Investigation into the circumstances surrounding the death of a man at HMP Belmarsh in January 2005

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the circumstances of the death of a man at HMP Belmarsh in January 2005. The man's cause of death was given as asphyxia following epileptic fit with left ventricle failure. He was 25 years old. I extend my sincere condolences to the man's family and friends for their loss.

The investigation was carried by one of my colleagues and a clinical review was carried out by a senior nurse from a hospital in a different area to the prison. (The arrangements for the review were outside my normal arrangements.) I am most grateful to the clinical reviewer. I would also like to thank the Governor of Belmarsh at the time of my investigation and her staff for their help and assistance.

The man had been on remand in Belmarsh since June 2004. On two occasions, first in July and then in October, he suffered a series of epileptic type fits. Each fit was followed by a period of extreme involuntary violence. The man was taken to outside hospital on both occasions, and each time remaining in hospital overnight. When he went back to Belmarsh after his second hospital admission his discharge letter said that he had refused clinical investigations.

In the early hours of a day in January 2005, the man suffered a third occurrence of similar fits. Officers restrained him outside his cell and he was then taken to the healthcare unit and put in a cell there. Due to the configuration of the healthcare cell the man was placed in a kneeling position. Staff went back into the cell around 55 minutes later to put the man in a more comfortable position. However, when he was checked he was found not to be breathing. He was taken to outside hospital where he was pronounced dead.

The circumstances surrounding the man's death were subsequently referred to the Crown Prosecution Service (CPS) for consideration of a possible prosecution against any of the staff who dealt with him. In September 2007 I was informed that the CPS had decided there would be no criminal proceedings. I very much regret that the man's family have had such a long wait for the outcome of this investigation.

The investigation has revealed a number of concerns about the man's care and treatment. There seems to have been no consideration on whether he should have been sent to outside hospital. The cell in healthcare was not fit for purpose and its design led to the man being placed in a kneeling position with his back to the door. I have made three recommendations. One is about control and restraint, another is about storage of drugs. The third recommendation is about contact with families following a death in custody. I also endorse a further 21 recommendations made in the clinical review.

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

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SUMMARY

The man was a 25 year-old remand prisoner at HMP Belmarsh who died in the early hours of a day in January 2005. The man had been in custody since 6 June 2004 and had been in Belmarsh since 15 June 2004. On 7 July, he suffered several epileptic type fits and was taken to the nearby Queen Elizabeth Hospital. The man returned to Belmarsh with the advice that he should be referred to the hospital's neurology team should he suffer any more seizures.

On 25 October, the man suffered a further series of fits. There was an unusual component in that each would be followed by an episode of extreme violence requiring restraint by a number of officers. The evidence indicates that the violence was totally involuntary. The man was again taken to Queen Elizabeth Hospital where he stayed overnight. Having refused investigations into his seizures, the man returned to Belmarsh staying several days in the prison's healthcare unit. A care plan drawn up at this time included that the man should be located in a single cell.

By January 2005, the man was in a shared cell with two other prisoners in houseblock 3. At 2.48am one night that month one of the cellmates pressed the in-cell call bell. An officer responded and the cell-mate pointed to the man who was fitting on the cell floor. The officer called for support, including nursing assistance[1]. Among the first of the staff to arrive was the Night Orderly Officer (NOO)[2]. The NOO was aware of the violence that had been associated with one of the man's previous fitting episodes. In light of this and because there were three prisoners in the cell, the NOO decided it best to wait for more staff to arrive before entering.

To try to minimise the risk of the man harming himself, an officer asked one of the cellmates to place a pillow underneath the man's head. When the cellmate tried to do so, the man leapt up and began assaulting him. This prompted staff to enter the cell at that point and several of them, including the NOO, received injuries. More staff arrived and they were able to restrain the man and take him out of the cell.

When the two nurses in healthcare were contacted, they agreed that one (the first nurse) would go to houseblock 3. When she arrived in the houseblock she found that the man was already out of the cell and being held to the floor by officers. The first nurse told the investigator that she checked the man's pulse and respiratory rate and both were normal. She then went to treat the man's cellmate for the injuries he had sustained.

Standard treatment for a person suffering a fit is to give rectal diazepam. The first nurse spoke by telephone to the second nurse asking her to bring rectal diazepam to the wing. When the second nurse checked the drug stocks she could not find any supplies of this medication. There were, however, supplies of injectable lorazepam (both lorazepam and diazepam come from the benzodiazepine family of drugs and provide similar effects). The second nurse had earlier sent out a pager message for the out-of-hours on-call doctor and, while waiting for him to ring back, she went to houseblock 3. When she arrived she checked the man's pulse and respiration. Both

[1] There are two nurses on duty in Belmarsh at night-time. The prison holds just over 900 prisoners.

[2] The Night Orderly Officer is the officer in charge of a prison at night-time.

were elevated, but that would be expected given that he had been struggling against the officers. (The first nurse also said that she checked the man's pulse and respiration but neither nurse made any record of the readings.) The second nurse said that she told officers that the man needed to be taken to healthcare.

Records made at Belmarsh show that staff began taking the man to healthcare at about 3.28am. This was around 30 or more minutes from the time he had been brought out of the cell. Staff said that for most of this time the man had gone through periods of fitting, periods of sleep and periods of fighting. The officers carried the man to healthcare under control and restraint. As the term implies, control and restraint is a well-practised set of techniques used for controlling and carrying violent and/or un-cooperative prisoners.

When they arrived in healthcare the man was taken to the Intensive Care Suite (ICS). This was a cell designed specifically for holding prisoners deemed at high risk of self-harm and therefore requiring a high level of visual checks. The cell was of standard size (10' 5" x 6') but fitted with a solid bed plinth running across the width and at the back of the cell. Officers kept the man under restraint in the ICS while waiting for a decision about his clinical care and treatment.

The on-call doctor telephoned Belmarsh to discuss with the second nurse the treatment options. They agreed that the man should be given an injection of lorazepam and the second nurse administered the injection at about 3.45am. Once the injection had been given, first the second nurse and then the officers left the cell. There are set procedures for officers to leave a cell safely when dealing with a potentially violent prisoner. The physical layout of the ICS meant that the only way for officers to follow safe exit procedures was to place the man in a kneeling position facing the cell bed with his back to the cell door. The man's head was placed resting to one side on the mattress. Once staff left the cell he was checked by staff looking through the observation flap. A number of the officers refer to observing the man on at least one occasion. Staff said that the man had a patch of blood on his shirt that had probably come from his injured cellmate. They could see the patch rising and falling as he breathed.

