Investigation into the circumstances surrounding the Death of a man in a prison Healthcare Centre

Report by the Prisons and Probation Ombudsman for England and Wales

October 2006

This is the report of an investigation into the circumstances of the death of a man in a prison Healthcare Centre. I would like to extend my condolences to his mother, partner and brother, and to all those touched by his death.

The cause of the man's death has not been ascertained by pathologists despite two separate post mortem examinations. He died in the prison's healthcare centre after being located there following a period of irrational behaviour and hallucinations. It is known that he regularly used illicit drugs and alcohol outside prison. In prison, whilst he was not himself prescribed any medication, he obtained and used other prisoners' antidepressants and Subutex.

The investigation was led by one of my Fatal Incident Investigators. An independent review of the man's medical care in prison was commissioned from the Director of Prison Health at the local NHS Primary Care Trust. The review was prepared by the Prisons Medical Adviser for the Primary Care Trust. Regrettably, it was not received until July 2006 some ten months after the man's death, and hence has delayed the issuing of my own report.

My investigator and I would like to thank the management and staff at the prison and the local police for their assistance and co-operation during the course of this investigation.

Stephen Shaw CBE
Prisons and Probation Ombudsman **October 2006**

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Summary

The man who died in the healthcare centre had been received at the prison as a remand prisoner. He was 33 years old and was not receiving any prescribed medication. He had previously misused both drug and alcohol, but did not tell this to prison staff.

The man was admitted to the prison's healthcare centre In Patient Department (IPD) six days later in the late morning, having displayed irrational behaviour during the night and early morning. His behaviour had been reported to staff by his cellmate, and was then observed by wing and medical staff. He was moved from the accommodation block and re-located in the healthcare centre by a Control and Restraint (C&R) removal team.

He was assessed by the duty member of staff, and thought to be suffering from the effects of taking drugs. He was not physically examined by any medical staff during his time in the IPD except for the receiving officer, who obtained a urine sample and took his temperature. The urine test appeared to confirm the earlier diagnosis.

Shortly afterwards, the man who died was designated as a risk to staff who should not be unlocked by fewer than three members of staff. He was not seen as at risk of harming himself, and was not put on a regular observation regime. He continued to display irrational and agitated behaviour which included shadow boxing and energetic exercise for long periods, shouting and refusal to wear clothing. He also appeared to be suffering from hallucinations. He had lucid periods but they became shorter with time.

The man who died was reported by staff and prisoners to have been sweating profusely on the Houseblock, and throughout his time in the IPD except for one short period. During his time in healthcare he was advised to drink water and was assisted to do so by staff and prisoners who came into contact with him.

The man was seen by a doctor, nursing staff, and an In-Reach mental health nurse practitioner and members of the Substance Abuse Team, although no-one carried out a full physical examination. The ongoing consensus was that, although he denied it, the man was suffering from the effects of a drug induced crisis and a policy of waiting and observing until the effects wore off was adopted.

At 1.30am on the night before he died, the night nurse grew concerned that the man was becoming dehydrated and called the duty doctor at home. He did not come into the prison because the nurse misunderstand that she was authorised to ask him to do so. The doctor prescribed a low dose of diazepam, and advised the nurse to encourage him to drink water and that, if his condition worsened, she should send him to an outside hospital. She administered the drug, and observed him closely throughout the remainder of the night, but he was not sent out to hospital.

The next morning the man destroyed the furniture and fittings in his cell, and was moved by a C&R removal team into a nearby undamaged cell. He continued to be irrational, hallucinatory and unpredictable. In the evening, he was seen by staff and prisoner orderlies to be active at about 7.30pm, but by 7.45pm was lying on his bed.

He responded with a grunt to an enquiry by a member of staff, and at 8.30pm was described by the night nurse as lying on the floor on his back. She spoke to him, but got no response, though she believed that he was breathing. About five minutes later, the night patrol officer saw him lying on his front. Again he did not reply when spoken to. The officer switched the cell light off, believing that the man had tired himself out and was sleeping.

At 10.25pm, the officer switched on the light and checked the man a second time. He was lying in the same position, and there was a pool of pink liquid behind his head. He received no response from calling him or kicking the door. Because of the unlock restrictions applied to the man, the officer did not unlock the door but called for assistance. Shortly afterwards the nurse and Night Orderly Officers (NOO) arrived and entered the cell. It was evident to them that he was dead and they made no attempt at resuscitation. They withdrew from the cell, and awaited the ambulance crew who on arrival confirmed that the man had died.

The police were informed, and the prison's contingency plan for responding to a death in custody was initiated.

The news of the man's death was broken to his brother and mother early the following morning. They were told separately but in a way that ensured that they were informed at about the same time. An attempt was made to ensure that the man's partner was informed simultaneously, but contact could not be made and she was informed later in the day.

I make ten recommendations.

The investigation process

1. The investigation into the death was conducted by a Fatal Incident Investigator from the Prisons and Probation Ombudsmans Office. Notices were issued to staff and prisoners telling them of the investigation and its terms of reference, and offering them the opportunity to participate.

2. The Investigator's first visit to the prison was made six days later. He visited the healthcare centre and saw both cells occupied by the man who died. He also visited the Houseblock where the man had been located previously. He obtained relevant documentation relating to the man's period of imprisonment. Interviews were conducted over a period of days with two prisoners and a large number of prison staff who had significant contact with the man.

3. The investigator also wrote to the man's cellmates on the Houseblock to ask for interviews. Both had been released from the prison. The first did not reply to the letter and could not be contacted, but the second initially agreed to be interviewed. However, subsequently he sent a message to the effect that all he had to say had already been recorded in his police statement.

4. One of my Family Liaison Officers (FLO) arranged a meeting with the man's mother and his partner, who was named as his next of kin. My investigation has attempted to answer their questions and concerns voiced at the meeting, and in subsequent conversations with the FLO.

5. The man's partner requested that copies of all relevant documents available to the investigator be supplied to her. The view of the Coroner was sought, and agreement to disclosure was given. All relevant documents were forwarded to the man's partner with a request that she maintain their confidentiality prior to the Inquest. The man's mother later made the same request and again, having sought the Coroner's views, the documents were forwarded with a similar request to maintain confidentiality.

6. I am very grateful for the assistance my investigator received from the Detective Inspector in the case, who led the police investigation into the man's death.

7. A copy of the post mortem report was requested from the Coroner and was received. A second post mortem examination was commissioned on behalf of the man's family, and a copy of the report was duly received.

8. A Clinical Review of the medical care the man received at the prison was commissioned from the Director of Public Health for the Primary Care Trust (PCT). The PCT Prisons Medical Adviser carried out the review. My investigator was informed by the Director when the Clinical Review could be expected. From then on a number of contacts were made with the PCT and the review was received some months later. This factor significantly delayed the issuing of this report beyond the receipt of the second post mortem report.

