

**Investigation into the circumstances surrounding
the death of a man in January 2009
following his release from HMP Manchester**

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

December 2009

This is the report of the investigation into the death of a man, from a drugs overdose, within hours of his release from HMP Manchester on 28 January 2009. This investigation has been carried out under the Ombudsman's discretionary power to consider deaths following release from custody.

I offer my sincere condolences to his family and partner for their loss.

The investigation was conducted by one of the Ombudsman's investigators. The investigator received excellent support from the Safer Custody team at Manchester. I would like to thank the Governor and his staff for their co-operation with the investigation.

Manchester Primary Care Trust (PCT) commissioned a clinical reviewer to undertake a review of the clinical care the man received at Manchester. The man spent the first four months of his time in custody at HMP Hewell and the clinical reviewer's review has also considered the clinical care provided to him there. I am grateful for her thorough review.

The man had a history of intravenous drug use, and had sought treatment for this in the community. Before he was remanded into custody, he was being prescribed the heroin substitute, methadone. Whilst at Hewell, the man continued to address his substance misuse, engaging with the prison's substance misuse service. He was offered further support on his transfer to Manchester but, at the time, felt he did not need it.

The man also had a history of mental health problems, and was being prescribed medication. Staff at both prisons struggled to gather information about his medical history in the community, although this does not seem to have impacted on the care he received. However, I have identified some shortcomings in the clinical care provided at both prisons. In addition, the management of discharge processes at Manchester has been examined. I make three recommendations in relation to healthcare provision at Hewell, three regarding healthcare provision at Manchester, and three concerning release arrangements from Manchester.

The transition from prison to the community is fraught with difficulties for many prisoners and it is important that prisons do all they can to properly prepare those in their care. That said, despite the warnings he had received and having apparently been drug free for eight months, the man chose to return to drug use on the day he was released.

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

December 2009

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SUMMARY

The man who died was remanded into the custody of HMP Hewell on 8 May 2008, charged with assault and affray. He told reception staff that he had a history of substance misuse and was being prescribed methadone. The man also said he had mental health problems and heard voices when he felt stressed. He said he was receiving treatment from a doctor linked with a community drugs service in his local area and had been prescribed anti-psychotic and anti-depressant medications. He was assessed by a prison doctor who requested that further information about the man's medical history be sought from the community drugs service. (However, it appears that no confirmation was ever received.) In the meantime, he prescribed the two medications the man had named at the same dosage level he said he had been prescribed previously. He also directed that the man undergo a 14 day methadone detoxification. (This is when the individual is prescribed a decreasing dose of methadone, until it is no longer necessary. The process is managed by healthcare staff.)

Whilst at Hewell, the man engaged with the prison's substance misuse team. He said that he wanted support in prison and to remain drug free when he was released. He told the substance misuse worker that he had overdosed once in the past. In June 2008, the man completed a four week programme for prisoners with substance misuse problems. During the programme, and in one to one sessions with his substance misuse worker, the risks of returning to drug use on release were explained to him. He was told that after a period of abstinence, drugs in the community would be stronger than he was used to. He was warned that if he returned to drug use on his release, he should use smaller amounts of drugs until his body became accustomed. The man was also told that using drugs whilst taking prescribed medication could be dangerous.

Staff on the wing where the man lived were concerned that the prescribed doses of medication were too strong. They asked healthcare staff to reassess him, and his medication was altered.

In early September 2008, the man was found guilty of his offences and sentenced to 15 months in prison. On 9 September, he was transferred to HMP Manchester because Hewell was overcrowded. The man saw a nurse in reception but did not undergo a full assessment. He told the nurse about his mental health problems and the medication he was prescribed. He was assessed by a doctor and the same medication was prescribed. He also saw a mental health nurse who told the man that she would approach the community drugs service for further information about the treatment he had received.

Following his transfer, the Hewell substance misuse service transferred the man's file to Manchester. He was allocated to a substance misuse worker at Manchester, who visited him on 24 September. The man said that he did not currently need any further support. The substance misuse worker told him that he could ask to see him at any time and said that he would visit again before he was released. (In fact, due to an administrative error, the substance misuse worker did not see the man before his release.)

During his time at Manchester, the mental health nurse continued to try to trace his medical history from the community, with limited success. She referred the man to the prison psychiatrist, who treated him during his time at Manchester and liaised with the mental health nurse. However, the man's case was not managed by the mental health in-reach team and due to confusion, he did not undergo a full mental health assessment.

The man was due to be released on 28 January 2009. He met with a principal officer two days beforehand, who completed the discharge paperwork. No issues were raised and the man was released from the prison at 2.00pm on 28 January. He did not see a nurse before his discharge and was not provided with a supply of his medication. The man was released on licence, to be supervised by probation. He was returning to the flat he had lived in prior to coming to prison.

Several hours after his release, the man was found in an "intoxicated" state in his local area. He quickly lapsed into unconsciousness and, despite efforts to resuscitate him, died at 7.18pm. The post mortem concluded that he had died of a heroin overdose.

This investigation has identified shortcomings in the (mental) health systems in place at Hewell and Manchester, and in the discharge procedures at the latter. I make nine recommendations in total.