Meanwhile, the first nurse sat in the nursing room where she could observe the dormitory room where the injured cellmate had been located. She could also watch a television monitor linked to various in-cell cameras, including a camera in the ICS.

At about 4.40am, the second nurse told officers that the lorazepam should have had an effect and that it was now time to go into the ICS to make the man more comfortable by putting him onto the bed. When staff lifted the man onto the bed they found that he was not breathing. Attempts were made to try to resuscitate him and an emergency ambulance attended and took him to outside hospital. Unfortunately, all efforts proved unsuccessful and the man was pronounced dead later that morning.

The investigations conducted following the man's death included obtaining expert opinion from five clinicians and a forensic scientist. These opinions are summarised more fully later on in this report. However, in brief:

- the injection of lorazepam did not cause or contribute to the man's death

- the Consultant Pathologist gave the man's cause of death as asphyxia following an epileptic fit with left ventricular failure

- another Consultant Pathologist instructed by solicitors acting for the man's family concluded that the cause of death was multi-factorial with contributing factors being epilepsy, the struggle and restraint and the position in which the man was placed in the ICS.

The man was young and in seeming good health, apart from his apparent recent history of fits. He died on a day in January 2005 and was clearly unwell that morning. This investigation has found that the ICS was both an inappropriate and inadequate facility for dealing with a person with the man's needs. One of the deficiencies was a fault with the CCTV recording equipment. The clinical review has also raised concerns about the ability of the nurses to manage the man's needs.

I believe that such an extended period of struggling with control and restraint lasting well in excess of 30 minutes should have led to nursing staff considering very carefully whether the man may have reached a state of complete exhaustion and whether transfer to outside hospital was appropriate. It is not clear whether admission to hospital would have prevented the man's death, but it is clear that the clinical monitoring when he was in the ICS was inadequate.

THE INVESTIGATION PROCESS

1. In all cases of a death in prison custody the police visit to conduct an immediate investigation. In the man's case the police concluded that the circumstances surrounding his death should be submitted to the Crown Prosecution Service (CPS) for consideration of possible criminal charges. The police instructed that my investigation be suspended pending a decision by the CPS.

2. More than two and a half years after the man's death, my office was informed that the CPS had decided that there would be no criminal prosecution. My investigation officially began on 20 September 2007.

3. Because of the complexity of the issues and the number of professionals who had assessed the man's clinical care, I decided to appoint a clinical reviewer who was wholly independent of the prison. The clinical reviewer was an Assistant Director of Nursing at a hospital outside of the area. The man's sister, his acting next-of-kin, and her solicitors agreed to this approach. Greenwich Primary Care Trust, who would ordinarily have been required to conduct the review, were informed of this arrangement.

4. My officer was given access to the majority of the documents collected by the police during their investigation. This included the transcripts of their interviews with all the staff who dealt with the man on the night of his death. My investigator and the clinical reviewer interviewed nine of these staff for further clarification of certain issues. They also interviewed Belmarsh's Head of Healthcare.

5. My investigator and one of my family liaison officers met the man's sister and her solicitors. On a separate occasion, my investigator and the clinical reviewer met the man's sister (with her solicitors) for further clarification of her concerns. The man's sister is a nurse and her concerns focussed, in particular, on the nursing care provided to her brother. She pointed out that her brother had had two previous episodes of violent fits and she could not understand how he came to be in a shared cell in January 2005. She said that she had been given differing versions about the sequence of events as they occurred that night and she wanted to know clearly what occurred from beginning to end. She also wanted to understand about the nursing care her brother received, including the taking of clinical observations, how the nurses could have properly monitored her brother once he was locked into the cell in healthcare, what further support was available to the nurses that night, and why her brother was not transferred to outside hospital. The man's sister was also distressed about the delay in being notified about her brother's death, and that she was given the news over the telephone.

6. When the draft version of this report was sent to the man's sister her comments included questioning of the way her brother was carried to healthcare. She thought that his breathing may have been compromised given that his body was in a slumped position. She wondered whether it would have been better for staff to have used a trolley. A matter raised by her solicitors was to question

whether it was sufficient to have two nurses on duty at night for a prison holding over 900 prisoners.

HMP BELMARSH

7. HMP Belmarsh is a modern local prison, serving primarily the Central Criminal Court and Magistrates' Courts in South East London. Belmarsh holds just over 900 prisoners in total. Around 40 percent of the cells at Belmarsh are single cells. The other 60 percent are multi-occupancy cells.

8. Belmarsh received a full announced inspection from Her Majesty's Chief Inspector of Prisons (HMCIP), Ms Anne Owers, in May and June 2003. In the introduction to her report, Ms Owers wrote:

> "HMP Belmarsh is a core local prison, and one of the most complex in England and Wales. It holds a highly diverse population: ranging from 18 year olds awaiting trial for minor offences, to some of the most serious and high risk adult offenders … it is having to cope with the effects of overcrowding [with most prisoners] being held two or three to a cell."

9. In October 2007 Belmarsh received another full announced inspection from HMCIP (this report was not released until after the issue of the first draft version of my report). Under a section entitled "Clinical governance" Ms Owers wrote:

> "Every prisoner had a clinical record, but we found examples of poor record keeping …"

10. In its annual report for the period July 2004 to June 2005 the Independent Monitoring Board (IMB) at Belmarsh wrote:

> "There is approximately a 25% vacancy factor in the nursing establishment … necessitating an expenditure … on overtime payments and agency staff. Following a recruitment campaign 5 nurses were offered posts. However, this was at a time when there was a moratorium on recruitment and although Health Care was actually excluded from that moratorium, due to an unfortunate error the appointments were not substantiated and the vacancies remain."
>
> "Healthcare is one of the Board's major concerns within the prison."

KEY FINDINGS

Events leading up to the night of the man's death

11. In June 2004, the man was arrested and charged with a very serious offence connected with incidents that had occurred outside a public house in East London the previous day. The man was taken into police custody.

12. While still in police custody, the man was taken to Stratford Magistrates' Court where he was remanded into HMP Pentonville. On 15 June, the man attended court for a preliminary hearing and from there he was remanded into HMP Belmarsh. During his initial health screening at Belmarsh, the man reported having no significant medical problems. Nor had he reported any significant medical problems during health screening at Pentonville.

