Investigation into the circumstances surrounding the death of a man at HMP Norwich in March 2008

Report by the Prisons and Probation Ombudsman for England and Wales

July 2009

This is the report of an investigation into the circumstances surrounding the death of a man at HMP Norwich in March 2008. Shortly before 5.30pm on the day of his death, he was found hanging in his cell in the healthcare centre.

The loss of any family member is distressing but is especially so in the case of someone who dies in prison. I offer my sincere sympathy and condolences to the man's family and friends for their sad and untimely loss.

The investigation was conducted by my colleague.

I also commissioned a clinical review of the management of the man's health needs while he was in prison custody. This was carried out by a representative appointed on behalf of the local Primary Care Trust. I am grateful to the reviewer for her invaluable contribution to the investigation.

I should also like to thank the Governor of HMP Norwich and the Director of HMP Peterborough for the help they and their respective staff gave my investigator. I am especially grateful to the liaison officers at HMP Norwich and HMP Peterborough.

When the man entered prison at Peterborough in March 2008, he was withdrawing from drugs. He was given a reducing dosage of Methadone. Three days later, he left the prison for court and, because all places were quickly filled, he could not return. Instead, he was taken to Norwich in keeping with the provisions of Operation Safeguard, the Prison Service's contingency plan for transferring prisoners away from establishments that have reached their capacity. At the time of the investigation, Methadone was not available at Norwich.

I believe that the man's death may well have been linked to the impulsiveness associated with opiate withdrawal or with the absence of an appropriate detoxification medication. I am disturbed by the fact that Methadone was not available at Norwich for him, and note that since his death it has been agreed that funding is to be provided for its introduction.

My report makes a number of recommendations that I hope will help prevent a similar tragedy occurring at Norwich or elsewhere in the Prison Service.

This is the eighth apparently self inflicted death I have investigated at Norwich. None of the recommendations I have made in previous reports are relevant here.

At consultation stage, the man's family raised a number of points about which they felt strongly and which they believed were not adequately reflected in the draft report. These matters were put in writing to the Governor of Norwich and the Director of Peterborough. The questions asked of both, together with the responses received have been inserted at the end of this revised report. The man's family also specifically asked that the report should mention that they have been badly affected by his loss.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2009**

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SUMMARY

On 7 March 2008, the man was arrested on suspicion of committing actual bodily harm and criminal damage. He had a long history of offending and drug use and had been in prison before. He spent a night in police custody before appearing before magistrates the next day. A doctor who examined him thought he was showing signs of opiate withdrawal. There was also some evidence that he had previously self-harmed. The Prisoner Custody Officer who escorted him to court from the police station therefore raised a suicide/self-harm warning form. At his court hearing, the man was remanded in custody at HMP Peterborough and ordered to appear again three days later. Upon his arrival at Peterborough, he was not asked any questions about the contents of the suicide warning form in particular or about his current risk of self-harm. Nor did anyone question him about his history of alcohol abuse. However, he was placed on a Methadone detoxification regime.

The man was assessed as being fit to return to court on 11 March, but the assessment was not based on an interview. He appeared before magistrates at about 10.30am. He was again remanded in custody and ordered to return to court on 8 April. Later that morning it became evident that he could not return to Peterborough as there were no longer any vacancies. Instead, he was taken to HMP Norwich in keeping with the provisions of Operation Safeguard, the Prison Service's contingency plan for re-locating prisoners away from prisons that have reached their maximum capacity.

Shortly after appearing in court, the man had a seizure in the court cells and was taken to hospital, where he was admitted for observation. After a few hours, he discharged himself. He was then taken to HMP Norwich. As Methadone was not available there, he was given Diazepam.

During his reception health screen, the man said that although he had never been a psychiatric inpatient, but had received psychiatric treatment in and out of prison. He also said he had tried to harm himself whilst in the community.

The man was taken to a dormitory in the First Night Centre where, at about 9.15pm, he had another seizure. The member of the healthcare team who attended said he was initially so concerned that he called an ambulance. However, no ambulance arrived. The prison doctor was not called. After a short time, the man recovered. He remained overnight in the First Night Centre without further event but, at about 8.00am the next day, he had another seizure and was admitted to the healthcare centre.

During the morning of 12 March, the man's behaviour deteriorated. He spat at one member of staff and was rude to another. He was told that the observation hatch in his cell door would have to remain in the closed position. Thus, no staff could see him without lifting the hatch. At about 4.00pm, he was let out of his cell to make a telephone call. A little under an hour later, he was found hanging from the toilet door in his cell. All attempts to revive him failed. His death was pronounced at 5.21pm.

I criticise the standard of healthcare afforded to the man both at Peterborough and Norwich especially where the assessment of his risk of self-harm and the

management of his substance misuse are concerned. I am also critical of the fact that he was transferred away from Peterborough after appearing in court on 11 March, thereby denying him the opportunity to continue his Methadone detoxification programme. I believe this may well have contributed to his death.

I am pleased to be able to draw attention to the leadership shown by the Governor of HMP Norwich, in breaking the news of the man's death to his family in person. I also make special mention of the prison family liaison officer for the professionalism with which she discharged her duties in the aftermath of the man's death.

A number of recommendations are made by the clinical reviewer. I hope these and the one recommendation I make will help to prevent a similar tragedy occurring at Norwich or elsewhere in the Prison Service.

INVESTIGATION PROCESS

1. The investigation was opened at HMP Norwich on Monday 17 March 2008 by my colleague. On that day, he met the Governor, a representative of the local branch of the Prison Officers' Association and a member of the local Independent Monitoring Board. My colleague briefed those present on the nature and scope of the investigation. He also issued notices to staff and prisoners announcing the investigation and inviting those with information or concerns about the man's death to make themselves known. No one came forward.

2. On Tuesday 1 April 2008, my colleague conducted a similar meeting at HMP Peterborough.

3. Formal interviews were conducted with eight members of staff at Peterborough and with seven at Norwich. Informal discussions were held with two further members of staff at Peterborough and with one prisoner at Norwich.

4. On 2 May, my colleague and one of my family liaison officers met the man's family to invite them to express any concerns they wished the investigation to address. The concerns they raised related principally to the manner in which the man hanged himself and the medical care he was given when he experienced seizures. I hope his family find that I have dealt with these matters in my report.

HMP PETERBOROUGH AND HMP NORWICH

HMP Peterborough

5. The prison at Peterborough is situated near the town centre. Opened in 2005, it is a private sector prison managed by Kalyx, formerly United Kingdom Detention Services. The establishment operates as a local prison for both male and female prisons on separate sites. It also holds young offenders. At the time of the investigation, Peterborough could hold up to 528 prisoners in the male prison. The male residential unit has two houseblocks comprising four wings, each of which has two landings. All wings are self contained with servery, showers, baths, and association space.

6. Healthcare at Peterborough is provided by Peterborough Primary Care Trust. At the time of the investigation, Methadone was available in the establishment as an opiate substitute for detoxification purposes.

7. The establishment was last inspected by Her Majesty's Chief Inspector of Prisons in October 2006. None of the issues and recommendations made in the report of that inspection is relevant here.

HMP Norwich

8. Norwich is a multi-functional local and training prison holding adult men and young offenders. It also has a remand unit and a resettlement unit. The establishment serves Magistrates and Crown Courts in the east of England.

9. Between 1996 and 2004, Norwich underwent substantial reorganisation of its wings, some of which were converted into dedicated units. As a result, the resettlement unit, young offender units and the older prisoners unit (on the ground floor of the healthcare centre) are all located outside the main prison.

10. Healthcare at Norwich is provided by the Norfolk PCT provider arm, now known as the Norfolk Community Healthcare Service. The healthcare centre has inpatient facilities and is managed by the Head of Healthcare who is supported by a deputy and a team of nurses and healthcare officers.

11. Norwich does not have a dedicated detoxification unit. Prisoners in need of detoxification programmes are normally managed in one of the wings or in the healthcare centre. Prior to the man's death, Methadone was not available for detoxification programmes.

Her Majesty's Chief Inspector of Prisons

12. Her Majesty's Chief Inspector of Prisons has inspected Norwich twice in the last three years. In her report of the earlier of those two inspections, dated March 2005, she described Norwich as "an over-complex prison unable to fulfil its purpose properly".

13. The unannounced full inspection that followed in November 2006 found that the prison had tried, with some success, to grapple with some of the key problems identified earlier, but in many cases these attempts had been undermined or thrown off course by national population pressures.

14. Where suicide prevention was concerned, Her Majesty's Chief Inspector of Prisons said:

> "Our criticisms of suicide and self-harm procedures had been fully addressed by senior managers. We found robust systems to support and monitor those at risk of suicide (which indeed prevented a death during the inspection) though the prison needed to ensure that the chaplaincy was informed and able to be involved. Norwich had also improved its support for prisoners in the crucial early days of custody, with better reception, first night and induction processes. However, these pressures were significantly damaged by the consequences of population pressure. So many prisoners were entering the prison that not all could be held, or held for long enough, in the first night and induction unit and many arrived late, locked out from other nearer establishments. Crucially, at the time of the inspection, one in five of those arriving at Norwich had spent their first night in a police, rather than a prison, cell under Operation Safeguard – without the benefits of any specialised support."