Events leading up to the man's death

9. The man was arrested by Police during the evening and was detained at a police station. He told the police that he was well, but that he had schizophrenia. He also said that he had taken a quantity of cocaine and gamma hydroxybutyrate (GHB) earlier in the day, and occasionally took diazepam to relax. Whilst in police custody, he was first placed on a constant watch, reduced during the evening to observations every 30 minutes. Later in the evening, he became agitated and asked to see the nurse again, but she was unavailable. He went to sleep, and by early morning, was awake and appeared calm.

10. The man and another man jointly charged with kidnap and firearms charges and were remanded in custody by a magistrates' court to appear at Crown Court five weeks later. Whilst at the court the man was seen by custody staff every ten minutes. Nothing unusual was reported, apart from a request that he should be handcuffed and his subsequent refusal to go into court. At 7.42am, whilst still in police custody, he was offered breakfast. At 1.30pm, he accepted a meal and drink.

11. Late in the afternoon of day he was remanded, a Friday, the man and his co-defendant were taken to the prison. In his police statement the co-defendant described the man as "fine on the way up in the van and when he was taken to the Seg. He just said, 'See you later – he was laughing.'"

12. On arriving at the prison, a First Reception Health Screen form was completed. And the man reported that he had seen a doctor in the previous few months regarding a pain in his right leg, and had injured his lower right arm some 18 months previously which became stiff at times. He also said that he was a social drinker and used cannabis, but no indication of the frequency of use was recorded. This information is consistent with the Prisoner Escort Record (PER) form, signed earlier the same day by police. The PER form also recorded that the man had previous drug offences. The appropriate box was ticked, indicating that he misused drugs, although these were not specified. The First Reception Health Screen form also recorded that he was not at risk of self harm was fit for normal location and work. He said that he did not need to see a doctor although question 5, which asks if he has any physical health concerns, had been answered "Yes" in relation to his arm. The note following requires that referral to a doctor or clinic must follow, but this did not happen.

13. A Cell Sharing Risk Assessment was also completed and the man was assessed as low risk, and suitable to share accommodation. A short note was made on the form that "Both Co'D (co-defendants) put in together if possible". The information on the risk assessment is contradictory in that his offence was noted as "Kidnap – Firearms", but further on it records that it does not include either category of offence. The source of the information is also unclear.

14. The man who died signed the local PCT & Prison Service medication compact, which indicates he understood that he should not have any medication which had been issued to any other prisoner.

15. The man and his co-defendant were located in a Houseblock. The officer taking him there described him as polite, and said that they spoke about how things had altered since he was last in the prison. The man was interviewed by a member of the Resettlement Department who started the Induction Interview process. He said that he had no history of substance abuse, was not feeling suicidal and had no history of self harm. The Induction Interview booklet was not completed during the interview.

16. Later in the evening the man was moved from the houseblock to the Segregation Unit. The reason for the move was because he was potentially a Category A prisoner. (As noted, the prison holds potential Category A prisoners in the Segregation Unit - or in the healthcare centre.) The man was issued with a document to explain why he was potentially a Category A prisoner, and the regime he would be subject to until his status was confirmed. It is normal practice for Category A prisoners in the Segregation Unit to be observed every hour, and this applied to him. The observations were noted in the appropriate individual Observation Book.

17. The next morning a member of the Resettlement Department saw the man and completed the Induction Interview booklet. During the interview he indicated that he had numerous previous convictions, including possession of drugs, and that he had a history of cannabis abuse. Between 3.05pm and 3.40pm that afternoon, he was visited by his mother.

18. After the visit, the man returned to the Segregation Unit, and soon afterwards was returned to the houseblock, it had been decided that he was not a Category A prisoner. He was placed in a cell on a houseblock together with his co-defendant, and another prisoner. The third man later made a statement to the police, but was unable to give very much information about events leading up to the man's death. In his statement the co-defendant described the man as "happy as Larry", having been told he was staying at the prison rather than being transferred to another prison further away from his family.

19. The co-defendant said that at around 4.15pm on what he thought was the same day; he and the man went to another cell where they found the occupant preparing a line of Subutex. Both co-defendants snorted a thin line and then left the cell, and about half an hour later the Subutex began to take effect. That evening, the co-defendant said that the man was his normal self, but slept unusually well. He said that the man normally only slept for about four hours, and used to take diazepam and a bottle of vodka each night to help him sleep.

20. The third cellmate had been prescribed a course of anti- depressants (fluoxetine, commonly known as Prozac) which he kept in an unlocked cupboard in the cell. According to the co-defendants statement the man took a couple of the cellmate's tablets during the Saturday and over the next few days between them they took all 30 tablets.

21. The co-defendant says that the man was fine on Saturday with nothing eventful happening, except that he did not sleep at all. He goes on to say that the

Sunday was another uneventful day and the man was fine. However, during the afternoon the man had been shouting out of the cell window and was annoying other people on the wing. Afterwards all three were moved to another cell on the wing which annoyed the man but he went without any problems. The co-defendant thought that the man might have taken more fluoxetine.

22. During the early hours of Monday the co-defendant woke several times to hear the man talking as if he was on the telephone, including ordering pizzas. The co-defendant had not seen him behave like this before, and told him that "it's in your head, sort it out". He said that he thought the man was "losing it", but was able to bring him back to his senses. During the daytime, the co-defendant said that the man seemed to be fine again, but that it was the last time he saw him wearing any clothes. The man was already undressed when the two other cellmates got ready for bed, and did not dress again.

23. During the early hours of the following morning, the man woke his co-defendant several times and was, as he describes it, "talking gibberish. He was talking to people who just weren't there." At one point during the night, he woke to find the man placing a cigarette lighter beside his bed, and later he woke again when he was searching for something around his bed. He asked the man what he was doing, to which he named a mutual friend who was trying to communicate with him through the lighter and get inside his head. The co-defendant said that again the man did not sleep that night, but was continually pacing around the cell and making a noise.

24. At 7.00am on the Tuesday the man turned the in cell television on, with the volume up high, which woke his co-defendant. He said that the man was still talking to people who were not present, and added that he got him out of bed to get close to the television where he said the voices were coming from. The co-defendant said that the man had already eaten his breakfast, and so only had a couple of cups of tea in the morning. He said that "the man's eyes kept closing and flickering when they did so", and when they were shut he talked to people who he thought were present. The man began shouting at the mutual friend, whom he thought had stabbed his partner.

25. Just before 9.00am, the co-defendant telephoned the man's partner to ask her advice on what to do with him. She told him to talk to him, to which the co-defendant replied that he was beyond conversation and was not listening any more. He returned to the cell to tell the man that he had spoken to his partner, trying to reassure him that she was alright.

26. At 9.00am the man and his cellmates were due to be locked in their cell. According to the co-defendant, the third cellmate was so worried by the man's behaviour that he decided to go to the prison gym and left the cell. Just before lock up, the man told his co-defendant to leave as well, and then began shouting loudly. He came to the cell door to call the co-defendant back inside, after which he behaved normally for a while. The co-defendant said that he thought that the man was suffering from lack of sleep, as he looked tired and said that all he wanted to do was to sleep.