13. On the morning of 7 July, the man suffered two fits each lasting three or four minutes. A prison doctor examined him and referred him to Queen Elizabeth Hospital for assessment and advice. In his referral letter, the doctor noted that the man had no history of epilepsy. The man had at least one further fit either in hospital or on his way there in the ambulance. He remained in hospital overnight and he returned to Belmarsh the following day. The discharge summary noted that there was no planned follow-up, but if the man were to have any further fits he should be referred to the hospital's neurology team.

14. On 25 October, the man suffered a further series of seizures in his cell and was transferred to the healthcare unit. The man had further fits in healthcare and he was given rectal diazepam. A note in his clinical records states: *"… experiences fits followed by extreme violence requiring restraint [by four officers and use of handcuffs]".* The man was again sent to Queen Elizabeth Hospital.

15. Having remained in hospital overnight, the man returned to Belmarsh the following day. The discharge summary from Queen Elizabeth Hospital said:

> "Patient has refused all investigations and treatment for his seizures. He has been informed of the risk of such decision but states wants nothing done. We respect his wishes and have not initiated any management."

16. On his return to Belmarsh, the man remained for a period in healthcare. An entry in his clinical records made on 27 October said: "Doesn't remember his previous fits and states he just wants to go back to the houseblock. Appeared confused by his situation."

17. A care plan drawn up for the man on 31 October included a plan to minimise the risk to him, as well as staff and other prisoners. The action taken to achieve this was to locate him in a single cell (the healthcare unit at Belmarsh includes some dormitory accommodation).

18. An entry in the clinical records made on 3 November said: *"[The man] reported feeling worried about his fitting episodes stating 'I want to get better.'"* By this

time the man had been prescribed Epilim (a medicine used in treating various forms of epilepsy).

19. On 10 November, a note was made in the man's clinical records that he had: *"… remained stable on medication, no further fits, is able to return to [standard location] …"* An in-patient unit exit plan drawn up the same day included an assessment by the receiving houseblock manager. He indicated that the man should be allocated to a shared cell. The housblock manager told my investigator that he could not recall carrying out the assessment. However, in the case of a prisoner with a history of fits it would usually be preferable to put him in a shared cell. The danger, otherwise, could be of him having a fit when alone in a cell. In that situation there is always a possibility of the prisoner swallowing his tongue. The houseblock manager added that he would always place in a single cell a prisoner posing a risk of violence against other prisoners.

20. The man left healthcare later that day and was located on houseblock 1. On 29 November, the man was moved to houseblock 3 and located into cell 3-24. Cell 3-24 is a three bed cell.

The night of the man's death

21. At 2.48am one of the man's cell-mates pressed the cell call bell because the man was having a fit. The night duty officer in houseblock 3 went to the cell, looked in and saw what was happening. She then ran back to the wing control centre (referred to by staff as the 'bubble') to telephone for assistance. She contacted healthcare to say that the man was having a violent fit and that a nurse was required. She also telephoned the Night Orderly Officer (NOO) to report the same thing to her, and to advise that the man was in a three man cell so dog handlers were needed for when the cell was unlocked.

22. The NOO with two officers were the first to arrive in the wing. The NOO said that she knew the man because she had been the Orderly Officer in October 2004 when he previously had an episode of fitting. She said that what happened then was that the man would have a fit, followed by an episode of violent behaviour, and then fall asleep. That pattern repeated itself several times in succession on that occasion. The NOO said that the man was clearly unaware of what he was doing.

23. The NOO said that, when she arrived in houseblock 3 on this occasion she looked into the cell and saw the man lying on the floor. Because of what she had witnessed two months earlier, she did not intend to unlock the cell until the arrival of more staff, including dog handlers. One of the cell-mates was standing near the cell door and the NOO told him that staff would be coming into the cell shortly. The NOO then spoke with the night duty officer about her plans for dealing with the situation.

24. While the NOO was talking with the night duty officer, one of the other officers went to the cell door and spoke to one of the cell-mates. She asked him to place a pillow underneath the man's head to reduce the risk of him injuring

himself. As the cell-mate attempted to do so, the man began assaulting him. Out of concern for the cell-mate the NOO and two officers went into the cell. The time was 2.54am. Two more officers arrived on the wing shortly after and they also went into the cell.

25. The man was brought out of the cell. For around the next 35 minutes he apparently suffered a series of fits when he would struggle violently. Interspersed with the fits were periods when the man would fall into a more relaxed state. More officers arrive and assisted with trying to control the man. Two dog handlers were also present although they were there for general matters of security and did not have any direct involvement with the man. Several of the staff were injured in the struggle, including the NOO.

26. There were two nurses in Belmarsh that night. Both were in the healthcare unit when the request was received for nursing support in houseblock 3. The second nurse asked the first nurse to go to the houseblock as she (the second nurse) was collecting the clinical records for prisoners due for adjudication hearings[3] the following day. When the first nurse arrived in houseblock 3 she found the man being restrained on the landing outside his cell. The man was lying front down with his head to one side. The NOO briefed the first nurse about what was happening and about the man's previous history of fits.

27. The first nurse checked the man's pulse, timing it against her watch. She told the investigator his pulse was a normal rate of 70 beats per minute. The first nurse also listened to the man's breathing which was also normal. She did not have the man's clinical notes with her so did not make a record of her clinical observations. The first nurse said that the man was not fitting at this time. However, he was a little bit agitated and was struggling against the restraint. The first nurse told the man that she was a nurse and he grunted in reply. She asked an officer to get the pillow from the man's bed and she placed that under his head. At this stage the first nurse tried to telephone the second nurse in healthcare to tell her what was happening. The first nurse could not get an answer from healthcare so asked the control room to contact the second nurse to ask her to phone houseblock 3. While waiting for the second nurse to call, the first nurse briefly checked the cell-mate who had been assaulted by the man. He had some bleeding from wounds on his face and head but they appeared superficial. As an interim measure the first nurse wrapped a towel around his head and asked him to apply pressure to staunch any further bleeding.

28. In her interview, the NOO said that she asked the first nurse if the man could be moved to healthcare, but the first nurse did not respond. The NOO said that there was a lot going on in the wing with the three prisoners, and she did not feel that she was getting the advice she needed from the first nurse.