15. Where detoxification was concerned, Her Majesty's Chief Inspector of Prisons wrote:

> "Detoxification was limited to an inflexible 7 to 14 day non-opiate based rapid intervention. Despite there being an average of 32 detoxifications a month on the adult side, no opiate based alternative (for example Methadone) was available on reception, even if the individual had been subject to a maintenance programme in the community. In our survey, significant numbers of prisoners on both the adult side indicated that they had received no drug or alcohol support for their 24 hours in custody. In addition, not all prisoners received symptomatic relief. One-to-links between the detoxification team and the Counselling, Assessment, Referral, Advice and Throughcare service (CARATs) were good, but this had not translated into effective joint working."

16. In respect of these observations, Her Majesty's Chief Inspector of Prisons made, inter alia, the following recommendations:

> "The prison should update its policy for the clinical management of substance misuse to incorporate national guidance regarding stabilisation, detoxification and maintenance.
>
> "All prisoners entering the prison with a demonstrable substance misuse problem should be able to access symptomatic relief."

Independent Monitoring Board

17. In their annual report on Norwich for the period 1 March 2006 to 28 February 2007, the Independent Monitoring Board drew attention to no matters relevant to this investigation.

KEY EVENTS

Background

Arrest and police detention

18. The man was arrested in the early hours of 7 March 2008 on suspicion of committing actual bodily harm and criminal damage. He was taken to the police station. At about 7.50am, he was examined by a doctor who advised that he was fit to be detained and interviewed. The doctor recorded on a Detained Person's Medical Form that if, after six hours' detention, the man needed any medication, a doctor should be called again. The doctor was called again at 1.25am. He examined the man 45 minutes later and prescribed 5mg Diazepam. No reason for this decision was recorded. The doctor advised that the man could be interviewed after a further 30 minutes. At 7.20 that evening, he asked to be given Methadone. He was examined by another doctor who noted that he was showing signs of opiate withdrawal. The records of the man's time in police custody do not make clear whether he was given any Methadone thereafter. However, the doctor advised that he remained fit to be detained and interviewed. The doctor also noted that a further medical review was not required.

Appearance in court

19. The next morning, the man was taken to the Magistrates Court. The Prisoner Escort Record (PER) for the journey between the police station and the court carried the following notations of risk:

    Medical - no known risk
    Security - violence
    Other - drugs/alcohol, suicide/self-harm

20. The PER also recorded that the man had head-butted his cell door, had tied cloths around his neck earlier that day, and was in the habit of taking Methadone.

21. At his court hearing the man was remanded in custody and ordered to appear in court again on 11 March. He was taken to HMP Peterborough that day, arriving at about 12.50pm.

Suicide/self-harm warning form

22. A prisoner custody officer (PCO), who escorted the man between the court and the prison, completed a suicide/self-harm warning form on which he recorded the following information:

    > "DP [detained person] seems very upset at the moment. Has been crying whilst in GSL [Global Solutions Ltd - the private security firm contracted to escort prisoners] and seems very agitated at the moment. DP has a history of self-harm although last attempt was

in 2006. DP has punched cell window and has broken it and has
slight cuts to knuckles."

Peterborough: 8-11 March

Reception

23. On duty in reception at Peterborough when the man arrived were the senior prisoner custody officer (SPCO), another PCO, and a nurse. The SPCO took possession of the PER and suicide/self-harm warning form and signed both documents. At interview, he told my investigator he could only vaguely remember the man and had no recollection of the events of 8 March when he arrived. He said he would have passed the PER and the suicide/self-harm warning to both the reception PCO and reception nurse. He said it would have been highly unlikely for him to fail to do so.

First reception health screen

24. The reception nurse conducted the man's first reception health screen shortly after 2.00pm. She made the following electronic record of the health screen:

> "Urine Methadone level positive
> Adult male
> Urine opiate level positive
> Urine benzodiazepine level positive
> Prisoner has been in prison before? Yes – 'Peterborough did not ask him when last here very upset and crying.'
> Fit for normal location work and any cell occupancy? Yes.
> Common law partnership
> Prisoner has received treatment from a psychiatrist outside prison? Yes.
> Says has personality disorder but says very little about this.
> Seems to be far more interested about Methadone and when he will get this. Also has expressed that will do something to make sure he gets it.
> Refer to doctor re substance misuse."

25. At interview, the reception nurse admitted she did not conduct a full screen. By that, she meant that she did not ask the man any questions about his risk of self harm, or about his alcohol abuse. She said this omission was caused by the fact that during the reception process, he was shouting and complaining that he needed Methadone. She thought his truculent behaviour was due to the effects of withdrawal. She told my investigator that her lack of concern was based on the absence of any written comments in his record. She said she saw neither the suicide/self-harm warning form nor the PER. However, the reception nurse referred the man to a doctor.

Cell sharing risk assessment

26. Every new prisoner has to undergo a cell sharing risk assessment, the purpose of which is to assess what risk the prisoner would present of harming a cell mate if he were to share a cell. The assessment must balance his risk of harming others against the risk of harming himself if he is left alone. The man's risk assessment was conducted by the reception PCO and the reception nurse. The man told the reception PCO he had abused drugs and was currently dependent on both drugs and alcohol. He said he was not currently subject to Assessment, Care in Custody and Throughcare (ACCT) procedures. (These are used by the Prison Service to monitor and manage those prisoners who are considered to present a risk of self-harm.) The man disclosed that he had previously been on an open ACCT form but he gave no further details. He said he had no concerns about sharing a cell.

27. The reception nurse completed the healthcare element of the risk assessment. In answer to the question, "Following the self-harm assessment, have any concerns been raised?" she recorded that there were no concerns, despite her admission at interview that she did not ask the man any questions about self-harm. She noted in the record of the assessment that he was "detoxing badly".

Induction

28. Another PCO, who regularly worked in the Induction Unit, collected the man from reception and took him to the unit. At interview, the PCO said he remembered the man well from his previous period of custody at Peterborough. He described him as a pleasant man but with a propensity for getting angry. The PCO recalled that on 8 March, the man seemed agitated, probably because he was withdrawing. He said he was not aware that a suicide/self-harm warning form had been raised by GSL or that his PER carried a notation of a risk of self-harm. He said that, although the man seemed agitated, he did not behave in a manner suggestive of a risk of self-harm.

29. The induction unit PCO also told my investigator that, once a doctor had prescribed detoxification medication, the prisoner concerned would normally be allocated to the detox wing if there were any vacancies. In the man's case, there were no vacancies on 8 March. He was therefore located in the induction unit to await a vacancy in the detox wing. As none became available in the wing in the short time he was at Peterborough, he remained in the induction unit throughout.

30. The man was examined by a prison doctor at 10.30am on 9 March. The doctor wrote in the clinical notes:

> "Problem. Was on community script Methadone 60mls last Thurs. [home area] checked with Lloyds pharmacy, seen late Sat as

distressed. Commenced Methadone 30mls second dose Sun morning also Diazepam script. Today no sign withdrawal symptoms. Will need review on Monday to see if change needed. History of poss personality disorder. No current treatment."

31. At about 9.15am the next day, the man attended the "medical hatch" (treatment room). He was shaking and unable to speak or coordinate his actions. The treatment room nurse decided to take a urine sample from him. He tested positive for Subutex, a narcotic pain reliever otherwise known as buprenorphine, THC (tetrahydrocannibol - an active ingredient of the cannabis plant), Benzodiazepines and Methadone. Afterwards, the treatment room nurse assessed the man in his cell and found he had difficulty in standing and still could not speak. She therefore asked the man to accompany her to the healthcare centre but he refused to do so.

32. Another nurse made the following entry in the clinical notes at 9.39am:

> "Refused to come to healthcare. Attended the hatch for his Methadone still stammering. No signs of drowsiness, no breathing problems. To come for assessment this pm. Does not want to come to healthcare. Has been informed that he will be assessed. Prisoner was here before and has a history of anxiety and strange behaviour. No reason identified why he cannot talk."

Second court appearance

33. The man was scheduled to appear at the Magistrates Court on 11 March. His medical record contains an entry made by another at 1.16am that day showing that she thought he was fit to attend court.

34. Both my investigator and the clinical reviewer, interviewed the nurse who thought the man was fit to attend court. She explained that she was an agency nurse employed to work from time to time in the healthcare centre. She said she often completed night shifts when she would be on duty with one other member of staff - a Prisoner Custody Officer. The nurse said she had to use most of her shift to bring her paperwork up to date. She explained that she made the entry in the man's record at 1.16am because this was the time she brought his file up to date. She admitted that she did not interview him. In fact, she said she had never met him. Rather, she said the assessment was based on an absence of any indications to the contrary in his notes. Thus, she was not aware of his condition when he arrived at Peterborough three days earlier.

35. The man's medical record was prepared for transfer to court but was incomplete as the administration sheet for Methadone was missing. The PER for the journey between the prison and the court shows that he arrived at the court building shortly after 9.00am. He was interviewed by a PCO who recorded on the PER that he said his last act of self-harm had taken place over two years before, and he felt alright at the moment and so there was no requirement to raise another suicide/self-harm warning form. The man was

interviewed by his legal adviser before moving up to the court room at about 10.30am. The magistrates remanded him in custody and ordered him to appear before them again on 8 April.

