Investigation into the circumstances surrounding the death of a man at HMP Whitemoor In December 2007

Report by the Prisons and Probation Ombudsman for England and Wales

May 2010

This is the report of an investigation into the death of a man in his cell at HMP Whitemoor in December 2007. He was on the Fens Unit at HMP Whitemoor, one of just four dangerous and severe personality disorder units (DSPDs) in the country. He died as the result of an overdose of heroin probably taken during the afternoon before his death whilst celebrating the forthcoming birthday of a fellow prisoner. That prisoner also took an overdose, but he survived. The man was 42 years old.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their loss.

This investigation was conducted by one of my investigators. I would like to thank the Governor of Whitemoor and his staff for their help and co-operation during the investigation. I also wish to thank a prisoner who agreed to be interviewed.

A clinical review of the care and treatment received by the man whilst he was at Whitemoor was conducted by a panel convened by the Cambridgeshire and Peterborough Foundation Trust I am grateful to the clinical reviewer and his team for their work. I must apologise for the delay in issuing this report, but it was necessary to await the final version of the clinical review which I received in November 2008.

Self-evidently, the apparently ready availability of substantial amounts of heroin on a DSPD unit in a high security prison is of great concern. I also judge that, had staff responded more appropriately to how the man presented, it is likely he would have survived. I have made five recommendations as the result of this investigation and endorse the eight recommendations in the clinical review.

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 **May 2010**

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SUMMARY

The man was convicted of rape and robbery, and in 1997 was sentenced to life imprisonment with a 15 year tariff. He was transferred to HMP Whitemoor in December 2006.

He was a resident on the Dangerous and Severe Personality Disorder (DSPD) unit at Whitemoor, one of two DSPDs within the Prison Service. It is a unit with specialised staff running a regime of group and individual support, with courses to help prisoners with their conditions and to challenge their behaviour.

After completing a 15 week assessment, the man commenced treatment on the unit. His lead clinicians were a consultant clinical psychologist and a consultant forensic psychiatrist. The psychiatrist diagnosed him as having bipolar affective disorder, causing him to have severe mood swings, and endeavoured to stabilise his moods with prescribed drugs.

The man had used various illegal drugs since the age of 18, including cannabis, cocaine, ecstasy and possibly heroin. However, during his sessions on the DSPD unit he made it clear that he was against the use of non-prescribed drugs.

Generally, during his time on the DSPD unit, it was thought by the staff and his clinicians that the man was responding well to treatment and taking part in the activities and group sessions.

He had a history of self-harm dating back to his time at HMP Brixton in 1996, with a total of seven suicide attempts being recorded. The majority of the time he would self-harm by cutting himself; whilst at Broadmoor Hospital in 1997 he cut off part of the little finger on his left hand.

In February 2007, an ACCT document was opened after the man was found inside a chest freezer in the wing kitchen. (ACCT stands for Assessment, Care in Custody and Teamwork. This is the Prison Service system to support and monitor prisoners at risk of suicide or self-harm.) He did not harm himself again and the ACCT was closed two months later.

On 22 October 2007, a second ACCT document was opened when the man was found trying to drive a screw into his forehead by banging his head against the wall. His medication was adjusted and the ACCT was closed on 5 November.

When the man’s cell was opened on 7 November 2007, staff saw that he had injuries to his hands. He said that he had been punching the cell wall up to 100 times during the night. A third ACCT was opened. Initially, he refused to co-operate with the ACCT procedure, refusing to attend the case reviews and saying that he did not feel he needed to be on it.

The man was friendly with another prisoner. The prisoner’s birthday was approaching, and on Saturday 9 December they and another prisoner cooked and ate a lunchtime meal to celebrate. Afterwards, the prisoner and the man took some heroin that they had obtained from another prisoner.

A short while later staff saw that the prisoner appeared to be intoxicated. He became worse so medical staff and an ambulance was called. Staff saw that the man was acting as if he too was intoxicated, but he did not seem as badly affected as the prisoner. Twenty-three paper wraps of heroin were found in one of the prisoner's socks just before he was taken to hospital.

The man was taken back into his nearby cell for a search. Nothing was found on him and his manner became loud and very aggressive when told his cell was to be searched. The officers withdrew and the cell was not searched. The ACCT observations were increased to four times an hour and he was left to sleep in his cell.

Just after 6.00am the next day an officer checked on the man who had been snoring loudly all night. He saw that some black/brown fluid was leaking from his mouth. The officer called healthcare staff for advice and was told to encourage him to sit up. The officer shouted through the cell door and the man got up but then collapsed to the floor. The nurse and other staff were called as well as an ambulance with paramedics, but their attempts at resuscitation were unsuccessful. He was pronounced dead at 6.50am.

THE INVESTIGATION PROCESS

1. The investigation was opened by one of my senior investigators on 12 December 2007. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. My investigator formally interviewed a number of members of staff and a prisoner regarding the man's death. The transcripts of those interviews were annexed to the draft report.

3. One of my family liaison officers contacted the man's mother as his next of kin. The family liaison officer explained the purpose of the investigation and provided the man's family with the opportunity to raise any issues or questions they wanted explored or addressed. His mother asked to be sent a copy of the draft report when it was complete. Having received and read the draft report, the man's mother did not wish to make any specific comments about the Ombudsman's findings. She did however comment that the recommendations reflected her own concerns about the care her son received.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The inquest into the man's death took place in October 2009 when the Coroner issued HMP Whitemoor with a rule 43 report letter. This set out matters of concern to the Coroner and asked that the Governor of Whitemoor respond to those concerns. The Governor of Whitemoor responded to the Coroner on 2 December 2009 and a copy of that response is attached as a new appendix (labelled as F1) to this report. The outcome of the inquest was that the man died as a result of non-dependent abuse of drugs.

5. Cambridgeshire and Peterborough Foundation Trust (previously called Cambridgeshire and Peterborough Mental Health Trust) was asked to prepare a clinical review of the care that the man received whilst at Whitemoor. A clinical reviewer was appointed to chair a clinical review panel. The review was also attached as an annex to the draft report.

HMP WHITEMOOR

6. Whitemoor is a maximum security prison for men in security categories A and B, and is one of eight prisons within the Prison Service's high security estate. The prison includes a pilot assessment spur which examines the links between a prisoner's dangerousness and severe personality disorder. The unit has developed in partnership with the Department of Health and Ministry of Justice's Mental Health Unit. In February 2002, this was complemented by the opening of another spur which has a pilot regime for the management and treatment of dangerous and severe personality disorder.

7. There are currently four DSPD units, two in high security prisons (Whitemoor and Frankland) and two in special hospitals (Broadmoor and Rampton). Together, these units provide over 300 places. They are in high demand, with over 600 referrals received in an 18 month period.

8. The DSPD is situated on D wing at Whitemoor. The staff-prisoner ratio is higher within the DSPD than the other wings, and is supplemented by a wide ranging multi-disciplinary team. Prisoners have their own cells and the facility to cook their own meals in kitchens on their respective landings. Additional background on DSPD units is given in an annex to the draft report.

