hooded top.) The police officer left him at his home at approximately 12.45pm, where he was met by his mother and sister. The police officer left almost immediately. The man's mother thought that he was a probation officer.

77. The man's mother said that her son's appearance and actions suggested that he had used drugs. She described him as very pale. Both his mother and sister said he was very high spirited, excitable, giddy and slurring his words. He assured them both that he was fine, but was very tired as he had not slept for three days because of the excitement of coming home.
78. According to his mother, the man was due to go to an appointment with the Probation Service at 4.00pm later that day (6 October). He left the house, accompanied by her youngest daughter's boyfriend, and returned at about 4.50pm, which was earlier than expected. His mother said that this was because "they (probation staff) had refused to interview him in his current state". His sister had left the house and telephoned him after he had returned home. She confirmed that, from the way he was speaking, "he was not with it" and she said "he was behaving as if he had taken something".
79. The man said he wanted to get some sleep and, after eating a small portion of a sandwich, he appeared to fall asleep at about 7.30pm. His mother told my investigator that it was not until about 12.00am -12.15am that she realised that something was wrong and discovered that he had died. She told the police that it was around 1.00am that she discovered him. Information provided to the investigator indicates that an ambulance was called at 1.49am and arrived at 1.55am. The paramedics attempted cardio pulmonary resuscitation (CPR) without success. He was pronounced dead at 2.16am. The police were called at 2.26am and his mother told them that he had bought some crack cocaine and had smoked it in the kitchen.

Events after the man's death

80. The man's mother said she tried to contact the probation officer to speak with someone about what had happened. Despite telephoning and leaving messages, she said she heard nothing further from the Probation Service.
81. The Probation Integrated Case Record shows that the man's mother contacted the Probation Office asking someone to contact her to discuss her son's death. The Offender Manager told my investigator that she telephoned the man's mother and that, although it was a difficult conversation, she believed that she dealt with it sensitively. She was told by her senior managers that she should take no further action and that the death would be dealt with by more senior staff. The man's Offender Supervisor told my investigator that she telephoned his mother on 16 or 17 October.

Post mortem and toxicology examination

82. The post mortem and toxicology examination concluded that the cause of the man's death was an overdose of dihydrocodeine (an opiate based drug) and

ischaemic heart disease (a disease which reduces blood supply to the heart). Urine samples detected levamisole, diltiazem and phenacetin, which are markers of illicit cocaine use. Traces of cocaine were also found.

ISSUES RAISED IN THE INVESTIGATION

Clinical Care

83. A clinical review was commissioned from the NHS. A Prison Healthcare Commissioner undertook the review. She reviewed the medical records and interviewed one member of staff, Nurse A, the Clinical Team Leader at Wayland. She makes ten recommendations in her report which are applicable to all the prisons that cared for the man. I draw attention here to eight.
84. Throughout his period in custody, the man stated he was taking clonazepam. However, no efforts were made at Peterborough, Highpoint or Wayland to confirm that he actually suffered from epilepsy. The clinical reviewer points out that clonazepam is not only an inappropriate long term medication for the treatment of epilepsy, but its use is cautioned with patients with a history of drug or alcohol abuse or depression. The man's dosage of clonazepam was increased on 3 August 2007. However, notes made in his medical record at Peterborough indicated that healthcare staff were still not certain that he did indeed suffer with epilepsy. The clinical reviewer makes the following recommendation

Healthcare staff should evidence that they have attempted to contact doctors and other service providers to ensure continuity of clinical care between prison and the community. Contact should be made with the home doctors for a medical history if it has not already been done by previous prison.

85. During his reception screening at Peterborough, the man was noted as using heroin, benzodiazepines, crack cocaine and drinking 12 – 13 cans of lager per day. There is no evidence that he was prescribed any treatment to manage the symptoms of either opiate or alcohol withdrawal he might experience. The clinical reviewer has made the following recommendation to HMP Peterborough, which I bring to the attention of the Head of Healthcare:

The Head of Healthcare at Peterborough should undertake a review of policy and procedures for the management of substance misuse and alcohol detoxification.

86. The provision of pain relief medication appears to have been an issue throughout the man's stay in custody and, other than his ongoing ear infection and the injury to his little finger, no other source of pain was noted. Codeine-based analgesia prescriptions were repeated without a review and no attempt was made to seek advice about his pain management.

The Heads of Healthcare (at Peterborough, Highpoint and Wayland) should review their medicines management processes including the triggers for the management of inappropriate prescribing and agreement what constitutes a "medication review".

87. There are concerns about record keeping in Peterborough, Highpoint and Wayland. At Peterborough, a comprehensive clinical history was not taken when the man arrived in reception. At Highpoint, an unsigned entry in the Continuous Clinical Record suggested that he had returned from hospital although there was no reason recorded as to why he had gone. At Wayland, on 25 September, it was noted that his medication needed to be reviewed but there is no record of what action was taken. On 3 October, a doctor restarted his clonazepam, although no reason is recorded.

The Heads of Healthcare (at Peterborough, Highpoint and Wayland) and Primary Care Trust providers should ensure there are systems in place to undertake regular audits of clinical records to ensure that minimum standards are met.