27. At around 10.00am, the man began to behave strangely again, telling his co-defendant that their mutual friend had put computer bugs in his arms and asking him to cut them out with a razor. The co-defendant took the razor from the man and hid it. The man also said that the man was arguing with him inside his head, and asked the co-defendant if he could hear him.

28. Half an hour later, the man rang the cell buzzer to call a doctor. A Prison Officer responded to the buzzer, and the co-defendant told her that the man needed to see a doctor. By 11.00am, the co-defendant had left the cell to go for exercise, and he spoke to the prison officer again about the man's lack of sleep, his behaviour and that he needed a doctor urgently. He also told her that it was not safe for the man to be left on his own in the cell. She told him that she would deal with it, and a Nurse working on the wing was asked to see the man in his cell. The Nurse was concerned about the man's agitated behaviour and asked for a second opinion from a Nursing Sister.

29. When the co-defendant returned from exercise the man was locked in his cell and the co-defendant was told to go to the cell next door for a while. A number of officers came to speak to the man through the door, including the Residential Houseblock Manager a Principal Officer (PO), but they met with little success. The man was insistent that doctors were trying to kill him with an injection, and he appeared to be trying to stop someone injecting him. A retired nurse and a member of the prison Independent Monitoring Board (IMB), heard and saw this exchange. The co-defendant was asked to try and communicate with the man which he did, and said that the man said, "Help, help me they are trying to kill me." The co-defendant believed that he was referring to the person he heard in his head. He said that the man was distressed and confused.

30. A prison officer described the man as standing between the beds, sweating profusely, moving jerkily and babbling loudly. She told a Senior Officer (SO) that she believed the man should be taken to the healthcare centre, which he agreed with. The Nursing Sister tried to talk to the man through the hatch, which he moved towards, appearing to see her. He was not wearing any clothes. She said that he was incoherent, confused, disorientated and hallucinating, and did not respond to anything that she said. The Nursing Sister told the Orderly Officer (OO) a PO that the man should be admitted to the IPD, and telephoned a Healthcare Officer (HCO) in the Healthcare Unit (HCU) to prepare for the admission. The Healthcare Governor authorised the move to the IPD.

31. The Orderly Officer arranged for a Control and Restraint (C&R) team to assist in the man's move to the IPD. The Residential Houseblock Manager explained what was happening to the co-defendant and thought he was pleased that the man was going to get the help he needed. The co-defendant said he asked the officers to inform him how the man was and said that he did not notice any injuries on him. The co-defendant returned to his cell, and noticed that the man's bed was soaked with sweat which was not normal for him.

32. On the instruction of the Orderly Officer, at 11.47am, a C&R Instructor took the role of supervising officer and three other prison officers assisted, with a Governor present throughout.

33. The supervising C&R instructor observed that the man was dressed only in a pair of underpants, was sweating heavily and was ranting. He said that he seemed aggressive, and staff were concerned for his safety and that of other people. He went into the cell, and asked the man to stand up. The man got to his feet, and was gritting his teeth and talking aggressively and complained that his skin felt as if it were on fire. The supervising C&R instructor explained that he wanted the man to turn away from him, and that two officers would handcuff his wrists behind his back. The man complied with the instructions, although his behaviour continued to be bizarre and he was noisy. He asked for drinking water and was told that he was going to a room with access to water. The man walked with the C&R team members, two holding his arms for support, from the cell to the IPD, with the Nursing Sister and the IMB member present throughout. At 12.40pm, the man was escorted into his room in IPD by the removal team and the handcuffs were removed. The officers left the room, and the door was closed. The room he was placed in is a 'safer cell', with reduced ligature points and the bed fixed to the floor. It is equipped with in cell sanitation and a tap for drinking water. The Healthcare Manager instructed that the supervising C&R instructor give the man a non tear garment, and his boxer shorts were removed from the cell.

34. The Healthcare Officer (HCO) in charge of the Red Team on that day was also the lunchtime patrol officer in the IPD that day. He received the man into the IPD at about 12.40pm, and saw him as he arrived. He said that the man was sweating heavily, his eyes were bulging and it reminded him of "steroid rage" episodes which he had seen before in other patients. The HCO was informed by the removal team that the man's co-defendant said he might have taken Subutex, and that he was suffering from severe insomnia. He advised the man to drink and saw him scoop water from the tap to drink. Another Nurse also saw the man's move to the IPD, and she told the police that she saw no injuries on him.

35. After the removal and relocation, the C&R team completed most of the necessary forms and made written statements. However, the front of the Use of Force form shows an incorrect date, as does the supervising C&R instructor's statement. One of the C&R team members name is not recorded, although his statement confirms that he was present. His form was signed on 10 days later. Form F213 was not completed as is required.

36. Shortly after the man's arrival the receiving HCO carried out a limited examination through the observation hatch in the cell door. He said that the man was naked from the waist up. The HCO placed the back of his hand on the man's shoulder and established that he was hot and his skin was wet from perspiration. The HCO assessed his mental health, and completed a Mental Health Needs Care Plan. He recorded in the Problem section that there was "aggressive & incoherent behaviour - ?? drug induced problem". He went on to identify in the Nursing Action section that the man should be referred to the

Mental Health In-Reach medical officer or a psychiatrist. He said that the man's mood, behaviour, hygiene, thoughts, sleep pattern, orientation and diet should be observed.

37. A further undated and unsigned entry near the bottom of the care plan states that the man should only be unlocked by three officers at a time. The receiving HCO said that it was not in his handwriting, and the Nursing Sister who saw the man on the houseblock confirmed that she inserted the instruction after a discussion with three other nurses and the receiving HCO. From this time onwards, it appears that the instruction for a "3 person unlock" was interpreted as meaning that C&R trained staff were required to be present whenever the man was to be unlocked.

38. The Continuous Clinical Record shows that a nurse noted that the man was still sweating; his skin was reddened and hot to touch, with a temperature of 37 degrees Celsius. He was again encouraged to drink plenty of water. He was unable to produce a urine sample for drug screening. The nurse noted that a referral had been made to the medical officer and In-Reach.

39. The receiving HCO said he observed the man from his arrival in the IPD until about 2.30pm, during which time he remained agitated and sweat was dripping from his body. He also said that the man told him that he felt safer in IPD, because there was a contract out on his life and that the HCO had better arrange protection.

40. The prison Medical Officer (MO), a doctor, said he saw the man at 2.15pm, but was unable to obtain a proper history or examine him. He described the man as very disturbed, agitated, restless, suspicious and unpredictable. He said that his speech was rambling, and he was sweating profusely. The man denied taking any drugs, but he provisionally diagnosed that he was suffering a drug induced state. The MO encouraged the man to take fluids, and told staff to continue to observe him. No medication was prescribed by the MO.