29. When the second nurse rang the houseblock, she and the first nurse spoke about the man's treatment. They agreed that he should be given rectal

[3] Adjudication hearings deal with alleged infringements of prison rules.

diazepam as this is standard treatment for a person suffering an epileptic fit (this is what the man was assumed to be having). The second nurse went to the drugs storage cabinet but she could not find any rectal diazepam[4]. She then made a pager call to the out-of-hours on-call doctor. Records show that the pager call was sent at 3.10am. She also located the man's clinical records. When the second nurse checked the man's records she realised that he was the same prisoner who had had an episode of fitting and violence some weeks before. On that occasion, the second nurse's involvement in the man's care had been with his treatment in healthcare after his return from Queen Elizabeth Hospital.

30. The second nurse went to houseblock 3 to give assistance. When she arrived she saw the man face down on the floor being restrained by several officers. The second nurse checked the man's pulse and respiration. His pulse was around 96 beats per minute and his respiration about 27 breaths per minute. She said that these are elevated scores, as would be expected when a person has been struggling. The second nurse told officers that the man needed to be taken to healthcare. As the doctor had not responded to the pager call, the second nurse sent a second pager call at 3.20am.

31. At around 3.28am, staff set off to take the man to healthcare. He was carried by staff using control and restraint techniques. It seems that staff dismissed the option of using a trolley because of the difficulties and dangers if the man were to struggle while on the trolley. Much of the move was captured on closed circuit television (CCTV). The CCTV footage shows the man being carried face up with his arms handcuffed behind his back. Each of the man's arms and legs was held by an officer, while a fifth officer supported his head. The footage shows the second nurse walking alongside. The second nurse said that as they went she spoke to the man several times to ask him how he was. The CCTV footage supports this. The second nurse said that she also checked the man's pulse again and it was somewhere in the 90s (as with the previous reading). The CCTV footage also shows the first nurse walking behind with the injured cell-mate who was being taken to healthcare for further treatment. The CCTV record indicates that it took around three to four minutes to make the journey.

32. On arrival in healthcare, the man was taken into a cell known as the Intensive Care Suite (ICS). This is a cell designed for holding prisoners who are at increased risk of self-harm. Its design features include a reduced number of ligature points and an in-cell video camera. To help reduce ligature points further, the ICS does not contain a bedstead. Instead, the cell has a solid plinth of the same length and width as a bedstead with a mattress placed on top. The plinth is at the back and across the width of the ICS. Officers maintained their hold on the man while waiting to hear from the nurses about his care and treatment.

[4] When the drugs cabinet was checked after The man's death it was found to contain a stock of diazepam.

33. The doctor told the investigator that, when he was woken by the pager he saw there had been two pager calls. The first call had failed to wake him. He telephoned Belmarsh and spoke to the second nurse. She told him that the man had had a fit and that he was now in the ICS. She said that the man was still very agitated and also that there was no rectal diazepam. The doctor told her to give an intramuscular injection of two milligrams of lorazepam to calm the man. The doctor said that there was nothing about the conversation to cause him to feel any concern. The doctor and the second nurse did not discuss the option of sending the man to outside hospital. The doctor said that, in general, a transfer to hospital at night time would be initiated by the nurses and they would not even bother to telephone the doctor to ask for permission. Instead, they would simply phone for an ambulance.

34. Once the doctor had confirmed the treatment plan, the second nurse collected the medication, gave the injection and left the cell. The second nurse said that she took one more set of observations of pulse and respiration at around this time. The man's pulse and respirations were much the same as they had been before. The second nurse said that she did not think at the time that the man needed to be transferred to outside hospital: he had been given lorazepam and he was responding to questions with grunts.

35. Officers were still present and still restraining the man. Control and restraint procedures include techniques for officers to safely exit cells. A Senior Officer (the SO) told my investigator that the plinth, which lies crossways at the back of the cell, does not allow staff to exit safely when dealing with a potentially violent prisoner. Correct exit techniques require the final two officers to leave the cell being able to stand either side of the prisoner's back up until the final second. The SO said that the man had used up a vast amount of energy during the earlier struggle. To place him on his chest on the mattress would have carried the risk of positional asphyxiation. But to have placed him on his back would have made it difficult for staff to safely exit the cell in the case of the man jumping up to assault staff. The SO decided therefore to put the man in a kneeling position up against the side of the plinth with his head resting, to the side, on the mattress (which meant that his back was facing the door). The SO said that he checked that the second nurse was content with the man's position. At this point, officers left the cell and locked the door. The time was then around 3.45am.

36. The door observation hatch was lowered and staff were able to look through to check the man. No records were made of the frequency of checks, but at interview most of the staff said that they looked through the hatch on one or more occasions. The NOO said she looked into the cell the moment after staff had exited. She might have checked the man on one more occasion but she was not certain. An officer said that he looked into the cell once, within ten minutes of the cell being locked. Another officer said that he checked the man once and this was five to ten minutes after the door was locked. A third officer said that he checked the man twice but he could not estimate the timings. The SO said that he looked into the cell on two or three occasions all within 20 or 25 minutes of the cell being locked. The second nurse said that she looked through the hatch many times throughout the time the man was in the cell. She

also said that she spoke to the man through the hatch and he grunted in response. Most of the staff said that they could tell that the man was breathing as they could see the rise and fall of a patch of blood on the back of his shirt (the blood had probably come from the injured cell-mate).

37. The first nurse said that, after arriving in healthcare, she took the injured cell-mate to the treatment room to dress his wounds. He was then located into ward-room 1 – a multi-bed dormitory room. The first nurse went to the healthcare office. The office is equipped with a monitor linked to several in-cell cameras including the camera in the ICS. The equipment has movement sensors so the monitor will draw the viewer's eye to any movements. The first nurse said that she decided to remain in the healthcare office as her position there enabled her to look at both the man on the monitor and at the injured cell-mate in ward-room 1 (ward-room 1 has toughened glass panels allowing for easier observation of its patients). The first nurse said that she was not content with the man's position as she could not see his face. However, she did not mention her concern about this until just before staff went back into the cell.

38. It was at about 4.40am that the second nurse told officers that the lorazepam should have had an effect and that it was time to go into the cell to put the man onto the bed to make him more comfortable. The second nurse went into the cell together with the NOO and three other officers. When the man was lifted onto the bed the staff realised that he was not breathing. Staff attempted cardio pulmonary resuscitation (CPR) and an emergency ambulance was requested. Staff continued with their efforts to try to resuscitate the man until they were relieved by the ambulance paramedics at 4.54am. The man was taken to outside hospital where he was pronounced dead at 5.40am.