THE INVESTIGATION PROCESS

1. The Ombudsman's office was notified of the death of the man on 29 January 2009. The investigation was allocated to an investigator on 5 February 2009. The Investigator visited HMP Manchester on 12 February and met the Governor and representatives from the Prison Officers' Association and the Independent Monitoring Board.
2. The investigator issued notices inviting staff and prisoners to contact her with any information they felt might be relevant to the investigation. There was no response to these notices. The investigator was provided with copies of the prison records relating to the man's time at Manchester, and those relating to the period that he spent at HMP Hewell (formerly known as Blakenhurst), prior to his transfer. She conducted interviews with staff at Manchester in April. Relevant staff at Hewell were contacted by telephone.
3. Manchester PCT appointed a clinical reviewer to conduct a clinical review of the care the man received at Manchester. Her review also considered the clinical care provided at Hewell. Both the investigator and the clinical reviewer were given copies of the man's medical records. They conducted several joint interviews with members of healthcare staff.
4. During the investigation, the investigator also made telephone contact with representatives from his local Drug Action Team (DAT) and Drug Intervention Programme (DIP), and the man's probation officer in the community.
5. The investigator approached HM Coroner for sight of the post mortem and police investigation report into the man's death. The results of the post mortem are outlined later. It has not been possible, however, to arrange a copy of the police report in time for inclusion here. HM Coroner will be provided with this report to assist him with the inquest.
6. A senior family liaison officer for the Ombudsman, contacted the man's family and partner to invite them to be involved in the investigation process. The man's partner said that she had visited the man at Manchester three days before his release. He told her that he had stored a quantity of the medication he was being prescribed in prison, and had taken six tablets that day. She said that, although he appeared relaxed, he was unable to concentrate or sit still. His partner did not tell staff about her concerns at the time. She wanted to know where he had got the tablets from, and was concerned that he was not more closely supervised when given his medication. She also had concerns about the mental health care the man received.
7. The man's partner said that when he did not arrive at the family home as expected on 28 January, his family contacted the prison to check he had been released. She said that the prison was unwilling to confirm this. The investigator agreed to consider these concerns during the investigation. The man's partner was also unsure what had caused the man's death. I hope that this report provides the man's family and partner with a better understanding of what happened on 28 January, and during the preceding months.

HMP MANCHESTER

8. HMP Manchester is a category A local prison serving the courts of the Greater Manchester area. It holds up to 1,269 adult male prisoners on remand, convicted and sentenced. The prison became part of the high security estate in April 2003. However, as a local prison, it accommodates both category A and other category prisoners.
9. The National Offender Management Service (NOMS) publishes quarterly performance ratings of prisons in England and Wales, with each prison being assessed across a number of set indicators. Over the three published quarters of 2008/09, Manchester's performance has been deemed "exceptional", the highest possible rating.
10. HM Chief Inspector of Prisons, conducted an unannounced short follow-up inspection of the prison in May 2007, following a full announced inspection in July 2004. A further full announced inspection took place in July 2009. All inspection reports include a summary of the prison's performance against the model of a healthy prison. There are four criteria of a healthy prison: safety, respect, purposeful activity and resettlement. The resettlement test requires that "prisoners are prepared for their release into the community and helped to reduce the likelihood of reoffending".
11. The criteria used by the Inspectorate to assess the conditions in prisons and the treatment of prisoners is set out in their 'Expectations' document. Section 8 of the document details the criteria used to assess how the prison manages the resettlement of its prisoners. Amongst others, the expectations in this area include:
 - That the prison has an up to date resettlement strategy.
 - That prison staff work collaboratively with both statutory and non-statutory agencies to achieve positive outcomes for prisoners.
 - That all prisoners have a written plan that specifies how their specific resettlement needs will be met during and post custody.
 - That assessments and sentence plans are produced and reviewed jointly with the prisoner and all staff or agencies directly involved with the prisoner.
 - That there is a high level of integration between sentence planning and other functions within the prison.
12. During the follow-up inspection in 2007, the Inspectorate reported that the improvements noted in 2004 remained and that staff-prisoner relationships had improved. The Inspectorate found that resettlement "remained a fairly good story", noting improvements in sentence planning for both long and short term prisoners.
13. Each prison in England and Wales is also monitored by an Independent Monitoring Board (IMB), the members of which are volunteers from the local community. Members of the Board have full access to every part of the prison and each prisoner held there. The IMB produce annual reports for each

establishment, the latest available report for Manchester covering March 2007 to February 2008.

14. The IMB reported that, in their view, Manchester was a “well-run prison”. It was noted that the prison had retained its ‘High Performance’ status for a second consecutive year. The IMB reported that the prison had established good links in the community to assist prisoners’ resettlement.

HMP HEWELL

15. HMP Hewell was created in June 2008 by the amalgamation of three former prisons on the site (HMPs Blakenhurst, Brockhill and Hewell Grange). The prison mainly serves the courts of the West Midlands, Worcestershire and Warwickshire. It can hold up to 1,431 category B, C and D prisoners.
16. Hewell has not yet been inspected by HM Inspector of Prisons. However, Blakenhurst (where the man served some of his sentence) underwent a full unannounced inspection in December 2005. Then, the Chief Inspector found the prison to be “well-run and stable”. The prison was deemed to be performing reasonably well against each of the four healthy prison tests.

CARATs

17. CARATs teams (Counselling, Assessment, Referral, Advice and Throughcare service) are in place in each prison in England and Wales. The service provides support and non-clinical treatment to prisoners with substance misuse needs. CARATs offers a number of interventions for prisoners, including one to one counselling and groupwork, and liaising with community services prior to release.

Short Duration Programme

18. The Short Duration Programme (SDP) is a structured short intervention for prisoners with substance misuse problems. Participants attend 20 sessions over a four week period. The programme is based on a cognitive behaviour and harm minimisation approach. (Cognitive behaviour aims to help the individual change the way they think, feel and behave. Harm minimisation acknowledges that substance misuse will occur but provides individuals with information and techniques that reduce the risks involved.)
19. Week 1 of the programme covers substance awareness, harm minimisation and the treatment services available both inside and outside prison. Week 2 focuses on harm minimisation and relapse prevention. Week 3 covers “high risk situations”, coping with cravings and relationships. The final week reviews the programme and focuses on the individual’s relapse prevention plan.