41. An HCO on Treatments duty described the man who died as a big, intimidating man, and this view was shared by other staff. He said that he had peaks and troughs, when he shouted irrationally and talked to people who were not there. He also said that the man was lucid at times, when he spoke normally to staff. The Treatments HCO said that he checked the man, as well as the other patients, until going off duty at 8.30pm.

42. At 2.30pm the receiving HCO examined the man again through the observation hatch in the door, and was able to measure his temperature with a digital thermometer in his left ear. It remained 37 degrees Celsius. The HCO offered and saw the man drink several cups of water, which he recorded in the General Communication sheet.

43. The Continuous Clinical Record states that by 3.30pm a Mental Health Nurse (MHN) practitioner employed by the local In-Reach Team, had seen the man briefly. Her qualifications are not in general or substance abuse nursing. She recorded that the man appeared to be withdrawing from substances, although

he denied it. She recommended that a drug screen should be carried out as a matter of urgency and he should be observed for the onset of illusions or hallucinations, fluids should be encouraged and the mental health team should review daily until his situation improved. At interview, the MHN said that she had not seen a patient sweat as severely as the man who died was doing, and that she would expect replacement fluids to be given.

44. At 3.30pm the receiving HCO noted that a specimen of the man's urine had been screened for drugs which showed a positive result for Benzodiazepine, Brupenorphine, Cocaine, Cannabis, and Amphetamines, and a negative result for Opiates.

45. An hour later, at 4.35pm, whilst collecting the evening meals the receiving HCO met an Officer and a Nurse both of whom are members of the prison's Substance Misuse Team. He asked them to visit and assess the man and they agreed to see him at 9.30am the next day. The receiving HCO went off duty at about 5.00pm.

46. Two prisoners were working as orderlies in the IPD. One of them was also a Listener (a prisoner trained by the Samaritans). Both men remember speaking to the man who died on several occasions during the afternoon of the day he arrived in IPD. The first Orderly described the meal regime, although he was unsure whether he served the man that day but did remember that the man was sweating and naked whenever he saw him. The Orderly Listener said he spoke to the man just after he arrived in the IPD, and attempted to talk about the Listeners scheme. He said that the man was sitting on the bed. Although he was not very communicative, he did acknowledge that he had heard what the Orderly Listener had said. The Orderly Listener described the man as alright during the afternoon, although still sweating heavily and more agitated as the day progressed. He also said that the man began to cower behind the door, as if frightened of something. From his experience of 16 months working in the IPD, the Orderly Listener formed the opinion that the man was either drugged or going through some kind of mental crisis.

47. According to the staff on duty that day, informal, irregular but frequent observation was kept on the man throughout the afternoon and early evening. The Orderlies also saw him frequently, until 7.45pm when they were locked in their rooms for the night.

48. At 7.00pm, the Nursing Sister who had seen the man on the Houseblock recorded that he continued to perspire profusely, and was very confused and disorientated. He was walking around the cell naked, and his speech was slurred. She said that his food was scattered all around the cell. She had found him crouching behind the cell door earlier, and he did not respond when spoken to, but eventually moved to sit on the edge of the bed.

49. At 8.10pm an Officer Support Grade (OSG) arrived for his shift as permanent night patrol. He was briefed by the evening Orderly Officer (EOO) and made his way to the healthcare unit. On arrival, as usual, he counted the number of prisoners and noted that the man who died was in a high dependency cell. He

said that he was told that the man was in for observation. The OSG said he was naked and dancing around his cell, and periodically would take a breath and lie down on the floor by the door. He said that he could make no sense of what he said, and was told that the man had taken a cocktail of drugs.

50. At 8.30pm the duty night nurse also came on duty. She saw the man sitting quietly on his bed staring at the wall opposite, as if seeing something there. She was briefed by the day staff that the man had been admitted for mental health observation, was aggressive and should only be unlocked by a team of three trained personnel. The night nurse saw the man again soon afterwards, by which time he was screaming and shouting. He looked as though he was in a boxing ring fighting with someone. He was jumping up and down and then diving onto the floor. She saw him drink water from the toilet and asked why he was doing that, to which he replied that he was thirsty. Both the night nurse and the OSG continued observing the man, noting that he was noisy, banging on the door, dancing around and sweating. The night nurse described the man's skin as grey, his eyes were bulging, he was sweating profusely and panting as if out of breath. She offered him water and he took it.

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51. By 1.30am the next morning, the night nurse was concerned about the man's condition. She noted that he was shouting and kicking his cell door, panting, gasping for breath and sweating profusely, and formed the opinion that he showed signs of dehydration. She telephoned the on call doctor a locum for the local doctor's practice contracted to provide overnight medical cover to the prison. She explained the man's history as she knew it, his symptoms and the details of the positive drug test earlier in the day. The locum doctor advised that, if she felt that it was necessary, she could give him 2mg of diazepam to settle him and water for the dehydration. The night nurse says that he also advised that, if the man got worse, he should be sent to an outside hospital.

52. The night nurse then telephoned the Night Orderly Officer (NOO), to tell him that she had spoken to the doctor. She explained that she wanted to administer medication, but was unable to do so because the man was only to be unlocked by three members of staff. The NOO went to the IPD, where he and the night nurse spoke to the man through the hatch in the door, gave him the single diazepam tablet and watched him take it. The night nurse gave him a cup of water, which he drank and she refilled it a further three times. The NOO said the man was undressed, shadow boxing, noisy and sweating from every pore in his body. He observed him for about 15 minutes. During a short lucid period, he shared a cigarette with the man, who thanked him. The night nurse asked the man to go to bed, rather than sitting on the floor and the NOO gave the same advice, but he continued shadow boxing. The OSG noted that the drug did not take immediate effect, and the night nurse explained that it might take several hours.

53. The night nurse recorded in the Continuous Clinical Record that the locum doctor had authorised the oral administration of 2mg diazepam. At 6.00am, she summarised the night's events in the General Communication sheet, but did not mention the diazepam and neither document indicates that the medication was administered. My investigator enquired about the control of diazepam stocks, and was informed by the Healthcare Manager that it is not a controlled drug and so there is no record of individual withdrawals from stock.

54. The night nurse states that the man was noisy and active again within 30 minutes of administering diazepam, and so for the remainder of the night she observed him at half hourly intervals. She noted that he continued to be active, as if fighting someone in a boxing ring, and sweating, making the floor wet with the drips. She said that he settled at about 6.00am and was sleeping on the floor. By the end of the night shift, at around 7.00am the OSG said that the man had settled down and was lying on his bed. At 7.30am the night nurse handed over to the day staff.

55. During the staff handover period, at about 8.00am and as he was starting his shift, a Healthcare Assistant (HCA) heard loud banging from the man's room. He went to the room together with an agency staff nurse, and others. The HCA saw the man standing naked in the centre of the room. He was holding a large piece of the bed which he had managed to break off, and was using it to

hammer on the windows and the fabric of the room. Other broken material was scattered around the room. The prison MO saw the man briefly, but was unable to examine him because he continued to damage the room.

