INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP LEICESTER IN FEBRUARY 2006

Report by the Prisons and Probation Ombudsman

for England and Wales

April 2007

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This is the report of an investigation of the circumstances of the death of a man in February 2006 at HMP Leicester. The man was found hanging in his cell 15 hours after arriving at the prison. He was 38 years old. He had been in HMP Leicester on a number of previous occasions.

I would like to offer this public expression of sympathy and condolences to his family and friends on their loss. A key objective of all my investigations is to ensure that the bereaved family has the opportunity to raise any concerns and contribute to my inquiries. The man's sister raised a number of issues with one of my family liaison officers. I hope my investigation begins to offer answers to her questions. I regret the delay in the completion of this report.

The investigation was led by one of my colleague who was assisted by another officer. A clinical review was conducted by the Medical Director of the Eastern Leicester Primary Care Trust, and I am very grateful for his report. I also thank the Governor and staff of HMP Leicester for their co-operation and, in particular, the prison's member of staff who acted as the establishment's liaison officer with my office.

The man was a long-term drug user who had tested positive for heroin whilst being held in police custody. However, the drug test taken upon his arrival at HMP Leicester was found to be negative. Having been given the chance to take a further test, it was not carried out in accordance with manufacturer's recommendations, and his refusal to comply with instructions was regarded as a negative result. As a consequence, the man was not given any medication to help with the effects of drug withdrawal.

My report contains a number of recommendations, many of which are echoed by those in the clinical review. In what is an upsetting story, I have also found examples of good practice on the part of the Governor and the chaplain.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2007**

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Summary

The man was arrested in February 2006 for a shoplifting offence. He was drug tested at the police station and was positive for opiates/heroin. His custody records indicated that he would need to see a doctor for withdrawal if held overnight. Following the discovery of an outstanding warrant, he was not given bail and was kept in police custody until his court appearance the next morning. Records suggest that he did not see a doctor.

He arrived at HMP Leicester at 4.00 pm the next day. He undertook a First Reception Health Screen (FRHS) and, given his self-declared drug withdrawal and history, he was tested for opiates and benzodiazepines. The results were negative.

Once located on the First Night Centre (FNC), he saw the doctor. He insisted that he was withdrawing and wanted medication, known as a 'blister pack', to help with the symptoms. The doctor requested that he be given the opportunity to provide a second sample. He was angry about having to do this and complained that he had not seen a doctor in the police station.

Nursing staff went to his cell and asked him to urinate directly on the testing cassette, rather than providing a sample in a specimen jar. He did not follow the nurse's instructions and consequently a reading could not be taken. This was deemed to be a negative result.

Within a few minutes, he rang his cell bell and asked to see the doctor. He was told he would not be seeing the doctor that night. This was the last time the man was seen alive.

He was discovered hanging the next morning at 6.24 am during the roll check. No CPR was attempted as it was clear that he was dead.

The Investigation Process

My colleague conducted a preliminary visit to HMP Leicester in February 2006 and returned on a number of occasions to interview staff. During the course of initial enquiries, the investigator and her assistant were shown around the prison and visited the cell where the man died. They reviewed all the relevant documentation and established a chronology of events.

Notices were issued to staff and prisoners telling them of the investigation and offering them the opportunity to speak with my colleagues. No-one came forward as a result. My investigators met with representatives of the local branch of the Prison Officers' Association (POA) and members of the Independent Monitoring Board (IMB). They did not share any specific concerns with my team.

The Medical Director of the Eastern Leicester Primary Care Trust, undertook a clinical review of the healthcare provided for the man whilst at HMP Leicester.

Eleven members of staff, both discipline and healthcare, were interviewed on tape at Leicester. Of these, five were re-interviewed after further information came to light. The doctor, who works on a regular, sessional basis at the prison, was also interviewed. Joint interviews of healthcare staff were conducted with the medical director of the PCT. Two prisoners who were in neighbouring cells to the man who died were interviewed informally and notes were taken of these discussions.

The investigator contacted the man's probation officer and solicitor. Both were able to provide valuable background information. The investigators met with the investigating police officer to discuss the case and have been provided with a copy of his report.

One of my family liaison officers made contact with the man's sister, offering the opportunity to meet with the investigator. The man's sister chose to discuss her concerns with the family liaison officer over the telephone. His sister questioned why he had not been given any medication, whether staff checked his previous history at Leicester, what had been the nature of the last exchange he had with prison staff, was he checked throughout the night, and had he been given any medication in the police station. She was concerned that information about his drug history might not have been passed from the police station to the prison.

A draft version of this report was sent to the Prison Service. An action plan was provided which indicated whether they accepted the recommendations or not and how they intend to deal with the recommendations. The responses can be found under the recommendations section of this report and have been reproduced in verbatim.

The man's family were also given the opportunity to respond to the draft. They accepted the factual content of the report.

HMP Leicester

Leicester is a Nineteenth Century prison, the gatehouse dating from as early as 1825. It is one of the smallest local prisons in the prison estate and is only able to hold 385 prisoners. The main living accommodation is a long rectangular cell block with four landings. All prisoners coming into the establishment are housed for at least the first night in the First Night Centre (FNC), prior to being located into the main prison. The FNC is a dedicated landing currently located in the basement of the prison.

The First Night Centre mainly consists of shared cell accommodation with integral sanitation. At the time of the man's death, building work was in progress to make the cells safer by trying to eliminate ligature points. During the investigation, it was noted that building work obscured natural lighting in some of the cells although this was not the case in respect of the man's cell. However, it was noticed by my investigators that the cell in which he was located was opposite an electrical generator which made a continual humming noise. At the time of the investigation, attempts were in hand to brighten up the First Night Centre through a series of refurbishment programmes.