KEY EVENTS

20. On 8 May 2008, the man appeared at a local magistrates' court charged with affray and common assault. He was remanded into the custody of HMP Hewell. On arrival, the man underwent the first reception health screen with a nurse. (The first reception health screen is carried out when a prisoner first arrives in prison. It is designed to identify any immediate physical or mental health concerns which require referral to a doctor or other specialist service.) The man told the nurse that he was under the care of a doctor at Addaction (a substance misuse service in his local area). He said that he had mental health problems and was currently being prescribed anti-psychotic medication (risperidone) and an anti-depressant (mirtazepine). The man said he heard voices when he felt stressed.
21. During the first reception health screen, the man also said that he had used heroin in the month prior to coming to prison. He said he was currently prescribed 80mg of methadone a day. The man denied using cocaine, crack cocaine and cannabis. However, he underwent a drugs test which suggested he had recently used heroin, methadone, cocaine and cannabis. He denied using any drugs intravenously. The man said he drank about 18 to 20 units of alcohol every day. Following the health screen, the nurse recorded that the man should be referred to for a mental health assessment and to CARATs. The nurse noted that the man had a burn on his forearm, which had been dressed by a police doctor. Dressings were reapplied by healthcare staff over the next two days.
22. The following day, 9 May, the man was assessed by a member of the mental health team, who carried out the initial mental health screen. The man said he heard "mumbling voices outside his head" and sometimes found it hard to concentrate. He confirmed the medications he was currently being prescribed and the doses. As a result of the screen, the man was referred to the prison doctor for further assessment.
23. Later that day, the man was examined by a doctor who made a note of the appointment in his medical record. The doctor noted that confirmation of the man's medication should be sought from his doctor in the community. In the meantime, the man was prescribed risperidone and mirtazepine at the same dosage level as he said he had been prescribed in the community. A fax requesting the man's "relevant medical history ... or a summary of care" was sent to Addaction that day. There is no indication that Hewell received any information from Addaction in response. The doctor also recorded that the man should undergo a methadone detoxification. (This is when an individual dependent on opiate substances or methadone is prescribed a decreasing dose of methadone over a set period of time, until they no longer need to take any. The detoxification process is carefully managed by healthcare staff.) Despite the man's high intake of alcohol prior to his remand, the doctor did not suggest that he undergo an alcohol detoxification, and no direction was made that the man be monitored for signs of withdrawal.

24. On 19 May, the man was assessed by a CARATs worker at the prison. The man told the worker that he was currently receiving treatment for his drug use from his local DIP and Addaction. He agreed to work with CARATs during his time at Hewell. The CARATs worker recorded that the man needed structured support, including information on how to use substances safely and avoid overdosing.
25. The man and the CARATs worker drew up a care plan setting out the man's objectives and who was responsible for helping him achieve them. The man said that, once his methadone detoxification was complete, he wanted support to help prevent him returning to drug use. He said that he would like support in the community when he was released from prison. Finally, the man wanted the prison mental health team to help him with his mental health problems. The man and the CARATs worker agreed that the care plan would be reviewed over the course of his time in prison.
26. On 27 May, the man underwent a further mental health assessment, following the CARATs worker's referral. The man said he had trouble sleeping due to hearing voices. He thought the voices were stopping him from mixing with other prisoners. The nurse completing the assessment recorded that the man would benefit from an increased dose of risperidone at night time. As a result, the man was referred to the doctor and later that day, the doctor increased the risperidone dose.
27. The man met his CARATs worker again on 28 May and the Comprehensive Substance Misuse Assessment (CSMA) was completed. The CSMA provides a more detailed account of the individual's substance use, and helps to identify their support needs. The CARATs worker recorded that the man had now completed his methadone detoxification. He said that he would like to attend the Short Duration Programme (SDP). The CARATs worker recorded that the man would need a one to one session on the risks of overdose and tolerance levels as he had overdosed in the past. Following the meeting, the CARATs worker recorded that she had referred the man to the SDP and that he would begin the course in June. She also sent a fax referral to his local DIP advising them that the man would need their support on release from prison.
28. During the man's first few weeks at Hewell, staff on the wing where he lived appeared to have few concerns about him. Entries in his prison file indicate that they found him to be "polite and respectful" and thought he was settling in well. However, on 11 June, an officer recorded that the man "seemed in a confused state" and that he should be "monitored closely". Ten days later, the officer made a second entry noting that the man appeared to be a "heavily medicated individual" who "doesn't seem to know much about what's going on". Over the following weeks, staff recorded that whilst the man caused no problems on the wing, he seemed to be "in his own world". They wrote that he tended not to mix with other prisoners on the wing.
29. The man began the SDP on 18 June. The Drug Treatment Progress Report, written by the man's case worker, detailed the sessions he completed and the progress he made on the course. The man attended 19 of the 20 sessions and was praised for his "undoubted motivation". Of particular relevance is that

session 16 of the programme, which he attended, focused on overdose management, including “being aware of reduced tolerance levels, different strengths/purity of substances, not mixing drugs and not using alone”.