56. The IPD prisoner orderly believes that he made his normal morning round of the IPD at around 8.30am prior to serving breakfast and noticed nothing out of the ordinary. He said that, had he noticed the broken furniture, he would have reported it immediately to the duty staff.

57. At 8.30am a Temporary Senior Healthcare Officer (TSHO) asked the duty OO for a C&R Team to move the man who died from the damaged room to an undamaged safe room. The OO asked a team to prepare to move him and informed a member of the IMB that a removal was likely. He then went to the IPD to assess the situation and saw the man through the observation hatch. He noted that he was lying on the bed, face up and shouting loudly. He was unable to communicate with him and decided that he should be moved into another safe room with access to sanitation and drinking water.

58. By 9.00am the OO and three Officers had assembled in the IPD. They were dressed in helmets, boots, guards, and one was carrying a shield. The OO told them that the man might have a weapon. Another SO was also present, but did not take part. The IMB member was present, together with a Healthcare SO and a nurse.

59. The OO said that he spoke to the man through the observation hatch and, whilst he did not think that he was fully listening to what was said, after a while he would reply. He said that the man was shouting throughout the conversation. The OO gave him some boxer shorts which he put on he then opened the door to let the officers into the room. It was evident that the man did not have a weapon, so the team was stopped and the shield was removed. The man was instructed to leave the room and go into the other safe room. He was slow to follow the order, but eventually moved without incident. He was sweating heavily throughout. Because the man was naked immediately before moving the OO was satisfied that a weapon was not concealed, and so he was not searched. The door was closed behind the man, who went into the cell alone. Physical restraints, such as handcuffs, were not used and no-one touched the man during the move. For this reason the OO said that it was not necessary to complete the usual C&R documentation.

60. The IMB member gave a statement to the police about the move. It differs from that of the OO in that the IMB member said that the man's arms were held by the removal team as they escorted him to the new room. The IMB member also recorded his observations in the IMB Record of Rota Visit (but did not mention the officers touching the man). The Healthcare SO and Nurse who were there also said that they did not see anyone touch the man. The Healthcare SO recorded in the IPD Occurrence Book that no restraints were used. Some months later the IMB member signed a second statement for police confirming that he believed that no member of the C&R team touched the man during the move.

61. Soon after the man's move the Orderly Listener in the IPD went to clean the room the man had moved from. He said it had fluid all over it, possibly from perspiration, and a meal had been spread around.

62. At 10.00am the two members of the Substance Misuse Team, visited the man as arranged the previous day. They were unable to communicate with him and so could not assess him. Their only advice about the man's treatment was to encourage his fluid intake, and they intended to return the following day.

63. An hour later, at 11.00am, the prison MO went to examine the man, but was unable to do so because he was still constantly on the move, trying to rip his mattress cover and kicking the door. The MO described him as suspicious, screaming, and shouting. Because of the man's behaviour and the risk of physical violence the MO decided that a physical examination or conversation was impossible. The doctor encouraged him to drink fluids and indicated that observations should continue, but that admission to hospital was not required.

64. The two prisoner Orderlies in IPD said that they were unable to have any meaningful conversation with the man, whom the Orderly Listener said was just grunting. He said that the man was getting worse, and appeared to be becoming more violent. He said that when he tried to talk to the man he jumped into a defensive position and began throwing punches at the wall. He said that both orderlies and staff tried to talk to him periodically but without success, except when he asked a staff member for two cups of water. The first Orderly believed that the man did not have a meal at either midday or teatime, but he thought that he took two cups of water from him.

65. A nurse recorded that the man who died continued to be observed by staff during the afternoon, and he was a little more settled though still refusing to dress. The IMB member returned to the IPD later in the afternoon, when he said the man was still noisy but otherwise calmer.

66. At 5.00pm an agency psychiatric nurse, came on duty in the IPD. She said that the HCA told her at handover that the man was unwell. She and the other staff, the HCA and another agency nurse, maintained a close watch throughout the evening at approximately 10 to 15 minute intervals. She said that the man was active all the time, jogging on the spot, jumping up and down and shadow boxing. She encouraged him to drink, and on one occasion he took a cup of water from her. The last time that she saw him was 7.30pm, when he frightened her by jumping up suddenly from below the observation hatch where he had been lying on his mattress on the floor. He then stood with his back to the wall and began jumping on his bed.

67. Around the same time the first prisoner Orderly saw the man again and was concerned about his wellbeing. He spoke about it to the Orderly Listener thinking that because he was a Listener he might be able to get through to the man, but he was unable to do so. Fifteen minutes later, the HCA switched the light on and saw the man lying on his back on the bed wearing boxer shorts. He asked if he was alright, to which the man grunted in reply.

68. The night nurse was on duty again at 8.30pm she went round the IPD rooms to check those present. She switched the light on and saw the man lying on his back on the floor beside his bed, with his feet nearest the door. She called to him once, but got no response. In her police statement she said that she saw him breathing, and noted that his skin was grey in colour. In her interview for this investigation, she said that she saw him lying on the floor, but could not say definitely whether or not he was breathing. She was also unable to confirm whether the man had been lying on his back or on his front. She said that she returned to the office to ask the duty nurse why the man was so quiet, and was told by another nurse that he had been shouting just a few minutes before she arrived. The night nurse also said that she did not notice any injuries on the man or any blood around him.

69. At 8.05pm the OSG who was designated for night duty in healthcare again, received a handover from EOO. He reported at the IPD and by 8.35pm, as is routine, had gone round to count the prisoners. When he got to his room he found that the man was quiet and appeared to be asleep on the floor of his room. The OSG said that the man was lying face down, with his back to the door. He believed that he had tired himself out, so switched off the observation light to leave him in peace. He told the night nurse that he was asleep, and that he must have been tired.

70. Both the OSG and the night nurse continued with their normal duties. The OSG patrolled the IPD and answered call bells while the night nurse dispensed medication and dealt with her clinical paperwork and call outs to the main prison. The OSG described that night as part of a horrendous week. That night, three prisoners were on suicide prevention monitoring and another on an escape watch.

71. At around 10.05pm the night nurse was called to an emergency in the main prison from where she returned to the IPD about 20 minutes later. At 10.25pm the OSG reached the man's room on his routine patrol, switched the room light on and saw him lying in the same position as before. He noticed a pool of pink liquid behind his head. He told the police that he tried to get a response by calling his name loudly, and then kicked the door, but neither woke him. The night staff carry a key in a sealed packet to gain access to a room in the event of an emergency, but they did not use it because of the instruction that the man's room should only be unlocked with three staff present.

72. The OSG used his radio to contact the communications room and requested that they ask the night nurse to telephone him. She was upstairs in the healthcare office, and rang within minutes. He told her he thought that the man was not breathing, and that he did not respond when he called to him. The night nurse told the OSG to call the NOO, and said that she was on her way back to the IPD. According to the Incident Log, the OSG radioed the NOO at 10.31pm. The NOO together with four Officers arrived at the IPD within a few minutes, at the same time as the night nurse. They went immediately to the man's room which is a few yards from the bottom of the stairs.