9. Within the DSPD unit, the role of psychiatry fits within an overarching psychological model of treatment (in contrast to the predominantly medical model of most mental health service provision). I understand that the main focus of the treatment model is facilitating change in the personality disorder (and the associated risk), but management of mental and physical health problems is also important. One of the psychiatrists' specific contributions to treatment is prescribing and managing psychotropic medication.

10. The nursing team also play an important role on the unit, especially with distressed prisoners. Not surprisingly, many prisoners experience episodes of crisis throughout the phases of their treatment. The nurses' role is interwoven into the model of treatment. Through interpersonal, psychological and behavioural nursing techniques, it is hoped to reduce a prisoner's physical and psychological distress.

11. The model of treatment on the DSPD unit builds substantially upon the traditional role of prison officers. It has been recognised that discipline staff working on the unit have had to adapt to a style of working that focuses on the treatment, alongside the management, of individuals.

12. All the officers receive some mandatory training, including a three day course on personality disorder awareness, but those officers who work with prisoners in group sessions are trained in skills to equip them to co-facilitate cognitive interpersonal groups. This training is delivered on an ongoing weekly basis. Discipline staff tend to work exclusively on one part of the overall DSPD unit.

13. Aside from their individual therapy and group work, prisoners in the DSPD unit have access to education, gym, employment opportunities and training

workshops. Some prisoners work outside the unit as there are few employment opportunities within it.

14. Her Majesty's Chief Inspector of Prisons writes in her April 2008 report of the full unannounced follow-up inspection of HMP Whitemoor:

    "The Fens unit was one of two prison sites providing assessment and treatment of dangerous and severe personality disorder (DSPD) alongside two special secure hospitals offering parallel treatment. DSPD prisoners were allocated to either the Westgate unit in HMP Frankland, which worked in tandem with Rampton in the north, or the Fens unit in Whitemoor, which worked alongside Broadmoor in the south. The treatment was experimental, although grounded in the empirical literature concerning what works clinically with this group of offenders. Although each of the prisons and special secure sites operated a different treatment model, all strove to use a common set of assessment tools in order to measure the impact of treatment, which was subject to a national evaluation…

    "The DSPD programme on the Fens unit provided good staff training and support, with a comprehensive daily briefing and well established multidisciplinary work. A reflective learning environment had led to some understanding about the risk of self harm in the context of DSPD treatment, but this had not yet been incorporated into the safer custody strategy. There was a crisis intervention suite to help DSPD prisoners. Relationships were generally good but the dynamics on the assessment spur were not wholly therapeutic.

    "In common with the Westgate unit at HMP Frankland, levels of self-harm among Fens unit prisoners were high compared with mainstream high security prisoners, and three were on open Assessment, Care in Custody and Teamwork (ACCT) documents at the time of the inspection. There had also been three self-inflicted deaths of prisoners in the unit in the previous 18 months, underlining the potentially destabilising effect of DSPD treatment. In our survey, 41% of Fens unit prisoners said that they currently felt unsafe, compared with 33% of mainstream prisoners in Whitemoor. This elevated proportion was duplicated in the Westgate unit, where 40% said that they felt unsafe at the time of the survey."

    She recommended that, "The cluster of recent deaths should be examined to establish any learning, particularly in relation to procedures on the Fens unit, and the safer custody strategy adapted accordingly." (I understand the prison has taken all of the recommendations from my reports, alongside inquest verdicts, and incorporated them into its death in custody rolling action plan.)

15. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor the day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The IMB produces an annual report on their prison. In the latest report for Whitemoor, 2007-2008, the chairperson wrote about the DSPD unit:

"On average this Unit holds sixty to sixty-five prisoners deemed to have Dangerous and Severe Personality Disorders (DSPD). It is one of the four High Secure Units for men, two of which are based in the Prison Service and two in the National Health Service. They are 'piloting' this programme for offenders with severe behavioural problems. All participants who undergo the treatment are volunteers. Upon arrival, either from the wings in the prison or from other establishments, the prisoners undergo several weeks of assessment to ascertain if they are suitable to participate in the intervention programme. The programme itself is lengthy and may take several years to complete. The Unit itself is extremely well resourced, by both the Health and the Prison Services. It also has the benefit of the services of some very highly trained personnel and a staff/prisoner ratio that is the envy of the other wings. In fact there appears to be some resentment towards the wing from other parts of the prison for this very reason. Worryingly there is no funding, at present, for a 'step down' programme in order to offer support to those prisoners who complete the course. This appears something of an anomaly if the agencies involved are truly committed to its success and to resolving the problems of this group of prisoners.

"It will be many years before the effectiveness of the Unit is able to be assessed. Its success or otherwise will only truly be known when some of the offenders are released into the wider community at the end of their sentence.

"Fifty-three prisoners are presently logged onto the referral database, forty-five with Life sentences and eight with determinate sentences. There are twelve Lifer cases requiring a full review; twenty-seven prisoners who have been accepted for assessment are Life sentenced prisoners, ten of which are non-compliant. Five prisoners accepted for assessment are determinate sentenced prisoners and all are compliant. It is imperative that prisoners accept the treatment offered in its entirety, otherwise it becomes a pointless and costly exercise.

"The prisoners in the Unit often complain about lack of activity. However, the course itself can be very demanding and intense and requires a great deal of 'soul searching' by the participants. The truths that the prisoners learn about themselves can make them very vulnerable and in need of intensive support. ACCTs are more prevalent on this wing than other areas of the prison."

16. Since I was given the responsibility for investigating all deaths in prison custody in April 2004, there have been seven deaths at Whitemoor prior to that of the man. Four were apparently self-inflicted and three were from natural causes. Two of the self-inflicted deaths were of DSPD prisoners, although the issues raised in my investigation reports were not similar to those in this case.

KEY FINDINGS

17. The man committed offences of rape and robbery in March 1996. He was sentenced to life imprisonment with a 15 year tariff in May 1997.

18. The man entered the prison system in April 1996 on remand after his arrest. He was held at HMP Brixton before being transferred to Broadmoor Special Hospital a year later. It was not his first time in custody, as he had previously served prison sentences in the USA and the UK.

19. The man was held at Broadmoor until August 1997 when he transferred to Whitemoor. In September 2004, he moved to HMP Full Sutton where he remained until his transfer to the DSPD unit at Whitemoor on 7 December 2006. The unit has three sections or spurs. Red spur (where he was housed) is the assessment spur while green and blue spurs are for treatment. The DSPD unit is called the Fens Unit but is often referred to as D wing by staff at Whitemoor. There is no CCTV coverage on the spurs.

20. Prior to his arrival at the DSPD, the man had attempted to commit suicide seven times since 1996 and self-harmed on a number of occasions, mainly by cutting himself. In April 1997, whilst at Broadmoor he cut off most of the little finger of his left hand when he was told he would be returning to prison.

21. The man had been selected for the DSPD unit some years before when he was at Whitemoor but had declined as he had not wanted to give up being a Listener. (A Listener is a prisoner who has volunteered to be trained by the Samaritans to provide a similar service to that organisation within the prison.)