30. On 17 July, the man attended a post course review meeting with his CARATs worker, the SDP facilitator and his probation officer. The man said he had identified high risk situations and triggers for his drug use. He said that, in the future, he would seek support from the DIP team to avoid relapsing. The man’s probation officer warned him of the dangers of using illicit drugs while taking prescribed medication, telling him that he risked overdosing if he did so.
31. Another wing officer made an entry in the man’s prison file on 25 July, describing him as “zombie-like” and living a “worryingly lonesome existence”. A further entry that day recorded that, in the light of staff comments, the man should be assessed by the mental health team. On 29 July, an entry was made in the man’s medical record stating that he should be reviewed by both the mental health in-reach team and the doctor. However, the man did not go to an appointment with the doctor two days later. There is no evidence to suggest that the man was further assessed by either a doctor or the mental health in-reach team whilst at Hewell.
32. The man appeared at a local crown court in September. He was found guilty of his offences and sentenced to 15 months and 14 days imprisonment. Because of the length of time on remand, the man was due to be released on 28 January 2009. Two days later, the CARATs worker sent a fax to the local DIP informing them of the man’s sentence and expected release date. The following day, she faxed further information about the man to the DIP, reiterating that he would “require support upon release”.
33. On 9 September, eight days after his court appearance, the man was transferred from Hewell to HMP Manchester because Hewell was overcrowded. He saw a nurse in reception. The nurse was interviewed as part of this investigation but could not recall having seen the man in reception that day. The nurse explained that transferred prisoners did not always undergo a full reception health screen. Instead, the member of healthcare staff would talk to the prisoner to identify any immediate needs. If necessary, referrals could be made to the doctor or other service. The nurse recorded that the man was currently being prescribed risperidone and mirtazepine. She wrote “same prescribed here, referred to [mental health in-reach team]”. The nurse explained that she would not prescribe the medication and that the man would have seen a doctor in reception. There is no information in his medical record to indicate which doctor he saw, or who confirmed the prescription.
34. Later that evening, the man was assessed by a psychiatric nurse working with the mental health in-reach team. She noted that he had no connections with Manchester, and that his family and partner lived in a different area. The psychiatric nurse recorded that the man was known to mental health services in his local area. She wrote that she would “obtain further information from them tomorrow and to ascertain needs”.

35. The psychiatric nurse was also interviewed during the investigation. She said that the reception nurse who initially assessed the man had asked her to assess him because of his mental health history. The psychiatric nurse described the man as being “quite nervous” and possibly did not understand why he had been transferred to Manchester. The man told her that he was receiving treatment from a doctor linked with Addaction. The psychiatric nurse said that she would seek further information about him. She completed only a small part of the assessment and did not think she needed to complete the entire document as she did not intend to take him on to her caseload thinking he did not meet the criteria.
36. The man was located on H wing, where he underwent the first night assessment and induction with an officer. The man was described as being quiet and withdrawn, but polite and co-operative. He appeared to be “very nervous” about being at Manchester. However, the following day he underwent the second day interview, intended to provide a further opportunity to raise concerns and said that he had no concerns about being at Manchester.
37. On 16 September, the CARATs worker at Hewell completed a transfer plan and sent the man’s CARATs file to Manchester. She also faxed his local DIP to let them know that the man had been transferred. The transfer plan detailed the man’s main issues, and his “key achievements” to date. It also outlined his outstanding goals. They included being referred to the Blood Borne Virus (BBV) nurse and receiving Hepatitis B screening, liaising with the DIP team and undertaking an Enhanced Thinking Skills (ETS) course. (The ETS course is a short programme addressing thinking and behaviour associated with offending. It is available to all prisoners, not only those with substance misuse issues.) The CARATs worker also noted that the man would need a one to one session on overdose and tolerance. The investigator spoke to the CARATs worker by telephone. She said that it is common practice at Hewell to offer a final session on the risks of overdose and tolerance levels shortly before prisoners are released. This would have been offered to the man although he had already received the information via one to one sessions and the SDP.
38. On receiving the man’s CARATs file from Hewell, the Manchester CARATs team allocated him to a caseworker. The investigator interviewed the man’s caseworker as part of the investigation. He explained that the role of the CARATs worker is to “work in unison” with the individual to address their substance use. He said that the level of contact with prisoners on his caseload differed according to their specific needs and the length of their sentence. The caseworker was asked how many prisoners he had on his caseload in September 2008, when the man arrived at Manchester. He said that, at that time, he had around 40 prisoners on his caseload. More recently, his caseload had reduced to about 30.
39. The caseworker explained that, on receiving the man’s file, he checked to see what work had already been done with him and what his outstanding needs were. He met the man for the first time on 24 September and recorded the meeting in his file. He noted that the man said he was “fine at the moment and had done all his courses”. The caseworker told the man to contact him if he needed any

support. In interview, the officer said he told the man his file would remain open with CARATs and that he would see him again before his release. In fact, the caseworker did not see the man before he was released in January 2009.

40. My investigator asked the caseworker about the outstanding actions the CARATs worker at Hewell had outlined on the man's transfer plan. He explained that the referral to the BBV nurse and for Hepatitis B screening would normally take place about six weeks before a prisoner's release. He also said that the man was not suitable for referral to the ETS course because he was due for release in January and there was a long waiting list for the ETS course. The caseworker said that he would normally telephone the relevant DIP team prior to a prisoner's release to make an appointment. The caseworker did not refer the man to the BBV nurse or for Hepatitis B screening. In addition, he did not telephone the local DIP to remind them that the man was being released and make an appointment for him. (It would, however, have been the man's decision whether or not to attend such an appointment.)
41. My investigator also interviewed the CARATs manager. He confirmed that he expected his staff to arrange to see prisoners five to six weeks before their release date. At this stage, the CARATs worker should make the prisoner an appointment with the relevant community drugs service. He said that he would also expect his staff to reiterate messages about the risks of using drugs on release.
42. In interview, the caseworker explained that individual CARATs workers have their own systems for recording the expected release dates of the prisoners they work with. Although he recorded the man's release date in his files, he did not realise that the date was approaching. As a result, he did not see the man prior to his release nor make the usual pre-release arrangements for him.
43. During the course of this investigation, the investigator spoke to the Head of Offender Management at Manchester. He explained that the man would have been subject to sentence management and planning throughout his sentence. (Sentence planning ensures that individual prisoners receive the right interventions whilst in prison and that community ties, which will aid their resettlement, are supported.) The Head of Offender Management said that the man would have been invited to sentence planning meetings every two months. He also said that the man's probation officer would have been invited to contribute. Unfortunately, Manchester could not locate any sentence planning documents relating to the man. The man's probation officer in the community, was spoken to by telephone and said that he had not visited the man at Manchester. He explained that this was standard practice given the relatively low risk nature of the man's offending behaviour and the distance from the area he works in to Manchester. He confirmed that he had not received any sentence planning information from Manchester.
44. Following her meeting with the man on 9 September, the psychiatric nurse contacted Addaction in his local area on 26 September to gather more information about his mental health needs. Addaction told her that they did not know the man. The psychiatric nurse wrote that she would make further