After the man's death

39. The man had not provided any information about his next-of-kin when he arrived in Belmarsh. However, his records contained the names and addresses of two potential relatives and directory enquiries were contacted for telephone numbers. Directory enquiries were unable to help, so Belmarsh began ringing the numbers listed in the man's prison telephone records[5]. One of those listed turned out to be the man's sister. When she answered the telephone she was told about her brother's death. This was at 12.40pm. An unsigned and un-attributed note made at Belmarsh said that the first choice would have been for prison chaplains to visit to break the news in person. However, because it was a Bank Holiday none could be contacted.

40. Following the issue of the draft version of this report the author of the unsigned, un-attributed note mentioned above was identified to be one of Belmarsh's chaplains (although he now works elsewhere). The chaplain told my investigator that as best as he could recall he was not entirely certain that the person listed was the man's next-of-kin, but if not she would be able to provide that information. He said that he telephoned a prison close to the address to

[5] Prisoners use a PIN number when using the prison telephones so details are recorded of all calls made (as with an itemised private telephone bill).

ask for a chaplain to visit the house, but there were no chaplains in the prison. He also tried the parish chaplaincy for the area, but again no chaplains were available. The chaplain was conscious of the time that it would have taken to cross from one end of London to the other and he was worried that in the meantime the news of the man's death would have been released by the media. It was for that reason that he decided to telephone.

THE MAN'S CAUSE OF DEATH

41. Following the man's death a post mortem was carried out by a Consultant Forensic Pathologist. Additional clinical opinion was provided during the course of the consideration of possible charges against any of the staff. The other clinicians who gave opinions were Professor of Neurology and Clinical Epilepsy, a Professor in A&E medicine, a second Consultant Forensic Pathologist and a Consultant Home Office Pathologist.

42. A Forensic Scientist for the Metropolitan Police carried out examinations of the man's blood and urine. The examinations detected no presence of lorazepam in the man's blood sample. The Forensic Scientist explained that, in the case of an injection of two milligrams of lorazepam intramuscularly into the buttock, he would expect the drug to be detectable in the blood within 15 to 30 minutes.

43. These findings mean that the man died within 30 minutes of the injection being given. The findings also mean that the lorazepam did not cause or contribute to the man's death.

44. The Consultant Forensic Pathologist conclusions included:

> "There was evidence of asphyxial type changes and in my opinion the most likely sequence of events was a degree of left ventricular failure following [The man's] fit and violent behaviour aggravated by restraint that has compromised his airway. I give the cause of death: 1a. Asphyxia following epileptic fit with left ventricular failure and restraint."

45. The Professor of Neurology and Clinical Epilepsy referred in his report to SUDEP (Sudden Unexpected Death in Epilepsy) and concluded that, on the balance of evidence and in the absence of other causes, SUDEP was the most likely cause of death.

46. The Professor in A&E medicine explained in his report that lorazepam is a well-known drug closely related to diazepam and that either of the two drugs can be used in the control of excitable, violent or epileptic patients. The Professor expressed surprise that the man was left in the kneeling position, saying that it would have been more appropriate to have placed him lying on the bed in the recovery position. In considering the cause of the man's death, the Professor explained that the extreme violence that the man displayed resulted in him using up an extreme amount of energy. This would probably have resulted in a marked rise in body temperature leading to a further increase in his body's demand for oxygen. As a consequence, his heart was not able to keep pace with his body's demands for oxygen and energy. This led to the man developing left ventricular heart failure.

47. The second Consultant Forensic Pathologist and commented that:

> "Asphyxiation, especially during restraint, does not have to be an all or nothing process. Asphyxiation occurs when the body is not able to obtain sufficient oxygen for its current needs … Asphyxiation can occur with

minimal obstruction to the airways when an individual has a high oxygen requirement."

48. The second Consultant Forensic Pathologist and also commented that leaving an individual kneeling allows the chest to function correctly and is one of the positions advised following restraint to allow for unhindered breathing. Having considered all the evidence he concluded:

> "The events surrounding [the man's] death are well established but it is not possible to determine which, if any, of these many events may have played a part in his death and which, if any, can be excluded. Based on the material available to me it is not possible to determine with any degree of certainty the cause of death of …"

49. The Consultant Home Office Pathologist was instructed by Hickman and Rose Solicitors (solicitors for the man's family). He reviewed the reports from all of the other clinical experts before setting out his own opinions:

> "Deaths can occur following restraint. This may not be immediate. During a struggle body chemicals involving the 'fight' or 'flight' reaction are released. These chemicals which include adrenaline and nor-adrenaline sensitise the heart and may lead to an abnormal rhythm occurring. This is more likely in a person with a vulnerable heart. No obvious pre-existing heart disease was identified in this case. Heart failure is a mode of death rather than a specific cause of death. If someone is placed in a vulnerable position, breathing may be compromised. The placing of a person in a kneeling position could result in a degree of compromisation of the airway if not fully conscious … Overall, the cause of death is likely to be multi-factorial … including epilepsy and the struggle, position placed in and the restraint."

ISSUES

Should the man have been in a three man cell?

50. On arrival in prison all prisoners receive a cell sharing risk assessment. This procedure is aimed at ensuring that the particular prisoner is safe to share a cell. This is both in terms of his/her safety and the safety of potential cellmates. Whenever there is a change in circumstances, a review of risk should be undertaken. In the man's case, there was no reason on first arrival in Belmarsh for him not to be deemed suitable to share with others. However, on 25 October 2004, the man suffered a series of fits each of which was followed by an episode of extreme violence. The man had to be restrained by a number of officers and by use of handcuffs. After spending the night in outside hospital, he returned to Belmarsh and for several days remained in the healthcare unit. On 31 October, a care plan drawn up for the man in healthcare included that he should be located in a single cell (the healthcare unit in healthcare has dormitory accommodation as well as single cells).

51. The man remained in the healthcare unit until 10 November. On that day he was found fit for discharge to standard location and in preparation for that a healthcare in-patient exit plan was drawn up. The plan included locating the man into a shared cell. The houseblock manager who made that decision was unable to recall assessing the man that day. He said, however, that in the case of a prisoner with a history of fits it was preferable to place him in a shared cell. His cell-mates would be available to provide potentially life saving assistance in the case of further fits. However, he would not usually place in a shared cell a prisoner with a history of violence against other prisoners.