22. A consultant forensic psychiatrist working on the unit was interviewed by my investigator who asked her about how the DSPD unit operates. She said:

> "Well its part of the government's programme of managing men who are considered to be dangerous, i.e. at high risk of serious re-offending by reason of severe personality disorder. So this was the first of the four high secure units to be set up. It's been established here at Whitemoor on an existing prison wing with some adaptation, mainly the conversion of what were previous single cells into offices, interview rooms and other facilities for the use of clinical staff. And all the clinical staff who are attached, either employed to be at work on the DSPD Unit or who are seconded from an NHS trust are based on that wing. It's a residential programme, there's a process by which prisoners are referred, they would all be people who had committed serious offences in the past and for whom there is … clear evidence of personality disorder. They come into the programme, they undergo a residential assessment that usually lasts about four months and then if they meet the DSPD criteria, there's a set criteria concerning risk, personality disorder and the link between risk and personality disorder, if they meet those criteria they're recommended to stay for treatment. So in the man's case, he completed the assessment process and had started on the treatment programme. Some of the very first prisoners, it'll take them longer than five years but we expect the full treatment programme to take about five years, so he was starting a long treatment programme."

23. When the man arrived at the DSPD unit he underwent the 15 week assessment, which was led by a consultant clinical psychologist. She continued as his individual therapist until he died. My investigator asked her for her impressions of him when he first arrived at the unit:

> "… He initially, for about three weeks, was quite bombastic and projected himself in rather a grandiose way and then that suddenly stopped and he told me later he hadn't needed the bombast any more. And there developed a very good relationship I would say, we had a good working relationship. He was a very intelligent man so he was quite sceptical at first of what we could do but he also very much wanted to make changes in himself and I think in probably about the three years before he came on the unit he had gone through a fair amount of psychological change himself. So he was actually really ready for treatment and he always, really, really worked which is something a lot of the men find difficult."

24. My investigator then asked her to describe the type of treatment that he received. She replied:

> "He was getting the treatment that we practise here which falls under a model that we call cognitive interpersonal … and we combine an approach which encourages them to think about their personalities, their childhood trauma and how it's linked to their offending but also to access their emotions because it's been found that people with personality disorders are often very intelligent and can easily absorb a cognitive approach. But it doesn't actually necessarily change and we take the view that, because the trauma has caused a lot of emotional dysfunction, it's only by accessing that emotion that you can actually bring about some modification. So in terms of my work with him in individual therapy, as we all do here, I take a dynamic approach. It involves making links between the past and the present and what's going on in the therapy, understanding the relationship with the therapist and how the way they relate to you is reflected in their work in therapy and he was very motivated to do this."

25. The psychiatrist was asked for her opinion of how the man was responding to the treatment he received:

> "He was a very complex man. He was, had a very high level of social skills and I think this combined with his American accent and his physical presence, he was a huge man, made him really quite a commanding presence really. When he was first on the unit, he was very polite but you had a sense of this being his social skills and of not being sure whether this was the real person. I don't remember exactly when but at some point he began to experience very real distress, he became really quite severely depressed and at this point, it really became clear to me and to colleagues, that he had a bipolar affective disorder, manic depression. From my reading of his records, he had recognised depressive episodes before but it's not clear to me that anybody had ever considered that he really had full blown bipolar affective disorder. I feel absolutely sure that that was so and I also think that there were indications that there was a family history of this on his

father's side. So he did experience some periods of really quite severe depression and despair."

26. The man successfully completed the assessment period. The assessment was carried out by the psychologist, psychiatrist and some of the prison staff working on the unit. The uniformed prison staff on the DSPD unit have all requested to work there, and many have had additional training or 'on the job' training to better equip them for the task. Many of the staff take part in the prisoner group sessions and they are encouraged to spend time and converse with the prisoners. A number of the staff interviewed spoke of the man's love of chess and some played with him on occasion.

27. The man suffered from mood swings during his time on the unit. At the low points he would be withdrawn, often weeping and reporting having suicidal thoughts. When his mood was high he would often be loud and effusive, described as being grandiose in manner and speech. He was prescribed paroxetine for his depression and lithium as a mood stabiliser.

28. At 9.15am on 26 February 2007, the man was found lying in a chest freezer. He was wearing only his underpants and he had a plastic bag on his head. He said he was upset at the time about another prisoner having committed suicide during the previous week. A fellow prisoner told my investigator that it was a joke that the man decided to play on the psychologist, but the staff and his clinicians believe that his action was a serious attempt to take his own life. An ACCT was opened by Officer A. There were no further acts of self-harm and the ACCT was closed on 4 April by a multidisciplinary group chaired by Senior Officer (SO) A.

29. On 22 June, the psychiatrist opened another ACCT after a conversation with the man in which he told her that he had moments of anguish and thoughts of maiming himself. She prescribed additional medication for that night and over the weekend. The following day he said he felt a lot better after taking the additional medication. It was agreed by the staff and him that the ACCT should be closed.

30. A progress report, written on 1 August, identified that the man had been attending his one to one sessions with the psychologist regularly and taking part in the group work. Despite having a cleaning job (he was responsible for cleaning the ones landing on Red spur), he was easily bored as he felt there were too few activities.

31. On 10 October, the psychologist put an entry in the man's observation log sheet:

   "He became distressed and weeping in his individual session, not about an event, but he is quite emotional as a consequence of shift in therapy. If he should start wailing and weeping, however, he probably needs his meds adjusting. Calmer at the time of writing."

32. At 10.00am on 22 October, the man was seen to have pushed a drawing pin into his forehead. The superficial injury was treated in healthcare and he was

told that he would be seen later for a one to one session with the psychiatrist. At 2.30pm, just after the cells were unlocked, a prisoner saw him putting a one inch screw into his forehead. He said that he needed to relieve the pressure. He then began to try and force the screw further in by banging his forehead against the wall. Staff arrived and when he was told he would need to see the doctor he pulled the screw out. He then became very tearful.

33. The man was treated in healthcare (no stitches were required), before being moved into a gated cell which has a clear Perspex covered metal barred gate in place of the usual solid metal door. An ACCT was opened and as part of the immediate action plan, SO B agreed with the duty manager that the man could return to his normal cell and that he should be seen by the psychiatrist as soon as possible.

34. The psychiatrist saw the man the following morning for a psychiatric review. He told her he had been feeling down for the last few weeks and that his mind had been scrambled at the time he self-harmed. She increased the dose of diazepam for the next three days and also increased the regular dose of olanzapine.

35. In the ACCT assessment interview the man made it clear that he did not feel life had anything to offer him. Officer B asked him if he had been trying to commit suicide. Officer B recorded the reply as follows:

> "He wouldn't describe the act as a suicide attempt nor an act of self-harm, but a desire to pierce his skull to escape the dark depths [of] his suffering."

36. SO B set the ACCT observation levels to be four times every hour, with a quality entry made at every unlock. The man did not harm himself again and, at the case review on 1 November, SO A wrote:

> "Over the past few days he has picked up. He has been more humorous and is mixing again. He has had an increase in meds and this is helping. He said he does not feel in danger at this present time but also acknowledged that this is not always going to be the case due to the work being done on the DSPD."

37. The psychiatrist wrote a short psychiatric report on 29 October. Concluding her report she wrote:

> "Since the severe depression and self-harm in February, he has been on a low/medium dose of anti-psychotic medication (olanzapine) and on regular diazepam. In the medium term I expect that he will continue some regular medication with the aim of stabilising his mood but recognising that he will remain vulnerable to depressive episodes with risk of self-harm or suicide."