enquiries to establish who had been treating him in the community. Three days later, she spoke to the man on the wing and told him that she was unable to identify which community service had been treating him. The man repeated that he was under the care of a doctor working with Addaction.

45. The psychiatric nurse recorded that the man seemed low in mood because of the distance from his family and partner. He told her that he hoped to be transferred to a prison closer to them. The nurse recorded that she would refer the man to a the prison's associate psychiatrist for assessment.
46. On 6 October, the associate psychiatrist assessed the man. He noted that limited information on the man's previous medical history was available. He thought that the man might be suffering with drug induced psychosis, although his symptoms also suggested schizophrenia. The associate psychiatrist recorded that the man was experiencing some side effects from the medication he was taking. He prescribed procyclidine to combat the side effects, and agreed to continue the prescription for risperidone and mirtazepine. He arranged to assess the man again in four weeks.
47. In October, the man began attending education classes at the prison. The investigator spoke to his tutor. She said that the man had gone to classes every week day for three hours each day. She described him as quiet at first and so she had spent time talking to him. Over time, the tutor said that the man began to interact more with other prisoners in the class. He did well in his computing classes and gained a number of certificates as a result.
48. The man was assessed by a locum psychiatrist, on 3 November. The locum psychiatrist recorded that the man reported a "slight improvement" since his last appointment. He told the locum that he was hearing the voices less frequently and that they were more muffled. The locum recorded that the man had no thoughts of harming himself or anyone else, but that his mood was slightly low because his family were not able to visit. The locum directed that the man should be reviewed in six weeks.
49. Over the next few weeks, the psychiatric nurse continued to try to identify the community service which had initially prescribed the man's medication. She recorded that she had contacted the Community Drugs Team (CDT) in his local area, also known as Inclusion. They confirmed that the doctor the man had named worked with them. Unfortunately, the doctor could provide very little information about the man and suggested that the psychiatric nurse contact the man's community doctor. She did so, and asked the surgery to fax any information they held about the man to her. The psychiatric nurse received a response from the surgery on 10 December. The doctors there had not treated the man for any mental health problems and had not had any contact with him since 2007. The psychiatric nurse recorded that she would visit the man on the wing the following week, prior to his discharge from prison, in case anyone needed to be contacted on his behalf.

50. In interview, the psychiatric nurse told my investigator that, although she was going to some lengths to track down his medical history, the man was still not on the in-reach team caseload. She said that his mental health needs were being addressed by the associate psychiatrist and she did not feel there would be any benefit from a referral to the in-reach team. The psychiatric nurse said that she did, however, visit the man on the wing prior to his release. She asked him if there was anything he would like her to do for him. He replied that there was not, and that he planned to return to his local area on his release.
51. On 17 December, the associate psychiatrist assessed the man once more. He recorded that the man was “feeling well” and, whilst he was experiencing less severe side effects from his medication, he was still having some problems. The psychiatrist increased the procyclidine dose. He recorded that the man was expecting to be released on 28 January, and should be reviewed by the psychiatric nurse in four weeks time, prior to his release. The psychiatrist was under the impression that the man had in fact been taken onto the in-reach team caseload.
52. The man’s tutor told the investigator that he attended his last IT session on 12 January. She talked to him about his release and he said that he was looking forward to going home. The man told his tutor that he intended to take drugs on his release. The tutor did not pass on the man’s comments to other staff, or to the CARATs team, but said that she tried to encourage him to reconsider.
53. The man did not attend a scheduled appointment with the associate psychiatrist on 14 January and no reason is recorded. The psychiatrist noted that the man should attend a further appointment in three weeks time. (It appears that he had not realised that the man was due for release in two weeks time.) There is no record of any further appointments with healthcare staff prior to his release.
54. My investigator spoke to the prison’s Head of Healthcare. She said that all prisoners should be assessed by a nurse about a week before their release. A pre-discharge appointment was scheduled for 26 January, but the man did not attend. The reason for his non-attendance is not recorded, and there is no indication that any further action was taken to.
55. The man’s partner came to visit him on 26 January. She told the investigator and family liaison officer that the man was unable to sit still or concentrate during her visit. The man said that he had stored some of his prescribed medication and had taken six tablets that day.
56. The Head of Healthcare was asked about how medication was distributed. She explained that the man’s medication was ‘not in possession’. All medications prescribed at Manchester undergo a risk assessment. Those considered low risk may be held ‘in possession’, when the individual is given enough medication to last a specified period of time. They keep the medication in their cell and are responsible for taking the correct dose. Some medication is assessed as high risk. It might be dangerous if wrongly taken, or might be particularly likely to be traded or result in bullying between prisoners. This medication is distributed by healthcare staff to prisoners on a dose by dose basis and is called ‘not in

possession'. The Head of Healthcare said that prisoners given a dose of 'not in possession' medication must take it in front of healthcare staff. She said that staff carry out a visual check to ensure that it was swallowed. In her opinion, it is difficult for prisoners to hide medication, but she accepted that this can occur.