88. The clinical reviewer has commented that when the man was transferred from Highpoint to Wayland, Highpoint staff provided Wayland staff with a verbal handover of his medical history. This should be commended as good practice.

The Governor of Highpoint should commend its healthcare staff for providing verbal assessments on the healthcare needs on transfer of prisoners to other establishments.

89. There was some evidence to suggest that the man was trading and misusing his own medication. He had allegedly taken 50 paracetamol tablets, for which he was taken to outside hospital. There is, however, no evidence to suggest the "in possession" risk assessment was ever reviewed. He claimed to be allergic to paracetamol, but was, on several occasions, prescribed this medication in combination with other medication. There is no evidence to suggest that any allergies to paracetamol were investigated by healthcare staff.

The Heads of Healthcare (at Peterborough, Highpoint and Wayland) should review "in possession" risk assessments whenever there is evidence to suggest misuse.

90. In addition, on discharge, the man was given his medication at reception by a prison officer. Officers do not have health care qualifications and so it is reasonable to assume that they are unable to offer any advice to the prisoner about the medication. (This is termed as secondary dispensing of medication.)

The Head of Healthcare in Wayland should undertake an urgent review of prescribing practices and secondary dispensing of this nature should cease immediately.

Treatment of physical injuries

91. The man's mother asked why his face was scarred, and the tip of his finger missing. The scar to his face is likely to have been as a result of the alleged fit he suffered on 14 July. The tip of his finger was amputated in hospital after he said it had been trapped in a door during a fight with another prisoner.

According to medical records, his finger healed well with no complications. There are no entries on his medical record to indicate that he received any injuries as a result of the fighting incidents that he was involved in.

Preparation for release

92. The CARATs worker told my investigator that the man was frequently warned about the danger of using drugs in the community. He was told that any period of abstinence would have substantially reduced his tolerance to illegal drugs. He was advised that, to avoid the risk of overdose, he should not return to the same level of drugs he had used before coming into custody. She also said that prisoners were warned that drugs available in the community were likely to be of a higher strength than those available in prison.
93. I am satisfied that the man knew the risks he would be taking should he return to drug use on release.
94. The man's mother was concerned that she did not know that he was being released with a quantity of prescribed medication. At interview with my investigator, the DIP Senior Practitioner said that the DIP team work is under strict rules of confidentiality and do not contact the family as it would present as a conflict of interest.
95. The DIP worker who met the man on his release said that she was aware that he had medication in his possession as he showed it to her. He explained that he had medication for epilepsy and opiate based pain killers (which is why he was asked to provide a urine sample on his arrival at the DIP office in Peterborough).
96. The man's mother thought that the prison should have done more to consider his individual circumstances before prescribing a week's supply of medication, particularly as he was coming home and would return to the care of the family doctor. She believed that he was still on "suicide watch" at the time of his release, which should have meant that he was given less medication.
97. Nurse A explained that, as there had been suspicions that the man was abusing his medication, he had been discharged with one weeks, rather than a four week, supply. She told my investigator that the approach taken by the prison is the same as in the community. Patients are deemed to be responsible for any medication prescribed by their community doctor.
98. Nurse A also said that it was not normal practice for prison or healthcare staff to contact a prisoner's family about the medication they were being discharged with. Again, she explained that without the man's consent, it would have been a breach of medical confidentiality.

Transfer of medical records between prisons

99. The man's mother was concerned whether each prison had the correct information about his health. Nurse A told the investigator that records transfer from prison to prison. Systemone (a NHS computer system used by PCTs) allows for electronic transfer of records. However, not all establishments are connected to it. If they have their own computer system, they print out their records and transfer them with the prisoner. Records are transferred from prison to prison electronically or by hard copy. From the evidence available, staff at each of the receiving prisons had access to the man's previous medical records.

The decision to allow the man alcohol

100. My investigator raised this issue with senior police officers and it has been subject to a police investigation. The police investigation considered that the man asked the police officer to take him shopping to buy a pair of trainers but when he returned to the car he was drinking a can of lager. The police officer was not aware that the man intended buying alcohol and, as there is a drinking ban in force in the city centre, he had to decide whether to enforce the ban or remove him from the city centre and allow him to keep the alcohol. As he was not in custody, the police officer elected to remove him from the centre of town and allow him to keep the alcohol.

The man's contact with the Probation Service

101. The man was required to attend an appointment with the Probation Service at 4.00pm on the day of his release. However, he was turned away because of his behaviour and the appointment rescheduled for the following day. She asked why, given his appearance, probation staff did not do anything to intervene at this point.
102. One of the offender managers was supposed to see the man at 4.00pm. She told the investigator that it was actually a receptionist at the office who had telephoned her whilst she was travelling back from a meeting. Office staff were concerned about his condition. They described him as being "in a state" and using the toilet, in a communal area, with the door open. She explained that the reception staff are not trained to deal with these situations. She thought that they wanted reassurance that she was on her way back to the office for the appointment and that they were doing the right thing.
103. The offender manager believed that the man was under the influence of either drink or drugs. She thought that he was not in a fit state to complete the induction process. He blamed his condition on his epilepsy medication but she could not remember whether he said he had taken it or not. He said he had not taken anything illegal. He was acting differently to how he had when she had seen him in prison, but she did not think that he was a risk to himself. She said that there was nothing in his behaviour that gave her particular cause for concern. Another appointment was made and he left the office.