38. The man continued to improve and the ACCT was closed at the case review on 5 November.

39. At 8.10am two days later on 7 November, when his cell was unlocked, the man showed staff the injuries he had caused to his hands punching the cell wall

during the night. He had multiple small wounds to both hands on his knuckles and fingers. Nurse A opened another ACCT document. During the assessment interview, the man told Officer A that he was feeling angry and disillusioned at the system. He did not want to attend the case review the following afternoon. Due to his low mood the officers decided to keep the observation level at twice an hour in state A (State A refers to when the prisoners are locked in their cells).

40. The man was also seen by the psychiatrist and Nurse B that day. He complained of severe headaches since starting evening doses of lamotrigine (used to treat bi-polar disorder and as a mood stabiliser) on 2 November. He said that he punched the wall to relieve his mental pain. The lamotrigine was stopped and a trial of pericyazine (an anti-psychotic) was agreed.

41. On 12 November, Officer C wrote in the man's personal history sheet that he was very animated and agitated because property belonging to one of his friends who had been transferred to Broadmoor had not been sent on. He threatened to smash up the snooker table and then the spur if the situation was not resolved. He later withdrew his threats and, although he did not attend the case review later that day, said that he would accept the recommendations of those attending.

42. At the conclusion of her Individual Therapy Report dated 14 November, the psychologist wrote:

> "In summary, the man has made a surprising amount of progress in the first six months in therapy. This has also been noticeable in his behaviour and presentation on the spur. However, it has been at great cost to himself."

43. The next few days passed without incident although the staff believed that there were underlying concerns that needed addressing. That view was reflected in the ACCT case review held on 16 November. The man again declined to attend as he thought he did not need to be on an ACCT. SO A and Nurse B agreed to keep the ACCT open and to try and re-engage him in the process.

44. The next case review was held on 21 November when all ACCT prisoners were assessed after the death of another prisoner. The man said that he was unaware of the person who died. He did not attend that review or go to the next one on 26 November either. On that occasion he said that he was okay. In interview, Nurse B said that, although he presented well, he felt that he was still not mentally stable. The ACCT remained open. Throughout this period he still participated in both group and one to one sessions as well as participating in activities with other prisoners in the evenings.

45. In her interview with my investigator, the psychiatrist was asked whether the man was at a high or low point in his mood during that period. She replied that she thought his mood was below normal, although she added that he could "put on a show".

46. The man did attend the ACCT review on 5 December. SO B recorded the following summary:

> “He spoke about his signs that he is aware of prior to self-harm, which are bodily sensations and wanted staff to know. However he struggles with what he could do / talk to staff because of feeling worthless. He tried to explain what happens at these times, which was powerful and very moving. It became very difficult for him. He needed to leave the review due to becoming distressed. Observations reduced during night state to observe in line with Cat A check (once an hour). One quality entry from a conversation in each period of unlock.”

47. The man spent that evening playing ‘spot the intro’ with other prisoners on the wing and seemed in better spirits than earlier. He collected his breakfast the next morning and then spent the rest of his time writing in his cell. He occasionally came out of his cell and walked around the ones landing before returning to his cell. During the afternoon he sat at a table on the landing talking with another prisoner.

48. The next day Officer D put an entry in the ACCT document stating that the man had spent the morning cleaning and sitting talking with other prisoners.

49. On 8 December, Officer E entered in the ACCT document that the man had been in the kitchen cooking a cake for a prisoner’s birthday. According to the prisoner, he and the man bought a number of paper wraps containing heroin from another prisoner that day. The prisoner had ordered 30 wraps and the man five. He explained to my investigator that, as he was better off financially, he had bought more heroin. He said he had planned to share the drugs with the man. They were not given all they had ordered that day, but both of them took some heroin during the day.

50. At 7.00am on 9 December, Officer F recorded in the ACCT that the man had been awake all night and had ignored him when the officer had tried to talk.

51. The Senior Charge Nurse on D wing (DSPD) began a handover sheet that morning. Her entry for the man was:

> “Mood appears low – night staff concerned as behaviour appeared bizarre last night. States he is ok but a lot is going on in his head.”

52. In her interview with my investigator, she spoke about her own concerns for him that morning:

> “Well I think it actually started in the morning because when he came for his medication in the morning, he looked dreadful … He looked awful, he was slurring his words, he just looked, he looked like he was intoxicated …That was probably eight, eight-thirty in the morning. He said he’d had a bad night; he hadn’t slept because he’d over-indulged in food the day before. I asked him if I could check his observations (pulse, blood pressure, pupil dilation etc.) but he refused to let me do that.”

53. She said that his refusal was not unusual for him. She saw him again later that morning when she gave him his lunchtime medication. The nurse explained her concerns to my investigator:

"Later on in the morning I went again to see him and his presentation, he appeared to me again like he was intoxicated. I asked him if he'd taken anything he shouldn't have done, he denied that. I raised my concerns with the staff on the wing, gave him his lunchtime medication and he seemed even more intoxicated, that's a word I can use, under the influence of some substance should I say."

54. My investigator asked the nurse whom she had spoken to, but she could only say that it was a conversation with the wing SOs and that she had requested raised observation levels for the man. She did not make an entry in the ACCT document, but agreed with my investigator that with hindsight she should have done. My investigator has not identified any staff who recall such a conversation with the nurse at that time.

55. Nurse A is an agency Registered Mental Nurse who has worked on D wing for three and a half years. She told my investigator that she saw the man, the prisoner whose birthday it was and another prisoner sitting at a table just outside the man's cell. She remarked on the enormous meals they each had in front of them. They explained that it was to celebrate the prisoner's birthday, which was on the coming Wednesday. Nurse A explained that she was told they were having the meal on Sunday as they were not allowed to cook on Wednesday. When they had finished eating she went upstairs to the next landing with the other prisoner, leaving the prisoner and the man sitting at the table.

56. Two officers were on the landing above where the man was sitting. They could see that the other prisoner appeared to be asleep and that the man was making silly comments. The officers went down and were concerned about the prisoner. At 2.47pm the officers alerted the control room that they had a medical emergency.

57. Medical staff attended and saw that the prisoner was drifting in and out of consciousness and having some difficulty breathing. The Senior Charge Nurse said in interview that the man was having problems sitting up; he was loud and over emphasising his speech. She asked him if he had taken any drugs but he denied it. She relayed her suspicions to Nurse C who also asked him if he had taken anything and received the same reply. Nurse C did not think that he was under the influence of drugs, although she did describe him as being "a bit wobbly and perhaps a bit unsure on his feet."

58. A Principal Officer (PO) was the Orderly Officer, which meant that he was responsible for the day to day running of the prison that weekend (There are also two governor grade members of staff in charge of the prison over the weekend). When he arrived on Red spur and saw the man he thought that he was 'fully up' and jovial but alert and talking to staff. My investigator suggested that it sounded as though he had been out for an evening of drinking but was not drunk. The officer agreed that was a good analogy.