57. The investigator asked the associate psychiatrist what symptoms the man might have experienced as a result of taking a higher than prescribed dose of his medication. He said that the medications, if taken in excess, would have had the opposite effect to that his partner described and that he would have appeared lethargic. The psychiatrist was unable to say what might have caused the symptoms the man's partner described.
58. Prison Service Order (PSO) 6400 Discharge, advises that a discharge board be held no more than two weeks before the prisoner's release, to ensure that all resettlement work has been completed. Relevant personnel from across the prison and from the wider community may be invited to attend or submit a written contribution. A principle officer (PO) completed the discharge board with the man on 26 January. No other staff attended and no written contributions were made. The principal officer was interviewed as part of this investigation and explained that the board is normally held two days prior to release. She said it is the job of a PO to hold the board, and that the POs on duty receive a list of boards to be held each day. The principle officer explained that the discharge board serves two main functions. The first is to check that the correct prisoner is being released and that they have no further offences which might require the prison to hold them in custody. She also explained that the board serves a "decency" function, which is an opportunity to identify any problems the prisoner has prior to release.
59. During the course of the board, a form must be completed which sets out 18 questions. The purpose of the form is to record that the questions have been asked or the information checked. The prisoner's responses or any action taken as a result of the board are not recorded. Some questions relate to checking the identity of the prisoner, others cover whether the individual has accommodation to go to on release, or whether they have had contact with CARATs during their sentence.
60. The principle officer said that the board is usually held in the POs' office, with other staff coming in and out of the room. She thought that the lack of privacy might inhibit some prisoners from sharing any anxieties. She also explained that the PO holding the board would not necessarily know, or need to know, the prisoner due to be released. The principle officer did not know the man prior to the discharge board. She asked him if he had accommodation arranged for his release, and recorded that he did. She noted that he did not have any education, training or employment arranged. The PO also asked the man if he had had any contact with CARATs. She explained that if the prisoner said they had, she would normally ask them if CARATs had made any arrangements for their release. If the prisoner said that CARATs had not made any necessary arrangements for them, she would contact the team to remind them.

61. The discharge form requires the PO to sign their initials to indicate the question has been asked, but there is no space to record the prisoner's response or any other details. It is not, therefore, known how the man responded to the questions. The principle officer said that the PO who completed the board would make an entry in the prisoner's wing history sheet to that effect. She said that, depending on the prisoner's answers, she might sometimes make a more detailed entry to indicate any actions she had taken. She thought that, if she had contacted CARATs on the man's behalf, she would have made such an entry. The principle officer made one entry in the man's wing history sheet, which records "discharge board held ... No issues". The discharge board makes no reference to contact with healthcare.
62. Prior to his release, healthcare staff prepared a discharge letter (dated 26 January) for the man to give to his doctor in the community. It outlined the medication he was prescribed but provided no details of his contact with the associate psychiatrist. The man would have been given his discharge letter in reception at the point of release from the prison. The Head of Healthcare explained that prisoners are expected to make appointments with their doctor themselves after release. Prisoners are normally released with seven days' supply of their medication. The Head of Healthcare said that staff were unable to locate the man's discharge prescription and she was not certain that he had been released with any medication. (The clinical reviewer has concluded that the man was not given any discharge medication. He last received his prescribed medication on the evening of 27 January.)
63. On 28 January, the man was taken to reception to be released. The investigator interviewed the senior officer (SO) in charge of reception that day. He explained that prisoners arriving and being released from the prison are processed through reception. When a prisoner is being released, the reception SO is responsible for checking the information on the discharge form, to ensure that the correct person is being released. According to PSO 6400, it is good practice to warn all prisoners being released that their tolerance to drugs and alcohol will be significantly reduced and that they will be at a higher risk of overdose or intoxication. The senior officer explained that while reception staff do not verbally warn every prisoner of these dangers, they are all offered a discharge pack. The pack contains warnings about the risks of using drugs on release from prison, specifically that tolerance might have reduced whilst in prison and drugs available in the community might be stronger than any available in prison.
64. The man was one of nine prisoners released from Manchester on 28 January. PSO 6400 advises that prisoners should normally be discharged as soon as possible after breakfast. According to reception records, the man was discharged at 2.00pm with £365.95 in cash and a travel warrant to take him to his local area. (On release, prisoners are given a cash discharge grant of £46 to cover immediate expenses. The man was issued with the discharge grant and £319.95 personal cash.)
65. According to the man's licence, he was to report to his probation officer by 3.00pm on 28 January. However, the senior officer recalled that there had been a delay releasing the man, which meant he would not arrive in his local area in

time to report. A member of reception staff contacted the man's probation officer and it was agreed that he could attend first thing the following morning. (This is not recorded on the licence paperwork, or elsewhere in the man's file.)

66. It appears that the man arrived in this local area sometime that afternoon, and went to a pub. In the early evening, he was found in an "intoxicated" state near a local police station. He became unconscious and an ambulance was called. Despite resuscitation efforts, hospital staff pronounced that the man had died at 7.18pm.
67. The post mortem results revealed that the man had consumed heroin and cocaine and the cause of death was identified as heroin poisoning. The toxicology results indicated that the levels of mirtazepine and procyclidine (two of the medications being prescribed to the man) were slightly higher than expected from the prescribed doses. The toxicologist noted that this could, in theory, have added slightly to the toxic effect of the heroin. Alternatively, the report suggested that the raised levels could have been caused by changes that happen naturally in the body after death.

ISSUES IDENTIFIED DURING THE INVESTIGATION

68. Manchester Primary Care Trust (PCT) commissioned a clinical reviewer to review the clinical care the man received at Manchester. As the man spent the first part of his sentence at Hewell, her review also considered the clinical care provided there. The clinical reviewer's review is thorough and makes 12 recommendations. I have included some in the discussion below, but commend the entire review to both prisons and the relevant PCTs.