73. The man was seen through the observation hatch, lying on his front, facing towards the window in the rear wall. At 10.35pm, according to the cell access log, the NOO opened the door and went in with three of the Officers Dighton, Allen and Latham, followed by the night nurse. The NOO saw what appeared to be a pool of urine with a small amount of blood on the floor around the man's head. The first Officer attempted to find a pulse in the man's left wrist while the night nurse tried to find one in his neck but neither was successful. The night nurse noticed that the man was cold, stiff, grey/blue in colour and his hands and feet were clawed. She went to the treatment room for an oxygen pulsometer, which showed that there was no pulse. She formed the opinion that he had died, and from the condition of his body that he had been dead for some time. At 10.38pm, the local ambulance authority were called to attend.

74. The second Officer entering the room covered the man's lower body with a blanket, to preserve a degree of dignity. Because there was nothing further that could be done for the man the NOO withdrew all the staff from the room and locked it. The EOO arrived at the IPD to be informed by NOO that the man had died. She remained on duty until about 1.30am in order to assist the response to the man's death. The night nurse telephoned the Healthcare Manager and the duty doctor to inform them that the man had died.

75. Paramedics from the Ambulance Service arrived at the prison at 11.04pm, reaching the IPD at 11.10pm. They attached an electro cardiogram (ECG) monitor, which confirmed that there was no output. At 11.15pm, they confirmed The man's death and left soon afterwards.

The prison's response following the man's death

76. Following the confirmation of the man's death the NOO locked the room again and instructed the first Officer entering the room to remain outside, log events and prevent any unauthorised people entering the room. The time that the door was sealed is noted variously as 10.35pm in one handwritten log of events, 10.40pm in another log titled Incident Actions, and 11.55pm in a typed document titled Access to Cell. Another record, the Action Sheet – Duty Governor Death in Custody, records that the door was sealed but the time is omitted.

77. The Incident Log records that, at 10.42pm the Duty Governor was told that a prisoner might have died and made his way to the prison, arriving at 11.35pm. At 10.45pm Governing Governor was also informed of the probable death in custody, and he in turn notified the Area Manager. In the following 15 minutes, the Chaplain and a member of the IMB were telephoned. Both came to the prison soon afterwards.

78. The Chaplain reached IPD whilst the paramedics were still working on the man and he began to minister to the staff present. He discussed with the Duty Governor how and when to inform the man's co-defendant, as well as informing his next of kin. They deferred a decision on the timing of the process until the police completed their initial investigation and authorised the information to be passed on. Police were informed of the death at 11.01pm. At 00.05am, Prison Service Headquarters were informed.

79. At 00.59am a Detective Inspector and other police officers arrived, followed soon afterwards by the Scenes of Crime Officer (SOCO). They went into IPD at 1.45am, and remained until 2.20am. At 3.25am a Detective Chief Inspector arrived and was admitted to the room from 4.40am until 5.05am.

80. At 1.20am another member of the chaplaincy team spoke to the Duty Governor and the Chaplain. They decided that he and the governor would inform the man's mother and partner of his death at about 7.00am, and the Chaplain would speak to his co-defendant at about 7.30am. The arrangements were coordinated with the aim of giving the information in the first instance to the man's partner and close family in a dignified and controlled way. After the information had been shared, the co-defendant telephoned the man's mother, and it was arranged by the chaplaincy that they should meet in the prison chapel later that morning. At 9.20am, the undertakers moved the man's body to the mortuary at a local hospital.

81. There was no debrief for night staff immediately after these events as it was considered that close contact had been maintained between them and the Duty Governor throughout the night. The Care Team, IMB and chaplaincy were actively involved either during the night or the following day to provide support for staff.

82. The Governing Governor sent a letter of condolence to the man's family soon afterwards and assistance with funeral expenses was offered. The man's

property was returned to his mother by a member of the chaplaincy team and he continued to keep in contact with her.

83. A Consultant in Forensic Medicine and Pathology and Home Office Pathologist, carried out the post mortem at the hospital mortuary two days later. An examination of the man's brain was commissioned from a Consultant and Honorary Senior Lecturer in Neuropathology. Further toxicological examination was undertaken by a Forensic Scientist. The post mortem report was received from the Coroner which stated that the cause of death was not ascertained.

84. A solicitor acting for the man's partner later commissioned a second post mortem which was carried out by a forensic pathologist. His report broadly agrees with the results of the first post mortem.

Issues considered during the investigation

Reception assessment of the man's use of drugs and alcohol

85. Before coming into police custody the man regularly used controlled drugs including cannabis, cocaine and diazepam. He also used anabolic steroids and his partner and family confirmed that he regularly consumed large quantities of alcohol. He became agitated whilst in police custody and, though it passed, it might have been the first, unrecognised, manifestation of his later illness. The police who arrested him were aware of the extent of his drug use, but those who saw him later were not aware.

86. When the man was remanded into custody documents from the police and escort contractor indicating that he was violent and misused drugs accompanied him to the prison. However, detailed information was not forwarded and the prison was not told of the extent of his drug use. The man was interviewed at reception, and gave information which understated the extent of his consumption of alcohol and minimised his drug use. In the second reception interview with healthcare staff the man who died again denied any history of substance abuse. Because of the information given to staff he was not referred for any support for alcohol or drug misuse.

87. The man was first held in segregation whilst his category and status were decided. He was observed regularly and nothing of note was recorded. He was interviewed for his prison induction, and again only admitted using cannabis, although acknowledging previous convictions for possession of a class B drug. He was moved to a wing where his co-defendant confirms that he acquired anti-depressants from other prisoners, which he took orally, and he also snorted Subutex. None of the drugs was prescribed for his own use, but the information provided suggests that they came from other prisoners. There is no evidence to suggest that the man himself brought the drugs into the prison.

Clinical Treatment

88. During the man's reception health interview he confirmed that he was concerned about his physical health, for which he should have been referred to a doctor. At the same interview he denied any mental health history, and so was not referred for a mental health assessment. The same interviewer completed the Cell Sharing Risk Assessment which confirmed the information. No medication was prescribed for him on reception and no medical intervention was necessary, which was consistent with what he told staff.

The Healthcare Manager should ensure that all follow-up requirements of the reception procedure are understood and adhered to by clinical staff.

89. The man was not physically examined by medical staff immediately after re-location because of the decision about unlock arrangements. The unlock arrangements meant that all subsequent assessments and examinations by doctors and healthcare, substance abuse, and mental health staff, were restricted in that they were conducted through the hatch in the cell door. He

continued to behave irrationally, was constantly active, aggressive, sweated heavily and suffered from hallucinations. He appeared only to rest when he became exhausted. At no point does any attempt appear to have been made to enter the cell and carry out a full examination, which might have indicated that other medical interventions, including hospital admission, were required.