59. The man was clearly upset by what was happening to his friend and he talked to the prisoner whilst staff attended to him. The other prisoners had been locked back into their cells. A Healthcare Officer then found 23 paper wraps

containing heroin hidden in the prisoner's left sock. The wing senior officer, SO A, knew the man very well and thought that something was wrong. In his interview he told my investigator:

> "I looked at him, tried talking to him at the table. He wasn't really responding, he was watching the prisoner, although he was trying to help, it was very – it wasn't very much help at the time so my concerns started raising then. I knew something was wrong, I asked the Senior Charge Nurse to take his observations, she said he was tired. I said I know the man, he's not tired, he does sometimes stay up all night long and he can cope with that, something was definitely not right. She said well he's okay, he's just tired."

60. At 3.15pm an ambulance was called for the prisoner, who was now lying on the floor whilst staff made him comfortable and maintained a clear airway. The orderly officer spoke to both the Senior Charge Nurse and Nurse C asking if there was any reason for the man to be out of his cell. They agreed that at that time there was not.

61. The orderly officer told two officers to return the man to his cell, and to search him and the cell in case he had any drugs. SO A went into the cell with them. A strip search was conducted by the officers but nothing was found. The man said loudly that he had nothing on him throughout the search and became more and more worked up. SO A then told him he was to be temporarily moved to the crisis suite (a separate unit within D wing with three anti-ligature cells for people in crisis) so that his cell could be searched. The man became more volatile and began to pace the cell, pump his arms and generally work himself up.

62. SO A decided to leave the cell rather than have an incident spill out onto the landing where the paramedics were treating the prisoner. He asked Officer G to stand outside the man's cell and watch for him disposing of anything or signs that he had taken the same as the prisoner. SO A reported back to the orderly officer. The two men have different recollections of the conversation. SO A says that he told the orderly officer that they had retreated from the cell search due to the situation and that Officer G was watching the man. The orderly officer recalls being told that the man had become irate but he made it clear that both he and his cell were to be searched. He has no recollection of being told that the cell was not searched.

63. Officer G spoke to my investigator about his conversations with the man from outside his cell:

> "I kept giving a running commentary what the paramedics were doing to the prisoner and it seemed to calm him down. At one stage he did switch his main light off so I put the night light on so I could see him, he asked me what the effing hell I was doing, I told him I've got to stand here and keep you in constant watch all the time, reasons why I've got to do it and he said, Officer G, he said I'm telling you he says, I'm not going to do anything. He said as a gesture of goodwill, I'm going to give you some blades and he actually handed out one razor blade underneath the door. He says I'm not going to

do anything silly, he said all I’ve got is my word, I’ve got nothing, everything’s been taken away from me, I’ve got my word, I’m going to promise you now I’m not going to do anything. I said that’s fine by me but I’ve got to stand here and talk to you, he says fine and he stood at the door. And I was at the door well until actually the incident was over …”

64. At 4.35pm, the prisoner was transferred to the district hospital. En route to the hospital, SO A spoke with him. The prisoner told the officer that he and the man had taken some heroin before and after lunch. SO A passed the information back to the prison when he arrived at the hospital.

65. The orderly officer maintains that he had a conversation with the Senior Charge Nurse and Nurse C regarding what should happen with the man, and where he should be located (possibly in a gated cell under constant observation). Nurse C told my investigator that she cannot remember talking to the orderly officer. The Senior Charge Nurse said that she told the orderly officer that if the man did not either go to Healthcare or was taken out (of the prison) he should go to a gated cell for close observation. She said that the orderly officer just nodded and was non-committal. He maintains that the nurses were content for the man to remain in his cell.

66. Before going off duty, the Senior Charge Nurse wrote the following on her nurses’ handover sheet:

> “Also becoming [increasingly] drowsy ? under the influence of illicit substance though strongly denies using any drugs! HCC (healthcare) aware – ACCT obs [increased] 4 per hour. On collecting meds [complained of] back pain, still appears heavily under the influence of unknown substance. Was searched by staff and he became extremely hostile when suggested he was relocated to crisis suite – to remain in own location and reviewed later by HCC.”

67. The orderly officer, who had left the wing to oversee the arrangements for the prisoner’s transfer, instructed PO A to tell Officer C to review the man’s ACCT and increase the observation levels to four times an hour. PO A was also told to arrange a second escort in case the man needed to be taken out of the prison.

68. Shortly before 5.00pm, the man was let out of his cell to collect his tea meal from the servery. Officer G described his condition as follows:

> “… he seemed to have gone into a bit of a curvature of the spine because when he came out, at first he started walking straight and then he just seemed to be going to one side and the best way to describe it is he started to walk like a monkey, bent down and one hand dragging along the floor. And he couldn’t actually stand up straight; he was white in pallor and starting to sweat. When we got him to the hot plate, I think it was Officer E actually carried his plate back to the cell. When we got back to the cell we said if he’s okay, he was very apologetic. He asked to speak to Officer H who searched him previously to apologise for his outburst, and while we were at the door he also asked to see the nurse who gave him a quick examination

because of this way his back had gone. Then after that he'd asked to speak to the chaplain … After we locked him up, we finally locked him up, we said we'll see you tomorrow and he said no problems gov, I'll be here tomorrow."

69. At 5.00pm, one of the prison chaplains spoke with the man when he returned to his cell. Afterwards the chaplain spoke with Officer C and told him the man had strong suicidal thoughts. The officer passed the information to the control room where it was entered into the log sheet. The chaplain wrote the following in the ACCT document:

    "He asked to speak with me; during the conversation he declared having strong suicidal thoughts and wants to end his life. From my observations he is currently in poor condition and needs close observation."

70. My investigator asked the chaplain if he thought the man's death was accidental. I think it is worthwhile to reproduce his reply in full here:

    "I think it was actually. When I first saw the man that afternoon, he was in his cell whilst the paramedics were dealing with the prisoner then there was the organisation of serving the other prisoners their evening meal Sunday afternoon. So I decided to stay put near the servery because obviously the other men had all been locked up and they would be anxious about what was going on. So I stayed put, some of them wanted to know some of them just walked past, reassure them that everybody was alright at that point. Then I was really shocked to find that they were bringing him out of his cell to go to the servery to get his own meal. The man came out, he looked as though he had been heavily drinking because he was staggering, he was leaning to one side, sweating, slurred speech. He made a beeline straight for me and said he wanted to see me and I was a bit surprised that the staff were allowing him to attempt to walk. He got some food, went back to his cell. I went back to the cell. I went in and staff stayed near the door. We sat on the bed, he then asked for confession so obviously I can't say much more on that because it is a Sacrament, so we dealt with that. After I had dealt with that it was then that he declared that he couldn't go on and this was the end. And I was under pressure from the staff to leave the cell because they wanted to lock him up so I had to say, 'Look, there is going to be somebody outside the door every 15 minutes. If you are feeling more ill tell them and I am sure they will get the medical team to you' to reassure him. But it was quite hard to leave the cell and have him locked up which is why I put that entry in."

71. Nurse A went into the man's cell to examine his back. The examination is not recorded in the ACCT document or his medical record. The only mention of back pain is in the nurse's handover sheet completed by the Senior Charge Nurse. There is no record of any diagnosis or treatment given.

72. Officer G stopped his observation of the man in his cell at 6.00pm when his shift ended. By that time the ACCT observation levels had been increased to four times an hour. However, that fact is not written on the front cover of the ACCT document, only in the on-going record section.