52. By November 2004, the man had suffered two episodes of fitting. The last episode occurred the month before and was described as including extreme violence. The violence, however, was directed against the officers who were trying to restrain the man. No violence was displayed that day against other prisoners. The houseblock manager probably believed that he was making a decision that would serve the man's best interests by placing him in a shared cell. I would not wish to criticise him for that decision.

The control and restraint of the man

53. When the man was brought out of his cell he continued to struggle and for the next 35 minutes staff endeavoured to restrain him. When staff thought it safe to do so, they carried him to healthcare. Although most of the journey from the houseblock to healthcare was captured on CCTV, this was not the case for the initial struggle outside the cell.

54. 'Control and restraint' is the term used for the set of techniques used in controlling prisoners who are violent and/or un-cooperative. There is no suggestion that the man was being deliberately violent or deliberately un-cooperative. Instead, it was his clinical condition that caused such behaviour. Staff were aware of this from the outset, the NOO having witnessed the man's previous fitting episode.

55. Prison Service Order (PSO) 1600 contains guidance and instruction on control and restraint. The latest version of PSO 1600 came into force in August 2005 (that is, after the man's death). Earlier versions of PSO 1600 were silent on the potential dangers associated with prolonged restraint. However, the version issued in August 2005 does refer to these dangers:

> "The amount of time that restraint is applied is as important as the form of restraint and the position of the detainee. Prolonged restraint and prolonged struggling will result in exhaustion, possibly without subjective awareness of this, which may result in sudden death."

I acknowledge the added guidance in the latest version of PSO 1600 but recommend that the Prison Service consider supplementing the guidance with an indication of the period of time beyond which restraint should not continue. To assist in the provision of such guidance the Prison Service may wish to undertake research into the correlation between prolonged restraint and sudden death.

Carrying the man to healthcare

56. When staff decided that it was time to move the man to healthcare, they carried him using control and restraint methods. The man's sister, a trained nurse, was concerned that the way her brother was carried may well have compromised his breathing (the CCTV footage shows the man being carried face up with his body in a slumped position). Her view was that more thought should be given to carrying the patient on a trolley, especially if they can be placed in the recovery position. In that situation there would be less likelihood of compromising the patient's breathing, especially when they have been under restraint for a long period before that.

57. I believe that staff made the right choice in deciding to carry the man to healthcare. Their evidence was that the man continued to struggle during the journey to healthcare. Had the man been on a trolley, his safety and that of the staff would both have been compromised. I am also satisfied with the way in which the staff conducted the carry. I reach that conclusion based upon my own viewing of the CCTV footage and based upon the opinion of a Control and Restraint national Prison Service instructor who advised the CPS during their deliberations.

Rectal diazepam and lorazepam

58. As the man was believed to be having an epileptic fit, the second nurse went to get some rectal diazepam. However, she could not find any stocks in the drugs cabinet. When the doctor subsequently rang Belmarsh in response to having been paged, the second nurse told him that there was no rectal diazepam but there were supplies of lorazepam. They agreed that the man should be given an injection of this drug instead.

59. The Professor in A&E medicine, one of the clinical experts who commented on the man's cause of death, has explained that lorazepam and diazepam are closely related and either can be used in treating an excitable or violent patient. Toxicological investigations following the man's death showed that he died before the lorazepam had been absorbed into his blood stream. This means that the lorazepam did not either cause or contribute to the man's death. Nor would it seem that the failure to give rectal diazepam had any bearing on the man's death. Even so, I am concerned that the second nurse was unable to find any rectal diazepam (an emergency medicine). Belmarsh's Head of Healthcare said in interview that the pharmacist had checked the drugs cabinet following the man's death and found that it did contain a stock of rectal diazepam. With the passage of time, I am clearly unable to resolve this discrepancy.

I recommend that the Governor and Head of Pharmacy satisfy themselves on the adequacy of arrangements for stocking and restocking the drugs cabinet *as* well as the arrangements for monitoring of stock.

The Intensive Care Suite

60. Once the lorazepam injection had been given, staff left the man in the ICS. He was kneeling, facing the bed with his back to the door and with his head resting to one side on the mattress. The second Consultant Forensic Pathologist, another of the experts who commented on the man's death, explained that leaving a person in the kneeling position allows the chest to function correctly. However, the Consultant Home Office Pathologist considered that the kneeling position could compromise a person's airway to some extent if they were not fully conscious. The Professor in A&E medicine has pointed out that it would have been better to have placed the man lying down in the recovery position.

61. The man's sister's response to the first draft version of this report was to further question the implications of leaving her brother on his knees. The problem that staff faced in choosing how to leave the man was that the design of the ICS does not easily allow staff to follow correct and safe exiting procedures when dealing with a potentially violent prisoner. Staff needed to exit the cell safely and regardless of the design of the cell they had few options in choosing how to position the man. Had they placed him chest down on the floor that would have put him at very obvious risk of positional asphyxia. Staff recognised the danger of that and decided instead to leave him positioned on his knees. In doing so, none of them believed that they had compromised the man's safety. **In light of this report the Prison Service may wish to review cell-exit procedures that maintain safety for both the prisoner and the staff, in particular whether prisoners should be left in the kneeling position.**

62. Having left the cell, staff kept a watch on the man by looking at him through the observation panel. Most of the staff said that they looked into the room on one or more occasions. Although staff could only see the man's back, they referred to a patch of blood on his shirt that they could see rising and falling as he breathed. Meanwhile, the first nurse was in the healthcare office observing the monitor linked to the in-cell camera in the ICS.

63. The timings for most of the events of that morning can only be estimated. It would seem though that the lorazepam injection was given at about 3.45am, and almost immediately after that staff left the cell. Almost an hour then passed by before staff went back into the cell at about 4.40am. Examination of the man's blood and urine led the forensic examiner to conclude that death occurred within 30 minutes of the lorazepam injection being given. That would mean that death occurred at 4.15am at the latest. That in turn means that there would have been no visible signs that the man was breathing for 25 minutes or more before the cell was re-entered.

64. When two of my investigators visited Belmarsh shortly after the man's death they found two problems with the monitoring equipment. When they tested the equipment, they found that the picture on the monitor remained static if the person in the cell made only slow movements. The other problem was to do with the video recorder that should have captured all the images. My investigators were told that when the video tape was checked by the prison and the police it was found that nothing had been recorded.