Clinical care at HMP Hewell

69. On his arrival at Hewell, the man told healthcare staff that he had a history of substance misuse and was being prescribed methadone. He said that he had mental health problems and had been prescribed anti-psychotic and anti-depressant medication by a doctor in the community. Prior to coming to prison, the man said he was also drinking 18-20 units of alcohol each day. He was placed on a methadone detoxification programme at Hewell. However, no entries were made in his medical record about his progress or how the detoxification was managed. Furthermore, the man's alcohol use was apparently not addressed.

The Head of Healthcare at Hewell should implement a nationally recommended pathway for alcohol and drug detoxification programmes in reception.

70. The man told staff at Hewell he had been prescribed medication in the community by a doctor working with a local drugs service in his local area. During his time at the prison, staff were not able to locate the doctor or confirm the prescriptions. Nevertheless, and without the man undergoing a full mental health assessment or being referred to a psychiatrist, he was prescribed anti-psychotic and anti-depressant medications. The prison doctor increased the dose of the anti-psychotic medication being prescribed and, despite wing staff concerns, there is no evidence that the effect of this increase was monitored by healthcare staff.

The Head of Healthcare should urgently develop policies and procedures for prescribing medication to prisoners where details of an existing medication regime have not been confirmed.

The Head of Healthcare should review the procedures and criteria for referring prisoners for assessment and monitoring by a psychiatrist.

Clinical care at HMP Manchester

71. The man was transferred to Manchester on 9 September 2008 and saw the nurse in reception. However, he did not undergo the full First Reception Healthscreen, or any modified version of this. The nurse explained that it was not normal practice at Manchester for transferring prisoners to complete the full assessment unless there was specific reason to do so. This is not in line with PSO 3050 Continuity of Healthcare for Prisoners which indicates that all transferring prisoners should be screened by a nurse before spending their first night in the

prison. The local protocol in place at Manchester meant that the man was not subject to a secondary healthscreen either.

The Head of Healthcare should ensure that all transferred prisoners are subject to reception screening in line with PSO 3050 and undergo a secondary healthscreen.

72. The man was referred to the mental health team because of his existing mental health problems and the medication he was being prescribed. The psychiatric nurse saw the man in reception and continued to have contact with him during his stay at Manchester. She did not, however, admit him to the mental health in-reach team's caseload as she did not think he met the criteria. Manchester Mental Health and Social Care Trust, which is responsible for the in-reach team, require a risk assessment for all patients. The psychiatric nurse completed only a small part of that assessment, thinking that she did not need to do more unless the man was to be taken on by the team. However, the risk assessment document contains a shortened one page section, which staff were unaware of. The psychiatric nurse should have completed the one page assessment.
73. The psychiatric nurse continued to see the man on an advisory basis, and he was also seen by the associate psychiatrist. However, it appears that the mental health in-reach team did not discuss the man's ongoing care, nor were any management plans completed. The psychiatrist did not realise that the man was not on the in-reach team's caseload, causing some confusion.

Manchester Mental Health and Social Care Trust should:

- **address staff confusion about the completion of the required risk assessment documents and management plans for patients in their care, and**
- **ensure that the mental health in-reach team understand and follow the correct procedures for assessing prisoners for acceptance onto their caseload.**

74. Prior to his release on 28 January 2009, the man should have seen a member of healthcare staff and received seven days supply of his prescribed medication. The man's medical record indicates that he did not go to his pre-discharge appointment and was not seen by healthcare staff before leaving the prison. In addition, he did not receive his discharge medication. It is not clear why.

The Head of Healthcare should carry out an audit of the discharge medication process to ascertain its effectiveness, reliability and safety.

The man's transfer to Manchester

75. The man spent the first four months of his time in prison at Hewell, in the West Midlands. His family and partner, who has a hearing impairment, live in his local area. In September 2008, with just over four months of his sentence left to serve, the man was transferred to Manchester because Hewell was overcrowded. The psychiatric nurse and a doctor both recorded that the man's mood was low because his family and partner were not often able to visit him there. The man

told the psychiatric nurse that contact with his partner was particularly difficult as they could not speak on the telephone.

76. Current prison population pressures mean, inevitably, that some prisoners are placed in prisons a long way from their sources of support. It is unfortunate that the man's transfer, in effect, cut him off from his family and partner. It is also unfortunate that he was transferred towards the end of his sentence when links with community agencies become so important to successful resettlement. That said, I do not believe that the man's transfer ultimately played a part in his death.

The man's contact with CARATs

77. On his arrival at Hewell, the man told healthcare staff that he had a history of drug use. While at the prison, he engaged with CARATs and completed the SDP. The man's CARATs worker, told my investigator that she also undertook one to one sessions with him that reiterated the dangers of returning to drug use on release. The man's CARATs worker informed the man's local DIP that the man would need their support on his release from prison. The CARATs file was comprehensively completed and sent to Manchester when the man was transferred there in September 2008.
78. The man's caseworker from the Manchester CARATs team visited him on 24 September, but he said that he had done the relevant courses and did not need his support at the time. The man's caseworker intended to see the man again before his release but did not. He explained to my investigator that, at the time the man arrived at Manchester, each CARATs worker was allocated about 40 prisoners. He said this made it difficult to work effectively with them all and he had to prioritise those with the greatest needs. The CARATs manager, said that since the man's death, they had worked hard to reduce the number of cases individual officers managed, and staff should ideally have a maximum of 25 prisoners each.
79. The CARATs manager and the man's caseworker told my investigator that individual members of staff developed their own systems for recording the expected release dates of prisoners on their caseload. They confirmed, however, that the CARATs administrator also circulated a weekly list of prisoners due for release. I think it would be sensible for the CARATs team to develop a robust and centralised system for identifying upcoming release dates.