73. At 6.00pm, Nurse C wrote the following entry in the man's medical record:

> "Reported by wing to have taken 'drugs', seen on wing 14.50, mobile and coherent but unsure and unsteady, denied taking any drugs and said he was just tired. Did not want Healthcare intervention. To be watched closely for signs of deterioration by wing staff, already on an ACCT."

74. Officer D was one of three officers on the wing that evening. He told my investigator that he and another officer carried out the ACCT observations on the man until the night duty staff took over around 8.00pm. The orderly officer said that he contacted the wing and spoke to Officer D. He said the officer told him that the man was 'sleeping it off'. He said that he instructed the officer to get a response from the man during the checks. The officer replied that the man was snoring so loudly he could be heard from the centre office, but they were checking him anyway. Officer D said that he could not recall being given the instruction to get a response by the orderly officer. In interview, the orderly officer was asked if he thought hearing the man snoring was enough for the checks. He replied:

> "I think there's two bits to it, obviously what I instructed was that they got a response and I think there was two bits to it, a) I was content because he was snoring however, Officer D had informed me that they were still getting a response, now without actually being there and seeing what he designated as a response, whether it was verbal or whether he was content that the snoring was a response, I really can't pass comment on that, I was content that if there was still a noise coming from his cell and they were seeing movement from the man then to use the terminology he was still alive and he was still ok."

75. From his interviews with staff, my investigator is inclined to accept that the checks were being carried out four times every hour. However, there is neither written evidence nor CCTV coverage on the wing to support it. The ACCT document shows six entries between 6.50pm and 6.15am the next morning. There is no requirement to record every check under the ACCT protocols.

76. The prisoner returned to the prison at 8.08pm and went straight to Healthcare. The night duty Orderly Officer was briefed by the day orderly officer and told my investigator:

> "He had handed over and during that briefing he explained that there had been an incident on Delta Wing at some time in the afternoon which involved a prisoner and the man. That incident included that the prisoner had taken an amount of heroin which was enough to render him unconscious and as a result of that he was taken to outside hospital. He stated that they suspected that the man had also taken heroin although his speech was only slightly slurred and he was fine. He'd been seen by Healthcare, no concerns had been raised that afternoon and he'd been placed in his cell just as normal. He did go on to say that, just because they suspected he'd taken heroin that he was on an open ACCT. And they'd increased his observations to four per hour which is a routine occurrence if somebody is suspected of self harming or anything like that. Other than that, no other

concerns were raised. He did say that there was an escort pack that had been made up and left in Population Management should any problems arise and we had to get him to outside hospital, so all the cuff bag and the documentation was ready to go. But there was no reason to suspect that that would become required."

77. The night orderly officer said he was quite happy with the situation which was handed over. He also said that he spoke to the night duty nurse at about 8.15pm. In her interview she described the healthcare briefing she received when she came on duty:

    "I was told that the prisoner, well he had actually been admitted to Healthcare, he had been out to hospital and then on his return came to Healthcare so that he could be observed during the night. And also that the man had been seen but the nurse who gave me handover wasn't the one that had seen him in the afternoon and that he was as far as I am aware ok, and I did just look in the IMR [medical record] and just read that but he had denied taking any drugs and he was tired, did not want any healthcare intervention. So as far as I was concerned that was it."

78. At 9.00pm, the night orderly officer and night nurse went to the man's cell and saw that he was asleep. It should be noted that the last person to actually enter his cell was Nurse A at about 5.30pm. All subsequent observations were carried out through the observation window of the cell door in line with prison policy.

79. The night duty officers were briefed about the afternoon's events when they came on duty. There was a prisoner on a constant watch in a gated cell a short distance from the man's cell. Although other officers carried out the required ACCT checks on him, he could be heard snoring by the seated officer on the constant watch.

80. Just after 6.00am, Officer I checked the man and saw that there was a small amount of black/ brown liquid coming out of his mouth. The officer went straight to the centre office and rang the night nurse. He was advised to try and rouse him and get him to turn onto his side. The officer returned to the cell and banged on the cell door and shouted. He told the man that he had been sick and needed to sit up. Eventually, he mumbled something and began to try and sit up. He then tried to stand, still mumbling. As he got to his feet he attempted to support himself, but ended up on his back on the floor. Officer I saw more liquid coming from his mouth.

81. Officer J watched the man while Officer I contacted the night nurse again. The night orderly officer had been in the gate office when the first call was made, and was walking back to the main prison when he got the radio call to attend D wing urgently. He went via Healthcare and collected the night nurse. They met the night SO and the three colleagues made their way to the man's cell. The night orderly officer said that they arrived at 6.15am.

82. The officers entered the man's cell and immediately started cardio pulmonary resuscitation (CPR). The night orderly officer requested an ambulance to

attend and began chest compressions, while the night nurse inserted an airway and attached the oxygen and bag. With each chest compression more dark fluid came from the man's mouth. The night nurse attached the automatic defibrillator which went through its checking cycle before advising that no shock was required and to continue CPR.

83. According to the control room log the paramedics arrived at 6.36am. They took over CPR from the prison staff and attached their own defibrillator. However, their attempts were unsuccessful, and at 6.50am the paramedics confirmed that the man had died.

84. Later that morning a 'hot debrief' was held for the staff involved. (The purposes of a hot debrief are to acknowledge what happened and the role of the staff involved and to ensure that the immediate staff needs have been met.) Officer I said that there was some anger from a couple of the staff that the man had been left on D wing rather than being moved to Healthcare.

85. When my investigator interviewed the prisoner he spoke about the heroin that he and the man had taken on 9 December. He said that he had been trying to work it out, but he estimated, having shared some of his own wraps of heroin with him, that the man may have had between five and seven wraps left. The prisoner said that he could not be certain, but thought it probable that, like him, the man would keep his drugs on his person - unless he felt it likely he would be searched, in which case he would hide them in the cell.

ISSUES

Clinical Care

86. As noted earlier, a clinical review was carried out on behalf of the Cambridgeshire and Peterborough Foundation Trust by a panel chaired by the clinical reviewer, a consultant psychiatrist. My investigator was invited to be a member of the review panel which met at Whitemoor on 16 May 2008. The review contains eight recommendations which I endorse and reproduce at the end of this report. The review concludes as follows:

    "As is clear from the information above, the man had a very troubled history. He clearly had a serious bi-polar disorder. All the antecedents indicate it was possible he could make a serious suicide attempt which might not be preceded by obvious behaviour that such an act was imminent. His history also indicated he would engage in erratic misuse of drugs but prior to this incident, he was not known to have done so in a prison setting. The view of the review team is that a serious suicide attempt by overdose or otherwise was always possible though not predictable. As a result the review team do not believe that the incident, which led to his death, was preventable.

    "The review team did have serious concerns about the lack of action taken in relation to the man's apparent intoxication. It is clear the collapse of the other prisoner preoccupied both operational and healthcare staff and distracted them from responding more appropriately to the man's needs. However, there were a number of discrepancies in the clinical and operational response to his needs once concern arose that he was intoxicated. His preceding history and the available knowledge about his involvement in the incident, should have led to a more vigorous and effective clinical response in relation to his care. It was though recognised that his behaviour throughout the preceding and subsequent period was not helpful to staff but the review team were of the opinion that he should have received medical attention. To prevent such an occurrence in future the review team have made a number of recommendations for action, which <u>must</u> be addressed.