90. The only exception, during the afternoon of the day he was admitted to IPD, was when a Healthcare Officer took the man's temperature orally and touched his skin to attempt to ascertain his condition. Even this limited physical examination was only achieved through the hatch in the door. The same officer later obtained a urine sample, again though the hatch, which indicated that the man had used various drugs and appeared to support the initial assessment of his condition.

91. Soon after location in the IPD the man was assessed and a Mental Health Needs Care Plan prepared, based on the assessment that he had taken illicit drugs. Subsequent observations by doctors and healthcare staff concurred with the explanation, and they adopted the policy of allowing the effects of the drugs to wear off. The doctor considered that the man might need to go to hospital, but thought it unwarranted at the time. He recorded that he did not examine him because he was disturbed, agitated, restless and suspicious, and he behaved unpredictably. This was indeed the case, but at no time did the man attempt to attack or abuse staff and he complied on all the occasions when staff dealt with him.

92. During the first night of the man's stay in the IPD, the nurse became concerned that he might have been dehydrated and contacted the duty doctor. The doctor prescribed a small dose of diazepam to calm him, and told the nurse to encourage him to drink more fluids. The doctor recommended that if his condition worsened he should be admitted to outside hospital, but he was not admitted. Soon afterwards the diazepam was administered, witnessed by the NOO, but not recorded in either the pharmacy or the man's records. The nurse explained that the omission in his records was an oversight, and the Healthcare Manager confirmed that a pharmacy record was not required. However, the Manager said that the following morning a retrospective prescription should have been signed by the doctor, but this was also omitted.

93. Although I do not believe that the omissions in the recording of drug administration made any difference to the eventual outcome, failure to record administration of drugs is a serious issue and should be addressed.

Clinical staff should be reminded of their duties in regard to professional standards of record keeping. Medical record entries should be clearly written with a date, time, name, position and signature of the author.

94. The level of nursing cover in healthcare at night is a concern, and it is apparent that the IPD is a busy unit in a local prison. One nurse has to look after the IPD, with up to 29 patients and orderlies, and the remainder of the prison. The only other member of staff is an OSG with no medical training who is in sole charge when the nurse is called away.

95. The night nurse believed that, although she could seek advice from the duty doctor at night, she was not authorised to ask him to attend the prison. The Healthcare Manager said that the nurse's understanding was incorrect, and other healthcare staff interviewed confirmed that they knew they were authorised to call the doctor out. There does not appear to be a written policy which defines the extent of their authority and responsibilities. The nurse was aware that she could send the man to hospital if required, and said that she observed him closely and did not think that admission was necessary. The doctor's attendance might have resulted in hospital admission, which in turn might have altered the eventual outcome. Nursing staff knowledge of the extent of their authority is crucial to the proper care of patients, particularly for those in sole charge.

The Healthcare Manager should ensure that all staff are fully aware of their authority and responsibilities in the management of patients, particularly during the night and out of hours.

96. During his stay in the IPD the man was seen by a doctor and mental health nurse practitioners, and was cared for by staff qualified in mental health issues, none of whom detected an underlying physical illness. The existence of underlying physical impairment is included in the pathologists' reports, which say that it was possible that drug and alcohol abuse explained some of the physical symptoms which made him vulnerable to sudden death.

97. There was no formal routine for observing the man and such routines were only implemented for prisoners assessed as at risk of harming themselves. Other prisoners in his immediate vicinity were on frequent observation regimes and staff said that, whilst monitoring those prisoners, they also took the opportunity to observe the man. All the day staff and prisoners interviewed said that he was frequently seen, sometimes at length and at irregular intervals.

98. This regime might suffice for the daytime hours, but it was not a robust arrangement as it depended on other prisoners in the area requiring observation and full staffing levels. The regime was particularly flawed during the night when staffing levels were reduced. Prisoners on formal observation regimes were seen by night staff as required, but the rest were only seen infrequently. The night patrol officer saw the man at 8.45pm at handover, but then continued his other duties on what he described as a busy night, and did not return until about 10.25pm. More frequent observations could have led to earlier intervention on the last evening of the man's life.

99. The post mortem indicates that, on discovery, the man had been dead for some time, though an estimate of the time of death has not been made. It is likely that he died at some time around the evening to night duty handover period.

The criteria for a patient's observation regime should be reviewed.

Restricted Unlocking

100. Just after the man was moved to the IPD, nursing staff made an informal decision that, because he was behaving aggressively, he should only be unlocked when at least three staff were present. Their decision was added to the Mental Health Care Plan after its initial completion on reception, but the addition was not timed, signed or dated.

101. This informal decision was subsequently interpreted by healthcare staff to mean that only staff trained in control and restraint could unlock the man who died. No trained staff work in healthcare, although the Healthcare Policy requires that they are trained in its use.

Sufficient staff trained to use control and restraint techniques should be available to perform an effective restricted unlock regime in the healthcare centre.

102. There is no evidence that the man who died directly threatened any staff, either in the houseblock, the IPD, or when he was moved within the IPD, and he complied with any instructions. It is therefore reasonable to consider whether the initial decision about unlocking arrangements was correct and whether it should have continued.

103. Given the circumstances when the man initially arrived in the IPD, it appears correct to have placed him under a restricted unlock regime at first, although it should have been properly documented, including specifying whether he could be unlocked by any three members of staff, or whether they had to be C&R trained. The decision should have been reassessed within hours, and periodically thereafter.

The decision making process which imposes a restricted unlock regime on a healthcare centre patient must be properly documented and that decision regularly re-assessed.

Consumption of food and fluids

104. The man appears to have eaten normally until the night before he moved from the houseblock to the IPD. He was given food in the IPD, some of which was thrown about the cell, and it is not apparent whether he ate any. The orderly who cleaned the man's first IPD room estimated that one meal remained scattered and uneaten. The evening duty nurse said she was aware that he had not eaten, but was unable to specify for how long. I understand from interviews with the HCO Treatments Officer and the senior prisoner orderly that a record of refused or uneaten food is only required for refusal after five days. Prison Service instructions however mandate that food refusal after three days is reportable.

105. The man who died was advised by the doctors and other healthcare staff to drink lots of water to replace the fluids lost because of intense activity. As well as the water he was given by staff, unlimited water was available in each of the

rooms and he was seen to drink. However no-one considered that he might require more than plain water to sustain him. The In Reach mental nurse practitioner said that she would have expected him to be given replacement fluids, but she did not enquire whether that was the case.

106. The man's behaviour should have resulted in closer monitoring of all aspects of his health, including his physical condition. The lack of appropriate replacement fluids is a basic nursing requirement that no-one appears to have addressed. The post mortem examinations suggest that plain water was insufficient to replace the complex fluids lost whilst sweating heavily, and that the lack of replacement fluids might have contributed to his death.