Locked out of Peterborough

36. At 11.45am the escort staff who were to take the man back to prison were told that HMP Peterborough could not accept any more prisoners. They were therefore instructed to take him to HMP Norwich in keeping with the provisions of Operation Safeguard. (This is the name given to the Prison Service's contingency plan for re-locating prisoners away from prisons that have reached their maximum capacity.)

First seizure

37. The PER shows that at 11.53am, while still in court cells, the man refused food and drinks offered to him. However, at 12.11pm he accepted a drink. A few moments later, he was found to be having a seizure. An ambulance was called and he was taken to the hospital where he was examined by a doctor. At about 2.15pm, the man decided to discharge himself from the hospital after being denied Diazepam. The doctor considered the man had recovered well from his seizure and judged that no further medical intervention was necessary. At 2.40pm, he boarded the escort vehicle and left for Norwich. He arrived at the prison at about 5.00pm.

Norwich: 11-12 March

Reception

38. An officer was on duty in reception at Norwich when the man arrived. He told my investigator that the man appeared to be jovial during the reception procedures.

Cell sharing risk assessment

39. The reception officer and the healthscreen nurse conducted the man's cell sharing risk assessment. He told them he had abused drugs and alcohol and that he was dependent on both. He said he was not currently subject to ACCT procedures but had been in the past. He said he did not have any concerns about sharing a cell. In answer to the question on the cell sharing risk assessment form, "Following the self-harm assessment have any concerns been raised?" the healthscreen nurse wrote that there were no such concerns.

40. The reception officer noted that the man had previously been convicted of a violent crime and that his current charge was associated with violence. He commented on the form, "Careful monitoring of potential cellmates."

41. At the end of his assessment, he judged that the man presented a medium risk of harming others. In practical terms, this meant that there was no

immediate risk but there was a need to keep the situation under review. The man was considered suitable for sharing a cell.

Health screen

42. The nurse conducted the man's health screen. He told her he was concerned about "medication issues" but had no worries about his physical health. He said he did not drink alcohol but had taken a "bag" of heroin the previous night. It is unclear whether anything was done to verify this. He said he was receiving "Diazepam Methadone 70mls". He was not referred to the detox nurse. No prescription was issued for opiate or Benzodiazepine detoxification. No urine test was conducted at that stage as there was a shortage of testing equipment.

43. The man gave the healthscreen nurse the name and address of his doctor in his home area. He said he had been in prison before, and had previously been at Norwich. He told the nurse he had been taken to hospital from court that day "because of a fit". The nurse noted in the man's medical file that he was not epileptic, but he did have "benzo" fits. The nurse noted the need to refer him to the "drug service" but did not specify which service she meant.

44. As far as his mental health was concerned, the man said that, although he had never been a psychiatric inpatient, he had received psychiatric treatment in and out of prison. He also said he had tried to harm himself outside prison.

45. The nurse summarised the health screen as follows:

> "Seen on reception after transferring from HMP Peterborough via court. Had a ?? (sic) fit at court. Taken to hospital. Being detoxed from heroin by Peterborough (drug chart at back of notes). Fit for normal location. Will need to see GP mane [tomorrow]."

46. The investigation found that no consent to acquire medical information from HMP Peterborough or from the man's GP or the CADS (Community Alcohol and Drugs Service) team was obtained. (The disclosure of any medical information can only be made the consent of the individual concerned.)

47. A Listener was employed in reception at HMP Norwich when the man arrived. (A Listener is a prisoner trained by the Samaritans to offer support to other prisoners at times of distress.) The Listener told my investigator he had known the man for about five years and recognised him as he came through reception. The Listener said he spoke to him that evening as a friend rather than in his role as a Listener. He said he thought he was perfectly alright at that time, although he was frustrated that he was not getting his medication.

Allocation to First Night Centre

48. The man was assessed as being fit normal location (i.e. on a wing rather than in the healthcare centre or other specialist unit) despite his drug dependency and his history of convulsions and self-harm. He was therefore allocated to

the First Night Centre. The reception officer took him across to the unit. In a statement submitted to the Governor after the man's death, the reception officer wrote that the man told him he would be having fits that night as his medication had been inconsistent over the last day or so. He said he hated having the fits.

49. That night, only two options were available for the man's location in the unit. There was a bed available in a double cell and another available in a four-bed dormitory. A senior officer was the manager in charge of the unit. The manager of the unit told my investigator that during her interview with the man he said that, because he had trouble with some African prisoners at Peterborough, he did not want to share a cell with anyone who was not white. She explained that as the prisoner occupying the double cell was not white, she decided to locate the man in the dormitory where there were two other white prisoners. He remained in the dormitory that night.

50. The manager of the unit estimated that the man arrived in the First Night Centre at about 7.00pm. She conducted an induction interview with him shortly after allocating him a bed in the dormitory. She told my investigator that he appeared to her to be perfectly normal. She also described him as being jovial. She emphasised that he gave her no impression of withdrawing from drugs. She did not know that he had been taken to hospital from court earlier that day after having a seizure.

51. During his induction interview, the man told the manager of the unit that, although he had self-harmed in the past, he did not currently feel suicidal. However, he was worried about his girlfriend who was pregnant. The manager of the unit said that, despite this, he gave her no cause for concern. She went off duty at about 8.15pm and was not on duty the next day.

Second seizure

52. At about 9.15pm, the staff in the First Night Centre discovered that the man was having a seizure. They called the healthcare centre to ask for someone to examine him. A staff nurse attended and was sufficiently concerned about the man to ask for an ambulance to be called. When, after about 15 minutes, no ambulance arrived, the staff nurse rang the control room to find out what was happening. He was told that no ambulance had been called.

53. The person on duty in the control room that night was an officer. At interview, the control room officer explained that his shift began at 8.00pm that evening and finished at 7.30am the next day. He showed my investigator the communications room log book for that night. The log book contained the following entry made against the time of 9.00pm: " [the man] fitting in cell E2-01. Hotel 2 and Oscar 1 in attendance. Treated by Hotel 2 in cell."

54. The control room officer was adamant that no one asked him to call for an ambulance that night in relation to the man. He said that, had he been asked to do so, he would have logged the request. However, he admitted during interview that the person who called over the radio did indicate that the

message was a “code blue”. (This code is used to indicate that a potentially life threatening situation has been discovered.) He said he forgot to enter this fact into the log.

55. The control room officer told my investigator that he was not automatically required to call for an ambulance when he received the code blue message. He said the decision as to whether an ambulance is required is made by the staff present at the cell. He said the Orderly Officer rang him at about 9.20pm and asked him where the ambulance was. He replied, “What ambulance? None has been requested. I will phone one.” He told my investigator that, just as he was about to call for an ambulance, the Orderly Officer said to him, “Don’t bother, the situation is under control.” The control room officer admitted that he did not make a log of that communication.

56. In the meantime, the staff nurse returned to the healthcare centre to find the man’s medical notes. He found a prescription for Diazepam that had been made out at Peterborough. He used that prescription as an authority to administer the medication to the man. The staff nurse did not consider seeking advice from a doctor. Although he told my investigator he left instructions for the night staff to “keep an eye on” him during the night, the investigation found no written evidence in support of this. The man had no further difficulties that night. Details of these events were not properly entered into his medical record.

Events on 12 March

Third seizure – admitted to the healthcare centre

57. At about 7.45am the following day, a prisoner in the same dormitory as the man pressed the cell bell to alert staff to the fact that he was having another seizure. An officer, one of the staff on duty in the First Night Centre at the time, later wrote in a statement:

> “On 12 March I came on duty at 7.15am into E Wing. At approx 7.45am, a cell bell E2-001 was pressed followed by banging on the cell door and shouting. Myself, [two officers named] went to investigate. On entering the cell the man was laying on his bed having an epileptic fit. We made sure he was safe from injury, i.e. not falling off his bed or banging his head and called for medical assistance. At no stage did the man fall off his bed or hit his head during his fit. Medical assistance arrived soon after and took over.”

58. Another staff nurse responded to the call for assistance. She confirmed that the man appeared to be experiencing a seizure and arranged for his transfer to the healthcare centre for observation.

59. The healthcare senior officer was on duty in the healthcare centre when the man was admitted. He said in a statement:

> "At approx 10.00am the man was admitted onto my unit due to medical issues from the night before and was located by staff into cell H2-15. After a short time he was asked if he would like to go on exercise with the other prisoners. He accepted. He commenced exercise at approx 10.25am. At approx 10.30am he returned to the landing. When asked why he returned he stated he had felt physically sick in the fresh air and wanted to see the doctor as soon as possible in order to sort out his medication."

Deterioration in behaviour

60. The healthcare officer (HCO) was also on duty in the healthcare centre that day. In a statement made out later, he gave the following account of events that morning:

> "On 12 March, I was on duty on the healthcare landing. At approximately 10.00am the man was brought up to the landing as admit. We located him in cell H2-15. At approximately 10.25am, he attended our exercise period. He was seen by the doctor between 10.30am and 11.00am."