    "Overall the review team do not believe the incident leading up to his death was preventable. It is though likely if there had been a more appropriate response to his physical healthcare needs when it became evident the man was intoxicated that he would have survived."

The Senior Charge Nurse

87. The Senior Charge Nurse is both a registered general nurse and a registered mental nurse, employed on the DPSD. Nursing staff on the unit administer prescribed drugs, remove clinical waste, and assist with the various assessment sessions. General healthcare and emergency first aid is expected to be delivered by the nursing staff employed in the prison's healthcare centre.

88. She told my investigator that she first became concerned about the man around 8.00am on 9 December, when he came to collect his medication. Although she

told my investigator she thought that he was intoxicated and he refused to allow her to conduct any clinical observations, she did not take the matter further, nor bring her concerns to the attention of anyone else. Her entry on the nurses' handover sheet also made no mention of her concerns:

> "Mood appears low – night staff concerned as behaviour appeared bizarre last night. States he is ok but a lot is going on in his head."

89. The clinical review panel considered the question of what action was taken that morning when he showed signs of being intoxicated. They reported:

> "Little action if any appears to have been taken. No formal observations e.g. BP [blood pressure], TPR [Temperature, Pulse, Respirations] blood/urine tests were done by the DSPD nurse. Whilst these checks are normally the responsibility of the Healthcare Department there is no reason why initial checks cannot be carried out by DSPD nursing staff. This would have been particularly necessary at the time when the healthcare staff were fully engaged in treating another prisoner who had collapsed. Clearer detailed records must also be kept of contacts with healthcare staff re physical health concerns. Healthcare staff must visit to assess the prisoner. Where there is significant concern a medical assessment must be requested."

90. The Senior Charge Nurse told my investigator that, when she next saw the man at lunchtime, he looked even worse. On that occasion she said she actually asked him if he had taken anything. He replied that he had not. Again there is no written record of the concern. I would have expected entries in the ACCT document, his medical record, and the wing observation book, as well as some medical observations and possible intervention. She did say that at lunchtime she spoke to staff on the wing and asked them to increase their observations of him. Whether or not those conversations took place, she did not carry out her duties as would be expected from her training and experience.

91. A memorandum of understanding between healthcare and D wing clinical staff which was in use in December detailed the healthcare responsibilities of both and made it clear that "D wing nursing staff will complete routine/non-routine blood pressure, temperature, pulse, food/fluid/weight checks, keeping records in the prisoner's current clinical file that will later form part of the prisoner's healthcare record." Regrettably in this case the checks were not carried out and I draw the matter to the attention of the Governor.

92. The clinical review panel came to the following view:

> "Where there are signs that a prisoner is intoxicated they must be placed under physical health care observations. If transfer to the Healthcare Department is not feasible for reasons of safety then the physical healthcare observations must be available in the setting where the prisoner is contained."

Response to the man on 9 December

93. The clinical review panel and I share serious concerns about the lack of action taken regarding the man's apparent intoxication during and following the afternoon of 9 December. My investigator reports that, almost without exception, the staff he interviewed believed that he should have been moved to Healthcare if not an outside hospital. The view of the clinical review panel is reflected throughout their report and in their recommendations.

94. The man was put into his cell and searched. The intention was to search both his person and the cell for any illicit drugs. The officers who were to carry out the search all knew him well. Staff on the DSPD work closely with the prisoners, help to carry out assessment procedures and take part in other prisoner activities. He became verbally and physically threatening when he was told he would be moved to the crisis suite while his cell was searched. He had objected to being moved to the crisis suite before so that may have been the reason on this occasion. However, the prisoner estimated that the man could have had as many as seven paper wraps of heroin at that time. SO A made a tactical decision to withdraw from the cell for the safety of the officers and avoid interfering with the prisoner's treatment just outside. A breakdown in communication then occurred between SO A and the orderly officer. The result was that the orderly officer believed that both the man and his cell had been searched and that nothing had been found.

95. The man was left in his cell with Officer G watching him. He called the officer by his first name and told him he was not going to do anything silly (meaning self-harm) and handed out a razor blade. My investigator took the view that he may have been trading on his relationship with the staff, both to ensure that his cell was not searched and later to re-enforce the lack of any need to search further by volunteering the razor blade. Of course, it cannot be known whether he had any drugs in his cell (none were found after his death) or whether he took any further drugs before his death. However, in a unit such as the DSPD, staff must be constantly vigilant for any signs of conditioning (the manipulation of staff behaviour by prisoners resulting in loss of vigilance on security matters) of themselves or colleagues.

96. The orderly officer decided that the ACCT observations should be increased from those in line with State A and one quality entry per unlock session to four times an hour. Staff involved at the time agreed that the man was concerned for his friend, but no one said that they were concerned about him harming himself. The orderly officer told my investigator that the increase was for the man's welfare and I accept that. I also accept that the prevailing opinion at the time was that he should be monitored for signs of deterioration in his condition. My concern is that the ACCT observations were being used in place of medical observations by trained professionals. I have learnt from other investigations that even a trained nurse would find it difficult to tell from outside a cell if a person inside is asleep or unconscious.

97. The following extract from the clinical review underlines the concerns:

“Whilst he [the man] received regular observation during the night, this was by operational staff and his condition required that he at the very least be transferred to healthcare so that he could be observed by trained clinical staff.” (Emphasis in original)

The Governor and the Healthcare Manager should reinforce to all staff that observations for healthcare reasons are required to be carried out by medical staff.

98. The movement to an outside hospital of a category A prisoner is both time consuming and manpower intensive, especially at the weekend. The orderly officer told my investigator that the prisoner was his priority and that he actually had no face to face dealings with the man. He was unaware that he had told the chaplain that he had strong suicidal thoughts or that he had trouble walking when he collected his tea meal.

99. As it turns out there were two emergencies, and not just one, for the staff to deal with on the DSPD Red spur during the afternoon of 9 December, although the gravity of the man’s condition was not appreciated at the time. The condition of the prisoner and the logistical requirements of his transfer appear to have overshadowed the care of the man. I think that as soon as it became clear that the prisoner would have to leave the prison, the orderly officer should have appointed another officer to assume responsibility for the man. My investigator has been told that there is no contingency plan at Whitemoor to cover the eventuality of two serious incidents happening at the same time. I have been reminded by the Prison Service that the orderly officer was not alone or in sole charge of the prison at this time. There were two governor grades on duty as well, a manager E and a manager F, both experienced operational managers.

The Governor should consider preparing a contingency plan relating to two or more serious incidents occurring at the same time.

ACCT document entries

100. The orderly officer instructed that the ACCT observation levels were to be increased to four times an hour, which was done. The staff on duty at the time and those working the night shift were aware of the increase. However, the increase was not written up as required by Prison Service Order (PSO) 2700 on the front of the ACCT document, only in the on-going record section where it could easily have been overlooked.

The Governor should review procedures to ensure that staff comply with the requirement of PSO 2700, annex 8HH, section 4.