The Governor should encourage the CARATs team to develop a centralised system for identifying and reminding staff of prisoners' release dates.

80. I conclude, however, that, during his prison sentence, the man received appropriate information about the risks of returning to drug use. It is not possible to say whether hearing that message again some five to six weeks prior to his release would have dissuaded the man from using drugs on 28 January. However, I believe it unlikely.

Discharge procedures

81. Because of the circumstances of the man's death, this investigation has focused on the discharge processes in place at Manchester. PSO 2300 provides instructions on how the resettlement of prisoners should be managed. It emphasises the importance of multi-agency working. Although the PSO largely refers to engaging agencies outside the prison, clearly it is important that the different disciplines within the prison work well together too. Interviews with staff from a range of disciplines suggest that the process is disjointed with the different disciplines and agencies working in isolation to prepare prisoners for release. As identified above, the man left Manchester without having been assessed by healthcare, without his discharge medication and without having a pre-release meeting with CARATs.
82. The Governor of Manchester, told the investigator he was considering establishing a pre-release centre for prisoners with substance misuse issues, with input from a range of disciplines. The purpose of the centre would, in part, be to make sure that prisoners are fully aware of the risks of returning to drug use on their release. The Governor explained however, that the Integrated Drug Treatment Service, due to be introduced at Manchester in October 2009 was expected to have an impact on the discharge and resettlement of substance misusing prisoners. In light of the man's experience, and the importance of properly preparing prisoners for release, the Governor will wish to give some consideration to this area.

The Governor should revise the current discharge procedures to ensure a cross-disciplinary approach is adopted.

83. The principle officer who carried out the discharge board explained that discharge boards were normally held in the principal officers' office, with staff coming in and out, and consequently, there was a lack of privacy. She thought this might inhibit some prisoners from raising issues or anxieties.

The Governor should allocate a suitably private room for holding discharge boards.

The family's concerns

84. Having had sight of the draft version of this report, the man's family remained concerned that staff at Manchester had not been able to confirm whether and at what time the man was released. Manchester responded to the draft report, explaining that, for security purposes, the prison cannot give out such information to members of the public who telephone the prison given the difficulties of establishing the caller's identity.

CONCLUSION

85. The man arrived in prison with a history of serious substance misuse. He had sought treatment in the community and, whilst at Hewell, engaged with the substance misuse service. He appeared to work hard to tackle his substance misuse problems, undertaking the SDP and a methadone detoxification. It would seem that he remained drug free during his time at both Hewell and Manchester. However, hours after his release from Manchester, the man died from a heroin overdose.
86. The man also had mental health problems and received interventions from the healthcare and mental health teams at both prisons. This investigation has, however, identified omissions in the treatment he received. Failings in the discharge planning at Manchester have also been highlighted and recommendations made.
87. This investigation highlights the very difficult transition from prison to freedom that prisoners face. It also illustrates the onus on discharging prisons to do all they can to properly prepare prisoners. That said, ultimately, it must be recognised that it was the man's choice to return to drug use on the day he was released.

RECOMMENDATIONS

To the Head of Healthcare at HMP Hewell:

1. The Head of Healthcare at Hewell should implement a nationally recommended pathway for alcohol and drug detoxification programmes in reception.

This recommendation has been accepted. A piece of work has been agreed to achieve this. The target date for completion is April 2010.

2. The Head of Healthcare should urgently develop policies and procedures for prescribing medication to prisoners where details of an existing medication regime have not been confirmed.

This recommendation has been accepted. The Prison Health Drugs and Therapeutics committee will review and action and a protocol will be developed by January 2010.

3. The Head of Healthcare should review the procedures and criteria for referring prisoners for assessment and monitoring by a psychiatrist.

This recommendation has been accepted. An improved referral and allocation process has been put in place. The Prison Health Directorate is also implementing a new mental health strategy for Worcestershire prisons, involving a review of access to mental health services. The new regional TAG referral process will be implemented.

To the Head of Healthcare at HMP Manchester:

4. The Head of Healthcare should ensure that all transferred prisoners are subject to reception screening in line with PSO 3050 and undergo a secondary healthscreen.

This recommendation has been accepted. The Director of Healthcare will ensure that all prisoners who transfer to HMP Manchester will have a secondary healthscreen.

5. The Head of Healthcare should carry out an audit of the discharge medication process to ascertain its effectiveness, reliability and safety.

This recommendation has been accepted and work will be completed by April 2010.

To Manchester Mental Health and Social Care Trust:

6. Manchester Mental Health and Social Care Trust should:
 - address staff confusion about the completion of the required risk assessment documents and management plans for patients in their care, and

- ensure that the mental health in-reach team understand and follow the correct procedures for assessing prisoners for acceptance onto their caseload.

This recommendation has been accepted. The Mental Health In-Reach Team leader will facilitate refresher training regarding the risk assessment process. An audit will be completed regarding the quality of care plans and any findings acted upon. The procedures for assessing prisoners for acceptance onto the Mental Health In-Reach Team caseload will be discussed at the October 2009 team meeting.

To the Governor, HMP Manchester:

7. The Governor should encourage the CARATs team to develop a centralised system for identifying and reminding staff of prisoners' release dates.

The Prison Service has accepted this recommendation and a system has been implemented.

8. The Governor should revise the current discharge procedures to ensure a cross-disciplinary approach is adopted.

This recommendation has been accepted. The current discharge procedures will be reviewed to consider including more members of the multi-disciplinary team.

9. The Governor should allocate a suitably private room for holding discharge boards.

The Prison Service has accepted this recommendation. During the review of discharge procedures, the location of the discharge boards will also be considered.