61. A healthcare staff nurse was with the doctor who assessed the man. She made the following entry in his medical record:

> "Was seen today by the doctor. Is alert today. Walks around and also hits the window of the landing. He says he wants to damage the place if he has to stay here. Gets prescription for rectal Diazepam and will be on a detox scheme."

62. During his consultation with the doctor, the man became aggressive and, according to the HCO, "stormed" back into his cell. On the way, he kicked two cell doors. The HCO went to his cell and found the senior healthcare officer was already speaking to the man and attempting to calm him down. The healthcare principal officer had also gone to the man's cell. The HCO therefore returned to the landing office.

63. The investigation found that no note had been made of the last time the man had received either Methadone or Diazepam. No withdrawal monitoring or formal observation chart was put in place.

Assault on the healthcare principal officer

64. The healthcare principal officer made out the following incident report form:

> "At approximately 10.55 hrs on 12 March, I was talking on the phone in the healthcare office when the man walked into the office and said if he wasn't taken back to the adult site he would smash his cell up. When I had finished the telephone conversation, I went to see him in his room to explain why he had been admitted to the

healthcare centre. He stated that if he wasn't returned to the adult centre he would harm himself. I stated that it would be his choice and again explained why he had been admitted to the healthcare centre. He then spat in my face. I left the room and attempted to shut the cell door. He continued to kick the door violently, preventing me closing it."

65. The healthcare principal officer placed the man on a disciplinary report. He also referred the matter to the police. A disciplinary hearing was scheduled to take place during the afternoon of 13 March.

66. At interview, the healthcare principal officer said he thought the comment the man made about self-harming was more associated with his "temper tantrum" than with any serious intention to harm himself. He said neither he nor any other members of staff on duty in the healthcare centre that day thought the man was at risk of self-harm or suicide.

67. The healthcare staff nurse told my investigator that, after a few minutes, the healthcare senior officer returned to the cell to see if the man was alright. He spoke to him through the cell door. The man told him he would not behave aggressively any more. He opened the observation hatch in the door so that he could see the man and asked him why he had become so upset. The man told him he was frustrated and did not mean to shout or cause trouble. He also offered to apologise to the healthcare principal officer for spitting at him. The man was due to attend a secondary health screen that day, but refused to do so.

Admission to healthcare centre

68. The healthcare staff nurse made the following entry in the man's nursing care plan. She wrote:

> "Fits on the wing (see system 1) transferred to HCC [healthcare centre] for observation. Commenced on Diazepam detox. Not happy to be in HCC. Has assaulted a member of staff by spitting. Hatch to remain up at present."

69. In his statement to the Governor, the HCO explained what happened next. He wrote:

> "Shortly after this, the man put on his cell bell. I answered it and he asked me about his medication. I told him the medication would be issued to him as soon as we received it from the pharmacy. During the lunch time patrol period, he put on his cell bell. It was answered by a nurse. Following their brief conversation, the man was abusive to [the nurse who answered his cell bell]. As a result of this I had no choice but write an advice notice."

An advice notice is issued to any prisoner whose behaviour has become a matter of concern to staff. At the top of each notice, the following text is included for the information of the prisoner concerned:

> "There are some problems with your conduct. These are highlighted below. Should these concerns continue you will be issued with a Warning Notice. This could lead to a change in regime."

70. The HCO further explained:

> "At 2.30pm, [the healthcare staff nurse] issued the man his medication. I accompanied her. He took his medication without incident. As we left I realised I had not issued him with his advice notice so I returned to his cell. I unlocked his hatch and issued him with the notice. He asked what it meant so I explained the IEP [Incentives and Earned Privileges] system. He asked if he could have his hatch down. I explained that until we could be sure he would not abuse the privilege of having the hatch open, it would have to remain shut.
>
> "Between 3.00pm and 4.00pm, the man put his cell bell on twice. Firstly to request some toiletries which he was issued. Secondly to use the landing telephone. I unlocked him and he went to the phone. He called me for assistance because he could not get through to his number. I tried for him and also could not get through as the system stated the number he was ringing was not authorised. I told him I would ring the PIN [Personal Identification Number] phone clerk and find out why it would not work, which I did after I returned him to his cell. The PIN phone clerk informed me that [the man] would need to fill in a phone list application form. I took the form down to him in his cell. I went into his cell and explained why his number was blocked and that if he filled in the form, I would get it processed as soon as possible. He apologised to me for his behaviour earlier in the day and told me that he was hoping to get judge in chambers and bail the next day. I asked him what he was on remand for and he told me it was for an assault on an ex-prisoner. We spoke for a short while about when he was on A Wing before it was closed. At this point his mood seemed more settled. I left the cell but returned between 4.05pm and 4.15pm because I realised I still had his PIN phone number in my pocket. I gave it to him and he thanked me. I then left the HCC to collect the evening meal."

The HCO was the last person to see the man alive.

The man found hanging

71. At approximately 4.50pm, the HCO and his healthcare colleague began unlocking the doors on the landing to serve the evening meal. About four

minutes later, the healthcare colleague unlocked the man's cell and found him in a sitting position suspended by a ligature fashioned from a bed sheet and tied to the handle of the toilet door. The toilet door had been pulled almost shut so that he was partially out of view. The HCO cut the ligature with an anti-ligature knife and, with the assistance of the healthcare principal officer and the healthcare colleague, lowered the man to the floor.

72. The healthcare colleague checked for signs of life but there was none. He began mouth to mouth resuscitation and cardiac massage and told the HCO to fetch the emergency bag. By the time the HCO returned to the cell with the emergency equipment, the healthcare manager had arrived and had commenced Cardio Pulmonary Resuscitation (CPR). The following extract from a statement she made out later explains the healthcare manager's actions:

> "When I got to the cell door, I saw the healthcare colleague preparing a bag for the patient. The male patient was lying on the floor with his head facing the cell door. He was laying on his back fully clothed. I noticed that he was purple from the neck up and his body was warm. The male patient's name is [the man's name]. I commenced CPR on him and while carrying this out my colleagues told me that [the HCO] had cut the sheet while the healthcare colleague supported the body. We carried out CPR with the paramedics arriving at 17.05 as stated in the primary survey. I then continued CPR while paramedics inserted lines into him. The healthcare staff nurse then took over chest compressions while I took over managing the airway. After a few minutes I took over chest compressions again and the senior healthcare officer took over the airway. Paramedics took over the chest compressions and airway at about 17.15hrs. We had been using our defib machine was used from the two minutes after I arrived (sic). The defib machine ran 5 cycles with no shock indicated. Paramedics had given 3 lots of adrenalin i/v and 1 atropine during the process. They also put up a drip to give [the man] a fluid challenge. At 17.21 hrs it was a team decision to discontinue CPR. He was in asystole throughout which means no heartbeat. The paramedics pronounced him dead at 17.21hrs."

(An 'airway' is an instrument that is inserted into the throat to enable oxygen to be passed into the lungs. The term 'defib' refers to a defibrillator, a portable electronic device that diagnoses potentially life threatening abnormal heart rhythms.) The healthcare manager's statement continues:

> "Prior to leaving the cell I noticed a piece of paper on the table under the cell window. I didn't touch the note but read it. It said, 'Dear [name removed], I'm sorry, I can't do this any more. Please take care of my body.' I think there were kisses but I cannot remember. The note was left in the cell."

73. The Roman Catholic priest said prayers for the man in his cell.

Informing the next of kin

74. The prison's family liaison officer (FLO) was at home when the man died. At 5.30pm, she was called by the prison and asked to join the Governor in the command post. Upon her arrival at 6.30pm, she was briefed by the Governor who decided that he and the prison FLO should both break the news of the man's death to his family in person. A document in the man's prison record showed his brother was his next of kin. The Governor and prison FLO left the prison at 7.30pm and arrived at the man's brother's house shortly after 8.00pm. His brother, girlfriend and sister-in-law were at home when they arrived. The Governor broke the news of the man's death to them, and both he and the prison FLO remained with them until it was appropriate to leave.

75. The Governor later wrote a letter of condolence to the man's family. This was delivered to them by the prison FLO in person.

Prisoner and staff support in the aftermath of the man's death

76. The cases of all those prisoners who were subject to ACCT procedures at the time of the man's death were reviewed afresh.

77. Members of the prison's care team were on hand to offer support to the staff involved in the discovery of the man and in attempting to revive him. Those staff who were interviewed confirmed they were content with the support offered.

Ongoing family support

78. In liaison with the Coroner's office, the prison FLO helped to arrange for the family to view the man's body at the mortuary on 14 March. The prison FLO supported the family in person before and after the viewing.

79. The man's funeral took place at 10.00am on 26 March at a Roman Catholic church in his home area. The prison FLO and the deputy governor represented the Governor at the funeral service. A wreath was sent to the undertakers from the prison with the agreement of the man's family. The full costs of the funeral were offered to the family

80. On 3 April 2008, the man's brother and other members of his family viewed the cell in which he died. With their agreement, and with the permission of the Coroner, a copy of the letter the man left for his family was given to them that day.