65. The Head of Healthcare said that following the man's death the ICS was decommissioned as it had often been used in inappropriate circumstances. He said that staff followed practice at the time in using the ICS, but the cell was not designed for a prisoner with the needs and problems that the man was presenting on that day. I am pleased that the ICS will no longer be used in similar circumstances and so have made no recommendation.

The man's clinical care and treatment

66. Several of the staff who were involved in dealing with the man were aware of the previous occasion when he had had a series of fits, each followed by an episode of apparent involuntary violence. On that previous occasion, the man was taken to outside hospital and recovered without seemingly suffering any ill effects. It seems likely that staff assumed or expected a similar outcome on this occasion. There was no explicit discussion between the second nurse and the doctor about whether the man needed to be sent to outside hospital although neither, it seems, believed that there was any indication for that course.

67. The Head of Healthcare, who is a nurse by profession, said that the difficulty in dealing with a situation such as the man's is that there is no other healthcare situation where nurses would not be physically present with a patient suffering periods of unconsciousness. His view is that, if it is not possible to have a nurse present with the patient, the patient should not be kept in a prison setting until the concerns have been dealt with.

68. The Head of Healthcare raises an interesting point. Most prisons have healthcare units with accommodation for patients comprising cells that are to all intents and purposes standard prison cells. Cell doors are usually kept locked most of the time and almost always kept locked through the night. The question that prison doctors and nurses need to ask themselves is whether the

patient's clinical condition is one that can be managed safely given these requirements.

69. The clinical reviewer has expressed concern about the ability of the nurses in managing the situation. In her review, she concluded the clinical staff were slow in taking charge of the situation and that the first nurse was not competent to deal with the difficulties posed in managing a clinical emergency. The clinical reviewer further concluded that record keeping and medicines management were generally poor. She has also referred to the lack of clinical decision making by the healthcare professional involved, including the fact that there was no discussion about a possible transfer to the local acute hospital. Having made those criticisms, the clinical reviewer has referred to the expert clinical opinions briefly summarised earlier in this report. She has indicated that even with all appropriate interventions and acute hospitalisation, the man's death might still not have been prevented given the time it would have taken for him to reach hospital.

70. In my view, there should have been a formal discussion between the nurses and the doctor about whether the man should have gone to outside hospital with a record made of the decision. (The clinical reviewer has made a recommendation about an escalation policy around transfer to outside hospital and another about record keeping.) And I link this finding back to my previous reference to the guidance contained in the current version of PSO 1600 and my recommendation on supplementing the guidance.

71. One of the issues raised by the man's sister was the taking of clinical observations. Neither of the two nurses recorded observations but both said at interview that they had taken such observations up until closing the cell door. Some, but not all, of the officers said that they saw the nurses taking observations. Whether clinical observations were taken is not a matter upon which I feel able to judge conclusively. However, no recording of any observations were made. Again, the clinical reviewer has made a relevant recommendation.

Nursing cover at Belmarsh at night time

72. Belmarsh has two trained nurses on duty at night time. The prison holds just over 900 prisoners. The solicitors acting for the man's family questioned whether that is an adequate staffing level. There is no set process or formula for calculating the number of trained nurses that a prison should have on duty at night time. Instead, the staffing level is at the discretion of the individual prison. However, I can say that Belmarsh has similar nursing cover at night time when compared to similar prisons. I can see no grounds to conclude that this is an inappropriate staffing level.

Contact with the man's family following his death

73. The man's sister and next-of-kin was distressed about being told of her brother's death by telephone. I understand her feelings entirely. However, Belmarsh held no next-of-kin details for the man so details of his visitors and

records of his telephone contacts were used to identify the likely family members. This resulted in the telephone call to his sister. A note detailing the contact with the man's family explained that the preferred option would have been for prison chaplains to visit her in person but as it was a Bank Holiday no chaplains were available. Following issue of the draft version of this report I discovered that the person who telephoned the man's sister was a chaplain at Belmarsh. The comment that "no chaplains were available" referred to there being no chaplains available either at a prison close to the sister's home, nor in her local parish. Due to the time it would have taken him to travel from one side of London to the other, the chaplain thought it best to telephone her.

74. As the man was young staff at Belmarsh should have expected that the news of his death would come as a complete shock to the family. Even if no prison or parish chaplains were available anywhere close to the man's sister's home, the news should still not have been broken by telephone. In the first instance Governor grade staff from a nearby prison should have been asked to make the visit. If that proved too difficult to arrange, the local police should have been asked. Since the man's death more detailed guidance and instruction has been issued by the Prison Service for dealing with this sensitive and difficult matter.

75. The man's sister was also upset about the length of time it took for her to be told the news (she was not told until after midday). The man was officially pronounced dead at 5.40am. It does seem a little surprising therefore that contact details for the family were not collected rather sooner. The man's sister told my Family Liaison Officer that it was only through the Coroner's office that she discovered that the prison should offer to pay funeral expenses. It may be that policy and practice at Belmarsh has moved on since January 2005. However, I would remind the Governor that families should always be informed that the prison will meet reasonable funeral expenses.

I recommend that the Governor ensures, in the case of all deaths in custody, that the prisoner's next-of-kin are informed in an appropriate manner and with the minimum of delay. An offer of funeral expenses should always be made.

Treatment and support of staff

76. Several Belmarsh staff complained to my investigator about the way they were dealt with following the man's death. They said that their clothing was confiscated by the police and they were supplied with ill fitting clothing and footwear by the prison. They had to make their own way home, using public transport, in this replacement clothing. Staff also felt unsupported in the days and weeks following the man's death.

77. Although it is extremely unusual, I can understand why the police took possession of the clothing in this case. The police would have been briefed on first arrival in Belmarsh that the man had been restrained for a considerable amount of time shortly before his death. As a result, they had to consider the possibility that staff might have been culpable and take appropriate precautions to safeguard anything that could constitute potential evidence.

78. It was reasonable, however, for staff to have expected support from their employer. In the circumstances, I consider it would have been appropriate for staff to have been sent home by taxi. More importantly, arrangements should have been made for the staff to have received full and on-going support from the prison care team. The circumstances surrounding the man's death were undoubtedly exceptional. Even so, I would remind the Governor that, in the case of any future deaths at Belmarsh, staff have a right to be treated in a manner that complies fully with the requirements set out in the relevant Prison Service Orders.

RECOMMENDATIONS

I make the following three recommendations:

1. I recommend that the Prison Service consider supplementing the guidance in PSO 1600 to include an indication of the period of time beyond which restraint should not continue. To assist in the provision of such guidance the Prison Service may wish to undertake research into the correlation between prolonged restraint and sudden death.