The Healthcare Manager should ensure that clinical staff are sufficiently aware of the dangers of dehydration during assessment and diagnosis of irrational patients. They must also be proficient in the appropriate re-hydration techniques.

Use of control and restraint

107. During the early hours of the morning the man disturbed his two cellmates by acting in an irrational manner. Houseblock staff were alerted later in the morning, and he was relocated to the IPD by a control and restraint team who used handcuffs. The removal was witnessed throughout by a nurse and a member of the Independent Monitoring Board, and no injuries were sustained by the man.

108. The second time that he was moved using a C&R removal team was within the IPD, after he damaged his first room. Although a C&R removal team was deployed, he complied with orders and the team merely oversaw the transfer and did not use either force or restraints.

109. Following removal of a prisoner under control and restraint, staff are required to complete Use of Force forms and provide statements. In addition, whenever there is an incident involving use of force, a F213 personal injury form should be completed whether or not the prisoner appears to have been injured. The forms completed after the man was moved to the IPD contain incorrect or missing information.

The Governor should ensure that Use of Force forms are properly completed and the accompanying statements from staff are accurate.

110. The second time that the man who died was moved by a C&R removal team, no documentation was completed. It was considered that, as staff said no force or restraint had been used, there was no need for the forms. The IMB witness said that he thought members of the team held his arms during the move, but the C&R team and others maintain that they did not touch him. I judge that the latter is more likely to be correct and the removal team had no physical contact on this occasion. However, it is also my opinion that, whenever a C&R team is deployed, the Use of Force Form should be completed to avoid any allegation that force had been used.

Consideration should be given to extending the Use of Force form to include all incidents where C&R removal teams are deployed but do not use mechanical restraints or C&R techniques.

Injuries noted at the post mortem

111. The injuries seen at the first post mortem and to a lesser extent in the second were indicative of a blunt impact. However, I have no evidence that they were caused by anything other than the man's own violent activity during the last two days of his life, none of which involved another person.

The man's location in the healthcare centre

112. Both rooms where the man who died was located in the IPD of the healthcare centre are designed to minimise any harm that prisoners may cause themselves. They are known locally as "refractory rooms" and should only be used for periods to ensure that the occupant does not harm himself or others. (I am bound to say I find the term 'refractory' somewhat archaic.) The rooms are normally well lit and heated comfortably. They contain fixed furniture, a lavatory and a tap. They appear stark but are adequate for the needs of patients. Given the man's behaviour and apparent mental condition his location in these rooms was reasonable.

Record keeping

113. The Cell Sharing Risk Assessment contains inaccurate information about the man's offence, in that kidnapping or possession of firearms was excluded although these are the charges he faced. Moreover, the source code for the information is not recognised as one defined on the Assessment form. The logs completed by staff following the man's death were also not signed and timings were inaccurate or omitted.

The Governor should remind staff of the requirement for accurate recording of information.

Conclusions

114. At reception at the prison and during induction the man who died understated the extent of his alcohol and drug misuse. He knew the type and quantity of drugs and alcohol he used outside prison, and had several opportunities to inform staff. Had he done so, it could have been incorporated when his medical and mental condition was subsequently assessed. The post mortem examinations indicate that sustained drug and alcohol misuse probably played a significant part in his death.

115. During the first days in custody, the assessment of the man's physical and mental condition was consistent with the information available to the staff dealing with him. Having indicated his concerns about an injury before his arrival, he should have been referred to a doctor but this did not happen. Had the appointment taken place, it would have been a further opportunity for him to disclose the extent of his drug and alcohol use.

116. The man's drug consumption continued in prison, and only became known when his co-defendant who was concerned for his health and welfare asked for help.

117. The man who died was a large, physically intimidating man who behaved irrationally and disturbed his cellmates and alarmed staff in the houseblock, after which he was moved to the healthcare centre by a C&R removal team. The next day he damaged his room, and was moved again overseen by a C&R team, although on this occasion no restraints were used. No injuries were sustained by him on either occasion. He was slow to comply with requests by staff at times but was compliant throughout.

118. After re-location he was not physically examined by a doctor and nursing staff decided that he should only be unlocked by three people. In practice, this meant C&R trained staff. Their decision was made informally and was neither documented nor reviewed. A consequence was that any examinations took place through the hatch in the cell door and were less thorough than if a full physical examination had been carried out. In my view, although the man was agitated and very active, he complied when staff spoke to him and it seems possible that he could have been examined. It concerns me that no examination took place.

119. The man was advised to drink plenty of water, from which it is clear that healthcare staff recognised that dehydration was a possibility and he needed to replace lost fluids. However, none of the staff addressed the possibility that plain water was insufficient and this basic physical requirement was not addressed. The post mortem examinations suggest that plain water was not sufficient to replace complex fluids lost from sweating heavily, and it is possible that the lack of properly formulated replacement fluids contributed to his death.

120. The night nurse believed that she could only speak to the duty doctor, and had no authority to call him out, although she was aware that she could send the man who died to hospital if required. The doctor's attendance might have led

to him being admitted to hospital and an early intervention might have made a difference to the eventual outcome.

121. The man was not placed on a formal observation regime because he was not at risk of harming himself, and observations occurred as staff monitored other patients who were on such regimes. This might have been sufficient during the day, but was inadequate at night when staffing levels were at a minimum. The decision not to formally observe him appears contradictory. If he was too agitated and disturbed to be physically examined, regular formal observations should have taken place to ensure that his condition did not deteriorate.

122. The post mortem examinations were unable to ascertain a defined cause of death, but suggest that the man's body showed signs of drug abuse and also that there were significant changes to his vital organs which might be associated with sudden death. I judge there were a number of omissions and failures in his treatment by healthcare staff that might have exacerbated the condition that caused his death.

Recommendations

I make ten recommendations:

1. **The Healthcare Manager should ensure that all follow-up requirements of the reception procedure are understood and adhered to by clinical staff.**

2. **Clinical staff should be reminded of their duties in regard to professional standards of record keeping. Medical record entries should be clearly written with a date, time, name, position and signature of the author.**

3. **The Healthcare Manager should ensure that all staff are fully aware of their authority and responsibilities in the management of patients, particularly during the night and out of hours.**

4. **The criteria for a patient's observation regime should be reviewed.**

5. **Sufficient staff trained to use control and restraint techniques should be available to perform an effective restricted unlock regime in the healthcare centre.**

6. **The decision making process which imposes a restricted unlock regime on a healthcare centre patient must be properly documented and that decision regularly re-assessed.**

7. **The Healthcare Manager should ensure that clinical staff are sufficiently aware of the dangers of dehydration during assessment and diagnosis of irrational patients. They must also be proficient in the appropriate re-hydration techniques.**

8. **The Governor should ensure that Use of Force forms are properly completed and the accompanying statements from staff are accurate.**

9. **Consideration should be given to extending the Use of Force form to include all incidents where C&R removal teams are deployed but do not use mechanical restraints or C&R techniques.**

10. **The Governor should remind staff of the requirement for accurate recording of information.**