ISSUES

81. Here I examine the following:

- Whether the man's health needs were properly assessed and managed. I place particular emphasis on the extent to which the effects of his drug abuse were identified, monitored and managed.
- Whether his risk of self-harm or suicide was properly assessed, monitored and managed.
- Whether the response to the discovery of the man hanging was prompt and effective.
- Whether appropriate courtesies were offered to the man's family in the aftermath of his death.

Were the man's health needs properly assessed and managed?

82. The clinical reviewer in her report says:

> "Having reviewed the care that [the man] received from the point of his arrest and placement in police custody to his death on March 12th 2008, it can be concluded that a number of key healthcare interventions were either omitted or not undertaken adequately. These collectively resulted in some aspects of the care [he] received falling short of the standard required for the care of patients with substance misuse issues and who may be at risk of self-harm/suicide."

HMP Peterborough

Reception health screen

83. The clinical reviewer has found:

> "The reception screening was taken by a healthcare assistant. No formal assessment training is given other than a session on what is included in the screening as part of the induction of new staff. A full reception screening was not completed because of [the man's] 'distressed state' and because he was referred to the GP urgently. Some important information was not captured, such as [his] history of self-harm, his history of alcohol consumption, his smoking status and his current physical health. When transferred from police custody to court, [the man's] Prisoner Escort Record (PER) showed he was assessed as presenting the following risks:
>
> Medical – no known risks
> Security – violence
> Other – drugs/alcohol, suicide/self-harm
>
> "The form was not signed by a Prison Officer on arrival at HMP Peterborough but the information was not available during his initial

reception screening. [The man] was placed in normal location because his risk assessment confirmed that he was not at risk of self-harm. The nurse had not asked [him] for any past medical history regarding self-harm and his PER showed he had notations of risk, including self-harm and suicide."

84. I endorse the following recommendation from the clinical review:

HMP Peterborough must review its policies and procedures for first reception screening to ensure these meet national guidance. Documents which would be useful are:

Prison Service Order (PSO) 3050 - Continuity of Healthcare for Prisoners
PSO 1025 - Communicating information about risks on escort or transfer
PSO 3550 - Clinical Services for Substance Misusers
PSO 0500 - Reception (section 4 and section 6)
Clinical Management of Drug Dependence in the adult prison setting

Particular note should be taken of the provisions of paragraph 4.4 of PSO 0500 and paragraphs 1.2 and 1.4 of PSO 1025 which set out guidance on the use of Prisoner Escort Records. Prison healthcare staff who are responsible for undertaking first reception screening should be appropriately qualified and receive regular training and supervision in effective assessment of prisoners.

Clinical assessment

85. The clinical reviewer judges as follows:

"The system in place for confirming that a prisoner is fit for court was discussed with the nurse responsible. There was no protocol available that described the process for assessing a prisoner's fitness for court. The review is a 'virtual' review using prisoners' medical records. It does not include a face to face assessment. This was a task which was performed by the night staff and there could be a large number that needed signing off each night. [The man] did not receive his daily dose of Methadone prior to leaving for court because of an error on his medical chart."

86. I endorse the following recommendation:

HMP Peterborough should review their processes to ensure that prisoners are seen as close to discharge as possible to confirm their fitness to attend court. The review should include ensuring that prisoners who require medication have received this prior to leaving and that all necessary documentation accompanies the prisoner.

Record keeping

87. The clinical reviewer has found:

> "The entry 'fit for court' did not include any reference to the concerns regarding [the man's] condition the previous day. His medical record was prepared for transfer to court but was incomplete as the administration sheet for Methadone was missing. HMP Norwich does not currently give Methadone. The impact of this omission was that there was a lack of clarity as to [his] current medication and when he was last given Methadone."

88. I therefore endorse the following recommendation:

The current process in place for confirming a prisoner's fitness for court must be reviewed to ensure that where prisoners have particular healthcare issues such as substance misuse these are taken into consideration.

HMP Peterborough should ensure that the provisions of paragraph 5.3 of Prison Service Order 3050 are followed when prisoners are transferred to court so that they have a summary of relevant medical details available. Where possible, this should be followed up with telephone communication confirming current health issues.

The decision to transfer the man to HMP Norwich under Operation Safeguard

89. As noted earlier, Operation Safeguard is the name given to the Prison Service contingency plan for relocating prisoners away from prisons that have reached their maximum capacity. The procedures to be followed when it is necessary to invoke the plan are set out in Prison Service Instruction (PSI) 30/2006. The following is an extract from the PSI:

> "5.3 Every effort must be made to avoid the use of police cells for the following groups of prisoners. In every case, when a prisoner from one of these groups is discharged from prison to court, his/her PER form <u>must</u> be endorsed '<u>return to discharging establishment'.</u>
>
> Juvenile prisoners
> Female prisoners
> Those at risk of self-harm on open ACCT forms
> Those with significant healthcare issues, including
>
> - prisoners undergoing assessment for, or are due transfer under the MHA 1983
>
> - any prisoner identified by the prison health team as unsuitable on clinical grounds. [This must be clearly identified on the PER.]
> - any other prisoner with a significant physical or mental health

problem that the healthcare provider to the police station feels is clinically unsuitable for their locally available service. E.G. clinically unstable substance misuse problem or a patient undergoing complicate treatment."

These conditions were not applied to the man.

90. A Notice to Prisoners is appended to the PSI. The following extract can be found at paragraph 3 of the notice:

> "Spaces retained at establishments
>
> You may not be able to return to the establishment due to population pressures. Spaces will only be kept for:
>
> Crown Court productions
> Those returning from the Court of Appeal (Criminal Division)
> Those requiring special care for medical reasons."

91. The provisions of the PSI were not applied in the man's case. His Prisoner Escort Record (PER) carried no endorsement of a need for him to return to Peterborough even though he had a "clinically unstable substance misuse problem". During his absence from the prison, no space was kept for him. It is not clear why this was the case. In my view, the wording of the PSI is such that the man was eligible to be returned to Peterborough after his court appearance because he was withdrawing from drugs and was subject to a Methadone detoxification regime. It is possible that the failure to retain a bed for him at Peterborough and to endorse his PER may have been either based on an oversight or on an assumption that he was ineligible.

92. My investigator consulted the Prison Service's Population Management Unit (PMU) about the PSI. He was told that its provisions could have been applied in the man's case. However, had his PER been endorsed with an instruction that he was to return to Peterborough, it could not have been guaranteed. This was because of a need for the escort contractor to prioritise the most pressing cases within the overall number of prisoners who were eligible. This suggests that the force of the PSI has been weakened by operational pressures. The investigation also found that the thrust of the PSI is directed towards the need to avoid the detention of prisoners in police stations. It does not cater for those, like the man, who may be transferred to another Prison Service establishment rather than to a police station after being locked out of the discharging establishment. In the man's case, this resulted in the disruption of his detoxification regime.

93. I find it unacceptable that the man was unable to return to Peterborough to continue his Methadone detoxification regime after his court appearance on 11 March. Equally unacceptable was the fact that, having transferred to Norwich, he found himself in an establishment that could not offer the same detoxification regime. This could be avoided in the future by revising

paragraph 5 of PSO 3050 so that it makes clear that those prisoners for whom 'clinical hold' is necessary include those subject to detoxification regimes. This latter recommendation is made by the clinical reviewer in her report. I repeat her recommendation here:

HMP Peterborough should review their policies in line with PSO 3050, 'Continuity of healthcare for prisoners' to ensure that prisoners who have not completed opiate stabilisation are able to receive continuity of care either through clinical hold of their accommodation or by ensuring that the receiving prison is contacted.

This guidance covers the facility to agree a 'clinical hold' on accommodation for patients whose clinical condition is such that they would be at risk if transferred. It states at paragraph 5.5, 'patients may need to be placed on clinical hold (i.e. withheld from transfer for a period of time for clinical reasons when indicated.'

This should be nationally reviewed to ensure that a clinical hold is available for remand prisoners who have commenced substance misuse stabilisation, to ensure they are able to return (to the discharging establishment) if courts decide to continue custodial arrangements.

HMP Norwich

Reception health screen

94. The clinical reviewer comments as follows:

> "A full reception screening was not completed. Questions regarding alcohol consumption were not asked. [The man] was recorded as being a substance misuser. His medical record and prescription charts were available to the reception nurse although the prescription chart did not include his admission sheet. No urine test was undertaken because of a shortage of testing equipment. No referral was made to the detox nurse. No prescription was issued for either opiate or benzodiazepine detoxification. The last time [he] received any medication to manage his drug dependency was not noted. He indicated during his screening that he had a history of self-harm, no ACCT form was initiated. No consent to obtain medical information from HMP Peterborough, the GP or the CADs team was obtained.

95. The man was assessed as being fit for normal first night location despite his unmanaged drug dependency and history of convulsions and self-harm.

HMP Norwich must review the content and implementation of the policies and procedures in use at first reception screening to ensure these meet national guidance. Documents which would be use would be:

Prison Service Order (PSO) 3050 – Continuity of Healthcare for Prisoners
PSO 3550 – Clinical Services for Substance Misusers
PSO 0500 – Reception (section 4 and section 6)
Clinical Management of Drug Dependence in the adult prison setting (published in November 2006).