   Prison Service response – Response to follow.

2. I recommend that the Governor and Head of Pharmacy satisfy themselves on the adequacy of arrangements for stocking and restocking the drugs cabinet as well as the arrangements for monitoring of stock.

   Prison Service response – recommendation accepted. Comprehensive arrangements are in place to check medicines stock and re-order appropriately in all clinical areas. Clinical managers and Charge nurses are responsible for the clinical audit of all related policies and procedures. Clinical audits are monitored within the Drug and Therapeutic Committee and Clinical Governance Committee.

3. I recommend that the Governor ensures, in the case of all deaths in custody, that the prisoner's next-of-kin are informed in an appropriate manner and with the minimum of delay. An offer of funeral expenses should always be made.

   Prison Service response – recommendation accepted. The establishment now has five trained Family Liaison Officers. All families since the death in custody of the man have been informed by this method. The establishment has offered to pay funeral expenses in all cases since the man's death.

I also endorse recommendations 4 to 24, which have been drawn from the clinical review:

4. It should be established to what extent the first nurse's knowledge and skills base have developed in the time since the man's death. If appropriate, she should have a period of supervised practice with some clear objectives set. I recommend that she is not left in charge of healthcare at night unless it is demonstrated that she is competent to do so.

   Prison Service response – recommendation not accepted. It is not appropriate to take measures today in relation to an incident three years ago in the absence of supporting evidence that the concerns raised remain pertinent to the first nurse's current performance. In the intervening three years she has completed night duty, covered Hotel 1 and 2, and as far as I am aware, has given no cause for concern, not has any concern regarding clinical competence been raised within her SPDR reviews. In addition, there has been significant joint investment in training and staff development for all trained nurses.

5. Policy on Hotel 1 and Hotel 2 to be revised.

Prison Service response – recommendation accepted. Local policy and procedures revised and implemented.

6. Green bag to be kept on each houseblock to save it being obtained from Healthcare in an emergency situation. Green bag to be obtained for all Hotel calls.

   Prison Service response – recommendation accepted. Included in the revised procedure.

7. Implement a record keeping awareness session for all clinical staff.

   Prison Service response – recommendation accepted. Clinical Record Strategy revised.

   Electronic Medical record system introduced March 2008.

8. Audit to be undertaken of record keeping: recommend using the Essence of Care (Department of Health February 2001) benchmark tool.

   Prison Service response – recommendation accepted. Clinical Audit programme instigated 2007.

9. Clear policy for monitoring acutely ill prisoners. This to include the taking and recording clinical observations: blood pressure, pulse, temperature respirations, and neurological observations.

   Prison Service response – recommendation accepted. All admissions to the inpatient unit receive a holistic nurse led assessment including a record of all baseline physical and mental observations. Secondary referrals are made wherever appropriate.

10. Nursing staff to be trained in the use of oxygen therapy.

    Prison Service response – recommendation accepted. Clinical management of Oxygen therapy is included within the Belmarsh development programme, an assessed clinical training package delivered to all registered nurses working within the prison.

11. Nursing staff to be trained in managing emergency situations.

    Prison Service response – recommendation accepted. Clinical management primary assessment is included within the Belmarsh development programme, an assessed clinical training package delivered to all registered nurses working within the prison.

    All registered nurses required to cover medical response posts receive mandatory training in CPR, use of defibrillator and first aid in the workplace.

12. Electronic medical record system to be implemented to aid easier and more accessible communication.

    Prison Service response – recommendation accepted. INPS Vision installed March 2008.

13. Education and training for nursing staff in the management of long-term conditions.

    Prison Service response – recommendation accepted. Clinical management of long term conditions is included within the Belmarsh development programme, an assessed clinical training package delivered to all registered nurses working within the prison

    A GP led long term condition management clinic was established on a weekly basis in 2007. All nursing staff are required to work as a part of the multidisciplinary team approach to long-term condition management.

14. Regular training updates on emergency situation management. Annual resuscitation training. Training compliance to be audited.

    Prison Service response – recommendation accepted. Training database maintained by Clinical Lead Primary care, including compliance with mandatory training for nurses covering emergency response duties.

15. Policy to be devised on the management of prisoners when they arrive in Healthcare under restraint. This policy to be audited.

    Prison Service response – recommendation accepted. Existing policy to be reviewed and revised (Lead - Head of Healthcare). Work on this is on-going.

16. Full set of observations to be completed on all prisoners immediately on entering Healthcare under restraint.

    Prison Service response – recommendation accepted. Existing policy to be reviewed and revised (Lead – Head of Healthcare). Work on this is on-going.

17. IMR documentation to be revised to incorporate entries from multi-disciplinary team.

    Prison Service response – recommendation accepted. INPS Vision installed March 2008.

18. Intensive Care Cell to be decommissioned for all prisoners regardless of their condition.

    Prison Service response – recommendation accepted and implemented.

19. CCTV Monitoring not be used as a tool to observe a prisoner whilst in an unstable condition. CCTV monitoring is no substitute for physical clinical observations.

    Prison Service response – recommendation accepted and implemented.

20. Quality of visibility through hatches rose as an issue. Simply observing through the cell hatch is not sufficient to see if a person is breathing or not. Cleaning contract to provide hatch cleaning as part of cleaning specification of the cell.

Prison Service response – recommendation partially accepted. All single cells in Healthcare have hatches which can be opened to facilitate observation.

Dimmable lighting has been installed to all wards and a works project has been commissioned to explore the possibility of installing dimmable lighting in all single cells to facilitate observation without disturbing the patient.

21. Escalation policy to be devised with alert scoring built in so staff have a tool to support decision making rather than relying on each others thoughts and opinions.

    Prison Service response – recommendation accepted. See response to recommendation 15.

22. Breaking bad news policy to be reviewed.

    Prison Service response – response to follow.

23. Policy around debriefing to be reviewed/revised and audited. GP should be part of cold debrief.

    Prison Service response – recommendation not accepted. Multi-disciplinary, multi-professional cold debriefs occur after every untoward incident including deaths in custody. GPs are involved wherever appropriate.

24. Policy and practice around distribution of medication to be revisited in light of this case. Medicines management audits to be undertaken across the prison.

    Prison Service response – recommendation accepted. Administration of medicines policy revised and implemented September 2007; includes clinical audit strategy.