The man’s back problem

101. When the man was allowed out of his cell to collect his tea meal, he required assistance to walk and a member of staff carried his food back to the cell for him. He asked to see the nurse about his back and was examined in his cell at about 5.30pm. There is no record of the complaint, examination, diagnosis or

treatment either in his medical record or the ACCT document. Nurse A said that the only record would have been in the nurses' handover sheet and indeed amongst the general pm entry relating to him is "on collecting meds c/o [complained of] back pain". Here was another missed opportunity for the healthcare staff to engage with him and move him to Healthcare where he could be properly observed.

The Healthcare Manager should ensure that medical staff accurately record examinations, diagnoses and treatments in a prisoner's medical record and other relevant documents.

Handover to night staff

102. As can be seen from the interviews with the night orderly officer and night nurse, the full circumstances of the afternoon and in particular the man's involvement and condition were not made clear at the handover. When they both went onto D wing at 9.00pm, he was already asleep in his cell. Nothing on the nurse's handover sheet instructs or advises the night nurse to carry out clinical observations. The last part of the medical record entry by Nurse C at 6.00pm reads:

> "To be watched closely for signs of deterioration by wing staff, already on an ACCT."

The first part of the entry made by the night nurse at 9.50am the next morning reads:

> "Whilst on wing last night, I told D wing night officers to contact me if they had any concerns about the man during the night. He was on four checks per hour for his ACCT."

103. The night nurse would have been unaware of the extent of the back problem from which the man appeared to be suffering at tea time as the details had not been recorded. The night orderly officer would also not have been aware of the back problem or that he was having strong suicidal thoughts at 5.00pm, as the orderly officer, who briefed him, was unaware of those facts. The night orderly officer may have read the entry by the chaplain in the ACCT document, but there is no evidence that he did.

104. The information either given to or left for the night staff, especially the night nurse, was minimal and did not truly reflect the actual circumstances. I accept that, due to lack of communication, no one person knew the full circumstances. After the events of the afternoon there should have been a de-briefing session with the staff involved to ensure that correct and full information was available to hand over.

The Governor should introduce a protocol to ensure the accurate gathering and handover of information following a serious incident.

105. The apparent ease with which the man and the prisoner were able to obtain heroin whilst on the DSPD unit is of great concern. However, I am aware that

the Governor and his staff take the matter very seriously. I also understand that they are putting measures in place to try to minimise the availability of illicit drugs throughout the prison. In support of the Governor, the Director of High Security Prisons will wish to assure himself that all reasonable actions are being taken to prevent the ingress of drugs into the DSPD and into Whitemoor as a whole.

106. In conclusion, I agree with the findings of the clinical review panel,

> "Overall the review team do not believe the incident leading up to his death was preventable. It is though likely if there had been a more appropriate response to his physical healthcare needs when it became evident the man was intoxicated that he would have survived".

I believe that the situation with the prisoner distracted and deflected staff from what would have been their expected response to the man's presentation.

RECOMMENDATIONS

1. The Governor together with the Safer Custody and Healthcare Managers should reinforce to all staff that observations for healthcare reasons are required to be carried out by medical staff.

   The Prison Service partially accepted this recommendation saying:

   Healthcare observations, diagnosis etc should be accurately recorded in the IMR, and possible nurse shift handover sheets. They cannot be recorded in the ACCT or prisoner history sheet for operational staff due to medical in confidence; however any concerns raised by nurses as to the immediate welfare of a prisoner will be annotated in the ACCT document.

   All healthcare staff have been briefed on the requirements to record information as required. DSPD staff have been informed that they need to proactively apply for training through wing management.

2. The Governor should consider preparing a contingency plan relating to two or more serious incidents occurring at the same time.

   The Prison Service have not accepted this recommendation saying:

   This has been considered but establishment are able to deal with this operationally as a process is already in place.

3. The Governor should review procedures to ensure that staff comply with the requirement of PSO 2700, annex 8HH, section 4.

   The Prison Service accepted this recommendation saying:

   Training is being undertaken to ensure all staff are fully aware of the requirements of Annex 8HH. Guidance to all staff issued on P60. Training to be conducted to ensure all staff are aware of recording equipment.

4. The Governor together with the Healthcare Manager should ensure that medical staff accurately record examinations, diagnoses and treatments in a prisoner’s medical record and other relevant documents.

   The Prison Service partially accepted this recommendation saying:

   Healthcare observations, diagnosis etc should be accurately recorded in the IMR, and possible nurse shift handover sheets. They cannot be recorded in the ACCT or prisoner history sheet for operational staff due to medical in confidence; however any concerns raised by nurses as to the immediate welfare of a prisoner will be annotated in the ACCT document.

   All healthcare staff have been briefed on the requirements to record information as required. DSPD staff have been informed that they need to proactively apply for training through wing management.

5. The Governor should introduce a protocol to ensure the accurate gathering and handover of information following a serious incident.

   The Prison Service has accepted this recommendation saying:

   A protocol has been put in place for all orderly officers to pass on the details of serious incidents and any instructions from hot de-briefs to oncoming orderly officers.

CLINICAL REVIEW RECOMMENDATIONS

1. DSPD nursing staff should be tasked with carrying out preliminary observations including, blood pressure, Temperature-Pulse-Respirations, urine tests in support of a request for primary healthcare staff to attend to assess a prisoner.

   This recommendation has been accepted. The Head of Healthcare has already met with the DSPD lead nurse and produced a memorandum of understanding.

2. Detailed records, including phone calls should be kept by both DSPD and healthcare staff of requests and responses for assistance.

   The Prison Service has accepted this recommendation and said:

   The control room have charge of all phone calls made and maintain an incident log. This is an ongoing action.

3. Where there is concern that a prisoner is unwell or intoxicated healthcare staff must visit to assess.

   The Prison Service accepted this recommendation saying:

   A Security Information Notice has been published to remind staff of the need to report suspicions of intoxication to healthcare for assessment. Healthcare staff have completed overdose recognition training. Other staff are to be trained with the role out of IDTS.

4. Any prisoner showing signs of intoxication must be placed under the care of the Healthcare Department.

   The Prison Service has accepted this recommendation saying:

   Healthcare staff are to draw up a local protocol for admitting a prisoner for observation following intoxication or overdose.

5. Stocks of antidote medication should be sufficient to respond to more than one case.

   The Prison Service has accepted this recommendation and said that by May 2010:

   All areas will have a stock of antidote and also defibrillators following the role out of IDTS. Training for its use is currently underway.

6. The lead nurse in partnership with a suitable medical expert and the prison pharmacist must draw up a protocol for antidote medication in the prison setting if it is required.

The Prison Service has accepted this recommendation and said that by May 2010 antidote medication would be available in all residential areas and the gym following the role out of IDTS.

7. A medical assessment must always be requested where there is evidence a prisoner is intoxicated.

   The Prison Service has accepted this recommendation and said a Security Information Notice would be published to remind staff of the need to report suspicions of intoxication to healthcare for assessment.

8. The decision to transport a prisoner to the A&E department must be based on medical grounds.

   The Prison Service has accepted this recommendation and say:

   All requests to transfer a prisoner to hospital are facilitated.