In particular, policies regarding recognition, management and stabilisation of prisoners who are receiving Methadone substitution and benzodiazepam detoxification should be reviewed and implemented.

First reception processes should be audited regularly for quality assurance and to confirm full implementation.

Prison healthcare staff who are responsible for undertaking first reception screening should be appropriately qualified and receive regular training and supervision in effective assessment of prisoners.

Access to a medical practitioner should be available to all prisoners who require to be seen on the day of their arrival. This might be delivered by reviewing current surgery hours to ensure that cover is available in the afternoon to see all prisoners who require to see a doctor during normal primary care hours of 8.30am to 6.00pm.

Managing emergency medical events

96. The clinical reviewer writes as follows:

> "[The man] was observed as having had convulsions, the cause of which was unclear. Medical advice and/or review were not obtained. It was recognised that [he] was an opiate substance user. However, no formal arrangements were made him to be observed and no opiate scale was initiated."

HMP Norwich should put into place protocols and care pathways for managing emergency medical events. This should include the requirement for requesting external medical assistance in acute medical events such as unexplained convulsions. Healthcare staff within normal cell location should receive regular training and supervision in the emergency assessment and treatment of prisoners who present with acute medical events. Staff should receive training in the management of prisoners at risk of opiate withdrawal which includes the use of opiate withdrawal scales for monitoring their condition.

During the investigation, the man's family expressed their concern that they were not consulted about his history of experiencing seizures. They believed that, had this happened, they might have been able to provide

valuable information that could have been relevant to his management. Although I make no formal recommendation on this point, I nevertheless believe that the family have raised an important point that healthcare staff may wish to take into account in future. I believe that the involvement of families, with prisoners' consent, is good practice.

Management of medicines

97. The clinical reviewer has found that the man was given medication which did not agree with that prescribed by a doctor at Peterborough. The drug was correct but the dosage was half of that prescribed.

Healthcare staff should familiarise themselves with medicines management to ensure that they administer medication in line with professional legal requirements.

Record keeping

98. The clinical reviewer concludes as follows:

> "Insufficient explanations were recorded in [the man's] medical record with regard to the request and non-attendance of an ambulance (on 11 March when [he] had his first seizure in the prison) and later Medicom. The suggestion made to [him] that he should be transferred to the healthcare centre was not recorded. The need for and the frequency of observations to be carried out on [him] was not recorded in his medical records. There was no follow up or review plan."

HMP Norwich should have in place both protocols and training available to staff to ensure that record keeping is standardised and includes all relevant information including plans of care management and patients' choices with regard top health intervention.

Calling an ambulance

99. I agree with the clinical reviewer's recommendation about the record keeping aspect of the non-attendance of an ambulance. I would add that the fact that an ambulance was not called when initially requested is a significant failure. Although on the evening of 11 March after he had a seizure, the man made a full recovery such that the ambulance was no longer required, a similar failure in the future could contribute to an avoidable death.

The Governor should review his contingency plans for calling for an ambulance and ensure that effective drills and procedures are put in place and rehearsed by control room and other key staff.

100. The clinical reviewer has further noted that the computerised medical record for the man was not available during consultation. She adds:

> "No care plan was present in the medical records presented for the clinical review. No review date was made for [the man]. No request was made for further information. No request was made for any further tests regarding substance mis-use."

HMP Norwich should review its policies and audit the successful implementation of medical records systems to ensure that they meet the current national requirements of Records Management – NHS Code of Practice (Department of Health, published April 2006)

Clinical assessment

101. The clinical reviewer has found:

> "On 12 March there was no note made of the last dose of either Methadone or Diazepam [the man] had received. There was no comment or plan of how to manage any withdrawal symptoms resulting from the omission in receiving his usual medication. [The man's] GP was not contacted to confirm current Methadone consumption either before or as a result of his consultation. This may have been undertaken at a later stage. No withdrawal monitoring or formal observation chart was put in place."

Clinical assessment of patients with substance misuse issues should follow national guidance set out in Clinical Management of Drug Dependence in the Adult Prison Setting published by the Department of Health in November 2006. This will require a review of the current (local) policy which was published in May 2006 and has not been reviewed to date. An interim review of policy must be undertaken and an implementation plan put in place as a matter of urgency and should reflect the current situation that HMP Norwich does not currently undertake (opiate) substitution prescribing.

Prisoners currently receive the majority of their care within normal location (i.e. on a wing) and consideration must be given to ensure that primary care within normal location is sufficiently resourced in terms of environment and staffing to provide a safe service.

Detoxification medication management

102. The clinical reviewer has found that a Diazepam detoxification regime was commenced but not given to the man as an urgent medication. No opiate regime was discussed. No reason for refusal to commence was made clear.

Prescribing management for substance mis-users should follow national guidance set out in Clinical Management of Drug Dependence in the Adult Prison Setting. This will require a review of the local

policy which has not been updated since May 2006. Protocols should be available in all clinical areas and should be part of prescribers' training and induction.

Closure of cell observation hatch

103. The man's observation hatch was closed during the afternoon because of his aggressive behaviour.

HMP Norwich healthcare policy and protocol for management of prisoners with substance mis-use should reflect national guidelines with regard to the closure of observation hatches for prisoners receiving substance withdrawal management. This can be found in the Clinical Management of Drug Dependence in the Adult Prison Setting.

Managing challenging behaviour

104. The clinical reviewer has noted that the man was placed on a disciplinary report for spitting at an officer and then issued a warning for unpleasant behaviour towards staff. She makes the following recommendation that I endorse:

HMP Norwich healthcare staff and prison officers (working in the healthcare centre) should receive training on the management of challenging behaviour in prisoners with substance misuse issues.

105. However, whilst I accept that there may be a training need here, I do not criticise the healthcare principal officer for taking formal disciplinary action against the man for spitting at him. This was a wholly unacceptable form of behaviour that no member of staff should have to tolerate. All decisions to use formal disciplinary measures are inherently discretionary. But the purposes of formal discipline include the protection of staff and the setting of standards for all prisoners. For those reasons, a decision to charge the man could be justified notwithstanding that he was withdrawing from drugs.

106. I should emphasise that the recommendations listed above should be considered in conjunction with the full list of recommendations shown on pages 22 - 27 of the clinical review itself.

Was the man's risk of self-harm or suicide properly assessed, monitored and managed?

107. When the man arrived at Peterborough from court on 8 March, his Prisoner Escort Record (PER) contained a notation that he was at risk of self-harm because, earlier that day, he had apparently head butted the door of his cell at the police station and had tied cloths around his neck. A Prisoner Custody Officer (PCO) had also raised a suicide/self-harm warning form because the man had admitted that he had a history of self-harm and had cut his knuckles as a result of damaging his cell window with his fists. Although the warning

form was signed by the reception staff, the investigation found no evidence that its contents were considered.

108. The nurse who conducted the reception health screen shortly after the man's arrival admitted to my investigator that she did not ask him any questions about his risk of self-harm. She said this omission was caused by the fact that, during the reception process, he was shouting and complaining that he needed Methadone. She also said she saw neither the suicide/self-harm warning form nor the PER. These are unacceptable failures which must not be repeated.

109. No ACCT form was opened on this occasion. It does not follow that had the man's risk of suicide or self-harm been properly assessed at Peterborough, there would have been grounds for opening one.

110. During the induction process at Norwich, the man told a member of staff he did not feel suicidal. Thereafter, he manifested risk behaviour on one occasion. This was at approximately 10.50am on 12 March after he had been admitted to the healthcare centre at HMP Norwich, when he threatened to harm himself unless he were returned to a wing. The staff believed this was more the result of a "temper tantrum" than of any active suicidal ideation. It is easy, with the benefit of hindsight, to judge against that view. However, I believe that, at the time, it was reasonable for staff not to open an ACCT form.

111. After the man was discovered hanging, a note was found in his cell that indicated his inability to carry on living. This suggests that he made a conscious decision to end his life. I believe that, however much he may have known what he was doing at the point of making that decision, the man was likely to have acted on impulse at a time when he was not receiving appropriate detoxification medication. My experience of other investigations has shown that there can be a relationship between drug misuse and risk of self-harm or suicide. I believe this to have been the case where the man was concerned. I urge the Director of Peterborough, the Governor of Norwich and the PCT to take seriously the comments and recommendations made in the clinical review and to implement the recommendations urgently.

Was the response to the discovery of the man's hanging prompt and appropriate?

112. The man was found hanging in his cell at about 4:55pm on 12 March by the healthcare colleague. He entered the cell straightaway, calling for assistance as he did so. His colleague the HCO cut the ligature from the man's neck with no delay. He and the healthcare principal officer laid him on the cell floor and checked for signs of life. Finding none, they applied CPR and continued to do so until an ambulance crew arrived approximately 10 minutes later. The healthcare manager arrived at the cell very soon after the man was discovered and assumed responsibility for co-ordinating the efforts of prison staff to attempt to save his life. The paramedic crew continued to apply advanced life saving techniques for a further 15 minutes. Sadly, their efforts were in vain. The man's death was pronounced at 5:21pm.