Probation contact with the man's mother

104. There seems to be confusion about the contact the Probation Service had with the man's mother after his death. While she maintains that she had no contact, despite leaving telephone messages, it seems that two members of the Probation Service did call her, one on the morning of his death, and the second some ten days later.
105. All three probation staff mentioned that client confidentiality was vital and, in normal circumstances, they are not allowed to provide information to family members. Additionally, they were not allowed to discuss the man whilst an investigation into his death was ongoing, and were aware that the Coroner had requested a report from probation staff.
106. The probation staff interviewed told the investigator that they had received no guidance from senior managers either about how they should deal with the man's death or how his family would be contacted or supported. Although circumstances such as these are uncommon, there should be procedures in place to ensure that families are contacted as appropriate and are offered support. Given that this is a difficult time for staff, I also expect them to be supported during any such events, including the death of an offender. It seems clear that guidance needs to be in place to allocate specific responsibilities (including to senior officers) to ensure that they are handled effectively and at the appropriate level.

There should be a policy in place for the support and guidance of probation staff in Peterborough in the event of any untoward incident. This policy should ensure that any family members involved are also given appropriate support and guidance.

CONCLUSION

107. The man misused several substances, including heroin and alcohol, and admitted this when arriving at Peterborough in 2008. He also said that he had epilepsy, and was given medication. During his time in prison, he claimed that he had several seizures and also had other medical problems. He threatened to harm himself.
108. This investigation has identified procedures that can be improved. In particular, prisons should ensure that they provide continuity of medical care by speaking to a prisoner's doctor when necessary. They also need to ensure that medical records are properly kept. It is surprising that it was never established whether he had epilepsy, but that medication for the condition continued to be prescribed. There are obvious risks involved to prisoners of such practice.
109. However, once someone is released from custody, they are responsible for their own care. He was properly warned about the possible consequences of taking illegal substances, but it seems he chose to ignore these warnings.

RECOMMENDATIONS

1. Healthcare staff need to be able to evidence that they have attempted to contact GPs and other service providers to ensure continuity of clinical care between prison and the community. Contact should be made with home GPs for a medical history if it has not been done by previous prison with an accompanying audit trail.

The NHS responded: "When medical records of serving prisoners at HMP Highpoint are requested from community GPs, there is always an audit trail to support this within the patient's clinical records, this includes written documentation and copies of written correspondence and the patient's consent. We also liaise with other relevant providers for example Community Mental Health and Drug Intervention Programme Teams and use the same process"

2. The Head of Healthcare at Peterborough should undertake a review of policy and procedure for the management of substance misuse and alcohol detoxification.

The Director of HMP Peterborough responded: "We have reviewed our protocols for the management of substance misuse and alcohol detoxification as part of the implementation of IDTS [Integrated Drug Treatment System] in September [2009]."

3. The Heads of Healthcare (at Peterborough, Highpoint and Wayland) should review their medicines management processes including the triggers for the management of inappropriate prescribing and agreement of what constitutes a "medication review"

The NHS responded: "At HMP Highpoint there is a robust Medicines Management process in place and a prescribing formulary, there is also a process to follow when GP's need to prescribe off formulary. When a medication review is undertaken the consultation is fully documented in clinical records using System 1."

The Director of HMP Peterborough responded: "We no longer prescribe codeine based medication."

4. The Heads of Healthcare (at Peterborough, Highpoint and Wayland) and Primary Care Trust providers should ensure there are systems in place to undertake regular audits of clinical records to ensure that minimum standards are met.

The NHS responded: "The Community Healthcare has an annual audit plan in place for the auditing of clinical records and the Community Healthcare Team based at HMP Highpoint participates in this."

The Director of HMP Peterborough responded: "We have ... already put in place procedures for ... regular audits of clinical records."

5. The Governor of Highpoint should commend its healthcare staff for providing verbal assessments on the healthcare needs on transfer of prisoners to other establishments.

The NHS responded: "The Governor of HMP Highpoint did commend the Healthcare Manager for the actions of her team when dealing with the transfer of Mr M to HMP Wayland, this was relayed to the Healthcare Team."

6. The Heads of Healthcare (at Peterborough, Highpoint and Wayland) should review "in possession" risk assessments whenever there is evidence to suggest misuse.

The NHS responded: "At HMP Highpoint there is a robust policy and procedure in place for the management of in-possession medication, this includes the management of reviews and makes direct reference to when these will take place; this includes any change in circumstances and misuse of medication."

The Director of HMP Peterborough responded: "We have ... already put in place procedures for reviewing in-possession risk assessments."

7. The Head of Healthcare in Wayland should undertake an urgent review of prescribing practices and secondary dispensing of this nature should cease immediately.
8. There should be a policy in place for the support and guidance of probation staff in Peterborough in the event of any untoward incident. This policy should ensure that any family members involved are also given appropriate support and guidance.