113. The man's family were concerned to be told as much as possible about the manner in which he hanged himself. Unfortunately, those who were interviewed by my investigator were unable to explain this in any detail.

114. I am satisfied that the response to the discovery of the man hanging was both prompt and appropriate. I commend those staff who tried to revive him for their determined efforts in very harrowing circumstances.

Were appropriate courtesies offered to the man's family in the aftermath of his death?

115. The Governor and his family liaison officer (FLO) broke the news of the man's death to his brother at their home,in person at about 8:00pm on 12 March. They both stayed with the family until it was appropriate to leave. The Governor later wrote a letter of condolence to the family. This was delivered to them by the prison FLO in person.

116. In liaison with the Coroner's office, the prison FLO helped to arrange for the family to view the man's body at the mortuary on 14 March. She supported the family in person before and after the viewing.

117. The prison FLO and the deputy governor represented the Governor at the funeral service that took place on 26 March. A wreath was sent to the undertakers from the prison with the agreement of the man's family. The full costs of the funeral were offered by the Governor.

118. On 3 April 2008, the man's brother and other members of his family viewed the cell in which he died under arrangements made by the prison FLO.

119. I am impressed by the manner in which the Governor personally took the lead in breaking the news of the man's death to his family. I also make special mention of the prison FLO, who, in my opinion, discharged her responsibilities in her role with the highest standards of professionalism and sensitivity.

PRINCIPAL CONCLUSIONS

120. The clinical reviewer has concluded that a number of key healthcare interventions were either omitted or not undertaken adequately and that, consequently, the healthcare the man received at both Peterborough and Norwich fell short of the required standards.

121. The reception health screen the man underwent at Peterborough did not adequately assess his risk of self-harm or his history of alcohol abuse. The assessment of his fitness to attend court the next day was not based on a face to face interview. Although he had been placed on a Methadone based detoxification programme, he was not given his daily dose of Methadone prior to leaving for court because of an error on his medical chart. After his court appearance, the man did not return to Peterborough as there were no longer any vacancies there. Instead, he was transferred to Norwich where Methadone was not available.

122. A full reception screen was not completed when the man arrived at Norwich. Although it was noted that he was a drug misuser, no questions were asked of him with regard to alcohol abuse. No urine test was undertaken because of a shortage of testing equipment. No referral was made to the detox nurse. No prescription was issued for either opiate or benzodiazepine detoxification. No note was made of the last time he had received any medication to manage his drug dependency. He was assessed as being fit for normal first night location despite his unmanaged drug dependency and history of convulsions and self-harm. During the evening of 11 March, the man had a further seizure, the cause of which was unclear. No advice was sought from a doctor by the member of the healthcare team who attended. An ambulance was requested but did not arrive. However, he made a full and prompt recovery such that the ambulance was no longer required. Although it was known that he was an opiate substance user, no formal arrangements were made for him to be observed in the aftermath of his seizure and no opiate scale was initiated.

123. The following morning, the man had another seizure and was admitted to the healthcare centre. During the afternoon, his behaviour deteriorated. He threatened to kill himself if he was not discharged to a wing. He spat at a member of staff who was trying to help him calm down. Because of this behaviour, the observation hatch in his cell door was kept for a time in the closed position. This was not in keeping with national guidelines for the management of prisoners subject to substance withdrawal programmes.

124. The clinical reviewer makes a number of recommendations for the improvement of healthcare systems at both Peterborough and Norwich so that these faults can be remedied. I argue that prisoners who are subject to detoxification programmes should be returned to the discharging prison to continue their prescribed detoxification regime after their court appearances. I am concerned that Operation Safeguard is not in practice ensuring the continuity of medical treatment. The dangers in respect of those detoxifying from drugs need no elucidation.

125. I am satisfied that the response to the discovery of the man hanging was both prompt and effective. I commend those staff who tried to save his life.

126. I am impressed by the manner in which the Governor personally took the lead in breaking the news of the man's death to his family. I also make special mention of the prison FLO, who, in my opinion, discharged her responsibilities in her role with the highest standards of professionalism and sensitivity.

FAMILY CONCERNS

At draft stage, the man's family raised a number of concerns they felt had not been adequately reflected in the draft report. My investigator therefore put their questions in writing to the Director of Peterborough and the Governor of Norwich. I repeat here, verbatim, the family's questions and the responses received.

Questions to the Director of Peterborough

1. Once someone has been prescribed some medication 'outside' why is this automatically stopped when someone goes into prison without even asking for previous medical records?

Response:

When a person enters prison it is normal for some drugs to be disallowed due to the establishment's protocol.

2. How long do you have to be in custody before your medical records are requested? Is there a procedure for this?

Response:

Previous medical records are sought from outside the same day unless reception occurs on a weekend. This is standard practice.

3. Peterborough knew the man was on methadone and diazepam (he told them) and they had put him on methadone in October anyway. Why didn't they check this out instead of letting him withdraw on a very reduced amount?

Response:

Due to the fact that the man had been in custody elsewhere and was unable to maintain his methadone during that period, when he recommenced his methadone at Peterborough it would have been unsafe to give him the amount he had taken previously. It was therefore safer to start him on a lower dose which should have been gradually increased up to, or close to, his normal dose. The man was on diazepam at the time he was in Peterborough. The doctor's entry in records dated 8 March confirms this.

4. If it was obvious that the man was withdrawing (and a number of staff mentioned they could tell he was doing so), why wasn't he referred to a drugs counsellor at either prison? What sort of counselling is available at both prisons?

Response:

There is a CARATs service at Peterborough and we also have a Substance Misuse nurse working within the prison to provide drug counselling support to prisoners.

The man's records show that he was asked to attend healthcare on 10 March 2008 for an assessment with the Substance Misuse nurse but he did not attend.

The Director Peterborough of Peterborough ended his letter with the following words:

"Once again I would offer our deepest sympathy to the man's family. I am sure that this has been a very difficult time for them and it will no doubt take a considerable time for the family to recover from the shock of their loss."

Questions to the Governor of HMP Norwich

1. The man arrived at about 5.00pm. Someone from the prison phoned (his sister in law) at about 5.30pm to tell her that he had arrived there. She got the impression that he had asked that they ring her. If someone could ring up about his arrival, why didn't anyone think to ask her about his fitting and medication? Or at least find out from her who his GP was?

Response:

The man arrived at HMP Norwich on 11 March 2008 and it is believed that a phone call was made by the First Night Centre staff (E Wing) at his request, to his sister in law to inform her that he was at Norwich prison and not at Peterborough. 'Courtesy' calls are made by First Night Centre staff on behalf of prisoners on the first night to inform family members/relatives that the person is at Norwich. It is not normal practice for First Night Centre staff to ask family members /relatives for further information, particularly of a medical nature. If the information is forthcoming from the family member, then that is written down and, if necessary, forwarded to the medical staff. The nurse in reception had access to the man's medical information from Peterborough. She saw him at approximately 5.00pm and, according to the medical information, a full reception screen was done. She recorded that he should be seen by the doctor in the morning.

2. She (the man's sister in law) is shocked that the man saw a locum agency doctor who did not have any knowledge of his medical history. Why does Norwich have to rely on agency staff? Surely a prison needs their own designated healthcare staff, including doctors? Is there a staffing problem? What is being done to address it? She (the man's sister in law) is also shocked that the doctor saw him in a room where the computer was not working. How could a proper assessment be made of the man's medical needs? Or at least register that this was inadequate and schedule an urgent full assessment with relevant information?

Response:

The tender for GPs sits with the Commissioners NHS Norfolk. The tender was not let at the time. It was re-tendered in July 2008. The Head of Healthcare has stated that even if there had been a substantive GP they still would not have known the man. Prison healthcare is part of the NHS and. Like the NHS, has staffing challenges Recruitment is on-going. Hence the reason for relying on agency staff. There is a core group of designated healthcare staff but not doctors. The man was seen by the locum doctor. At the time, he did not have designated access to the

computer. However, he did record his consultation under authorised access after seeing him. The consultation was recorded on the computer at 10.42am on 12 March.

3. The man tried to make a phone call at about 4.00pm on 12 March. His sister on law believes this could have been to her. He was clearly frustrated by his failure to get through. Why didn't staff try to help him communicate with the outside? There is no evidence of any empathy with someone who was getting increasingly wound up. Did anyone offer him the use of an official phone free of charge?

Response:

We do not know who the man was trying to contact at approximately 4.00pm in healthcare on 12 March 2008. It may have been his sister in law or it may have been his girlfriend who was believed to be pregnant at the time. The HCO, also tried the number but he was also unable to get through at the time. According to The healthcare senior officer, who was present at the time and had spent a lot of time with him that day, he (the man) did not state that the phone call was urgent or seem frustrated about it.

4. The healthcare principal officer at Norwich, said that he could tell the man was withdrawing just by looking at him. The man wanted medication and said he would kill himself if he didn't get any. Why then was a known self-harmer obviously withdrawing from drugs, allowed to be shut up on his own with the hatch up? He had clearly been labelled as a trouble maker and this seems to have dominated thinking about how to handle him. Why was the victim of the man's aggression (the healthcare principal officer) allowed to remain working with him when it would have been better to remove him from the situation?

Response:

Whilst on E Wing on 11 March 2008, the man had a fit at approximately 8.55pm and the nurse was called. He was given diazepam orally which had been checked against Peterborough's drug chart. The nurse advised him to move to the healthcare centre but he refused. He seemed fine for the rest of the night. He was seen again at approximately 8.30am on the morning of 12 March on E wing. As previously stated, the man was seen by the doctor that morning. According to the healthcare principal officer, the doctor had written him up for medication but this wasn't the medication that the man wanted. Methadone was not prescribed at the time. He kicked the staff office door open. The healthcare principal officer was on the phone at the time. The man proceeded to shout at staff to get him out of healthcare and back onto the residential unit. The healthcare senior officer was also present and he walked him back to his cell.

Later, the healthcare principal officer went to see the man to find out what the problem was. He informed him that healthcare was the better place for him and for the staff to observe him. He became aggressive and in the presence of the healthcare senior officer, he spat in the healthcare principal officer's face and said he was going to smash his cell. The healthcare principal officer tried to shut the cell

door as the man continued to kick it. They finally managed to shut the door. The healthcare senior officer stated that it was he who put the hatch up and not the healthcare principal officer as the man was aggressive: he had spat at a member of staff and was heard throwing furniture around the cell. The healthcare senior officer stated that at no point did he hear the man say he was going to kill himself. He was not on open ACCT as he had not been flagged as a known self -harmer at the time. It was only a few minutes later that the healthcare senior officer returned to the man's cell. He noted that the man had calmed down and spoke to him through the hatch. He convinced the healthcare senior officer that he was calm and would not throw anything at anyone out of the hatch so the hatch was left open. He was placed on report for his action towards the healthcare principal officer.

The healthcare principal officer also contacted the police who, according to the healthcare senior officer, interviewed the man about the incident that day. Although the healthcare principal officer was on duty he did not have any further contact with the man. The healthcare senior officer was on duty in the healthcare unit all day on 12 March.

5. Were medical staff aware that one of the side effects of diazepam is "fitting"?

Response:

According to the Head of Healthcare, medical staff are aware of the fact that the side effect of diazepam withdrawal (not diazepam) is 'fitting'. On 10 March 2008, the man was given methadone at Peterborough. When he arrived at Norwich on the evening of 11 March,it was not clear as to whether he had had his methadone that morning before leaving for court as his medical chart was incomplete. He was given diazepam orally on the evening of 11 March. On 12 March, he was prescribed benzodiazepine detox by the doctor and he received 10mg of diazepam at approximately 2.00pm that day.

6. If it was obvious that the man was withdrawing (and a number of staff mentioned they could tell he was doing so), why wasn't he referred to a drugs counsellor at either prison? What sort of drug counselling is available at both prisons?

Response:

The man's medical record shows that on 11 March, he was referred to the Substance Misuse Service by the nurse in reception. According to the Head of Healthcare, the Substance Misuse Service would normally have seen the man the day after referral.

LIST OF RECOMMENDATIONS

To HMP Peterborough

Reception health screen

1. HMP Peterborough must review its policies and procedures for first reception screening to ensure these meet national guidance. Documents which would be useful are:

   Prison Service Order (PSO) 3050 - Continuity of Healthcare for Prisoners
   PSO 1025 - Communicating information about risks on escort or transfer
   PSO 3550 - Clinical Services for Substance Misusers
   PSO 0500 - Reception (section 4 and section 6)
   Clinical Management of Drug Dependence in the adult prison setting

   Particular note should be taken of the provisions of paragraph 4.4 of PSO 0500 and paragraphs 1.2 and 1.4 of PSO 1025 which set out guidance on the use of Prisoner Escort Records. Prison healthcare staff who are responsible for undertaking first reception screening should be appropriately qualified and receive regular training and supervision in effective assessment of prisoners.

Fitness for court

2. HMP Peterborough should review their processes to ensure that prisoners are seen as close to discharge as possible to confirm their fitness to attend court. The review should include ensuring that prisoners who require medication have received this prior to leaving and that all necessary documentation accompanies the prisoner.

3. The current process in place for confirming a prisoner's fitness for court must be reviewed to ensure that where prisoners have particular healthcare issues such as substance misuse these are taken into consideration.

Transfer of medical information

4. HMP Peterborough should ensure that the provisions of paragraph 5.3 of Prison Service Order 3050 are followed when prisoners are transferred to court so that they have a summary of relevant medical details available. Where possible, this should be followed up with telephone communication confirming current health issues.

Continuity of care

5. HMP Peterborough should review their policies in line with PSO 3050, 'Continuity of healthcare for prisoners' to ensure that prisoners who have not completed opiate stabilisation are able to receive continuity of care either through clinical hold of their accommodation or by ensuring that the receiving prison is contacted.

To the Prison Service

1. The guidance in PSO 3050 covers the facility to agree a 'clinical hold' on accommodation for patients whose clinical condition is such that they would be at risk if transferred. It states at paragraph 5.5, 'patients may need to be placed on clinical hold' (i.e. withheld from transfer for a period of time for clinical reasons when indicated).

   The guidance should be nationally reviewed to ensure that a clinical hold is available for remand prisoners who have commenced substance misuse stabilisation, to ensure they are able to return (to the discharging establishment) if courts decide to continue custodial arrangements.

To HMP Norwich

Reception health screen

1. HMP Norwich must review the content and implementation of the policies and procedures in use at first reception screening to ensure these meet national guidance. Documents which would be use would be:

   Prison Service Order (PSO) 3050 – Continuity of Healthcare for Prisoners
   PSO 3550 – Clinical Services for Substance Misusers
   PSO 0500 – Reception (section 4 and section 6)
   Clinical Management of Drug Dependence in the adult prison setting (published in November 2006).

   In particular, policies regarding recognition, management and stabilisation of prisoners who are receiving Methadone substitution and benzodiazepam detoxification should be reviewed and implemented.

2. First reception processes should be audited regularly for quality assurance and to confirm full implementation.

3. Prison healthcare staff who are responsible for undertaking first reception screening should be appropriately qualified and receive regular training and supervision in effective assessment of prisoners.

4. Access to a medical practitioner should be available to all prisoners who require to be seen on the day of their arrival. This might be delivered by reviewing current surgery hours to ensure that cover is available in the afternoon to see all prisoners who require to see a doctor during normal primary care hours of 8.30am to 6.00pm.

Managing medical emergency events

5. HMP Norwich should put into place protocols and care pathways for managing emergency medical events. This should include the requirement for requesting external medical assistance in acute medical events such as unexplained convulsions. Healthcare staff within normal cell location should receive regular training and supervision in the emergency assessment and treatment of prisoners who present with acute medical events. Staff should receive training in the management of prisoners at risk of opiate withdrawal which includes the use of opiate withdrawal scales for monitoring their condition.

Calling an ambulance

6. The Governor should review his contingency plans for calling an ambulance to ensure that effective drills and procedures are put in place and rehearsed by control room and other key staff.

Management of medicines

7. Healthcare staff should familiarise themselves with medicines management to ensure that they administer medication in line with professional legal requirements.

Record keeping

8. HMP Norwich should have in place both protocols and training available to staff to ensure that record keeping is standardised and includes all relevant information including plans of care management and patients' choices with regard to health intervention.

9. HMP Norwich should review its policies and audit the successful implementation of medical records systems to ensure that they meet the current national requirements of Records Management – NHS Code of Practice (Department of Health, published April 2006)

Clinical assessment

10. Clinical assessment of patients with substance misuse issues should follow national guidance set out in Clinical Management of Drug Dependence in the Adult Prison Setting published by the Department of Health in November 2006. This will require a review of the current (local) policy which was published in May 2006 and has not been reviewed to date. An interim review of policy must be undertaken and an implementation plan put in place as a matter of urgency and should reflect the current situation that HMP Norwich does not currently undertake (opiate) substitution prescribing.

11. Prisoners currently receive the majority of their care within normal location (i.e. on a wing). Consideration must be given to ensure that primary care within normal location is sufficiently resourced in terms of environment and staffing to provide a safe service.

Detoxification medication management

12. Prescribing management for substance misusers should follow national guidance set out in Clinical Management of Drug Dependence ion the Adult Prison Setting. This will require a review of the local policy which has not been updated since May 2006. Protocols should be available in all clinical areas and should be part of prescribers' training and induction.

Closure of observation hatches

13. HMP Norwich healthcare policy and protocol for management of prisoners with substance mis-use should reflect national guidelines with regard to the closure of observation hatches for prisoners receiving substance withdrawal management. This can be found in the Clinical Management of Drug Dependence in the Adult Prison Setting.

14. HMP Norwich healthcare staff and prison officers (working in the healthcare centre) should receive training on the management of challenging behaviour in prisoners with substance misuse issues.

Commendations

1. I commend those staff who tried to save the man's life after he was found hanging.

2. I am impressed by the manner in which the Governor personally took the lead in breaking the news of the man's death to his family. I also make special mention of the prison FLO, who, in my opinion, discharged her responsibilities in her role with the highest standards of professionalism and sensitivity. I commend both of them.

At consultation stage, the Prison Service accepted these recommendations.