There were two apparently self-inflicted deaths at Leicester, one of which has proceeded to inquest, in the twelve months prior to the man's death. My report into one of these, in particular, featured a number of recommendations in relation to the healthcare department. Having been agreed by the prison, these recommendations were being put in place at the time of his death and were due for completion at the end of February 2006.

In line with HMP Leicester Substance Misuse Protocols, a test is carried out to confirm drug usage. Prisoners assessed to be heroin users are prescribed an in-possession seven day supply 'blister pack' containing Buscapan, Ibuprofen and Zolpidem. This is for the effects of early withdrawal such as a runny nose, aches, and to help the prisoner to sleep. The following day a prescription for Lofexidine starts for the later effects of withdrawal, and this dosage is decreased over a period of nine days.

On weekdays, a substance misuse nurse will see the prisoner the day after first reception to make an assessment. This will be to see whether they need to start the Lofexidine detoxification. A detoxing prisoner can be managed on ordinary location but, places permitting, would usually be admitted to the detox wing. For those prisoners arriving on a Friday or Saturday, the detox staff will not be available until the Monday to do an assessment. At weekends, there is a doctor present who can provide a prescription if necessary.

Key findings

On Thursday 16 February 2006, at 6.25 pm, the man was arrested for shoplifting a bottle of alcohol. He was taken to Euston Street Police Station, Leicester, and charged at 7.15 pm. According to the 'detainee integrated risk assessment and care plan' form, he told the custody sergeant that he had taken heroin the day before. He was asked whether he had ever self-harmed or was likely to self-harm whilst in police custody. He replied no to both questions. Under the section 'additional information', the custody sergeant has written 'at this time fine for I/V (interview) if still in at 23.00 d/p (detained person) will need doctor for withdrawal'. This form was completed at 7.20 pm. The author concluded that the man represented a low risk of harm and should be checked hourly.

At 10.13 pm, the man was refused bail as there was an outstanding warrant for the breach of his Community Rehabilitation Order. At 10.20 pm, he undertook a drug test. He was negative for cocaine but positive for heroin/opiates. He was offered the opportunity to see an Arrest Referral worker but declined to do so at that time. The form indicated that he had already seen the Arrest Referral worker. Records suggested that he did not see a doctor that night following the refusal of bail in spite of the earlier reference to him needing to see someone should he be held overnight. The reason for this is not known to my investigation team.

Following his court appearance the next morning, 17 February, the man was remanded to HMP Leicester until 10 March. His solicitor, who had represented him on previous occasions, saw him at court. He described him as 'a bit down' although he said that he was someone who presented as quiet and subdued. The man told him that a friend had committed suicide that week.

The man's Prisoner Escort Form (PER), which had been completed at the Police Station, and travelled with him to court and prison, highlighted his risk areas as 'drugs/alcohol issues'. In another section about risk issues, it stated 'took heroin yesterday, PNC (Police National Computer) warning markers'. (The PER document is used to communicate important information between the various criminal justice agencies).

Upon his arrival at Leicester at 4.00 pm, he was processed through reception. Part of the reception procedure for in-coming prisoners is to undertake a First Reception Health Screen (FRHS) which is carried out by a nurse. There were two nurses in reception that afternoon which was not usual. They were an agency nurse who had worked in reception for the past year, and a staff nurse who had joined the Prison Service a few weeks previously and was still in her induction phase. The FRHS was carried out by the staff nurse. The agency nurse was in the vicinity and available in a supervisory capacity. However, their accounts of exactly what the man said during the consultation do not completely concur with each other.

In interview, the staff nurse described going through the assessment with him. Of significance was his drug use. He said that he used £45 worth of heroin daily and that he had last used on 16 February, the day before. He also said that he used 60mg of Diazepam on the same day. In response to the question, 'signs of withdrawal?', the staff nurse ticked 'yes'. In interview she said that this was due to

him saying that he was having withdrawal symptoms. However, she did not see any indications herself such as sweating or tremors. She described his demeanour as calm, quiet and polite.

The nurse said that the man kept asking for a blister pack and whether he would get one that evening. In response to being asked 'do you think you need any help in relation to your drug or alcohol use?', he answered 'yes'. The staff nurse said that he did not tell her that he had tested positive at the Police Station. The agency nurse in interview, said that the man had told him about that test.

The next part of the FRHS asked whether the person received treatment for a mental health problem, and whether they had in the past self-harmed or currently felt like self-harming. The man responded 'no' to all these questions. The author of the assessment is asked to comment on their impressions of the prisoner's behaviour and mental health and the staff nurse has written 'co-operative'.

Question 17 of the FRHS asked 'have you suffered any recent loss of family or friends?' The man said that his best friend had died on 15 February, two days previously. The staff nurse in interview said that she explored this with him and explained to him that counselling was available or he could see the chaplain. The man said that he did not need any of this and that he was fine.

Given that he indicated that he used drugs, he was asked to provide a sample of urine. Drug tests are used as part of the assessment to see whether a prisoner needs to undergo detoxification. The test is done by taking a drop of urine from the specimen jar, using a pipette, and dropping it on a testing strip. Coloured lines appear or not, depending on whether drugs are present. Separate tests are used for opiates and benzodiazepines. The result of the tests are recorded in the FRHS by the nurse. No collaborative evidence is kept or retained on file. All new receptions see the doctor once they have been moved over to the First Night Centre. The doctor will write up a prescription for withdrawing medication at that consultation if needed.

The man provided a sample for the staff nurse before he was returned to the holding cell in reception. He was not present for the result. The agency nurse said in interview that the two nurses tested him together and that the results were negative. She felt that he was not showing any physical signs of withdrawing.

However, it was noted that the agency nurse interpreted the man's demands for a blister pack as a potential security concern. He checked the prison's database (LIDS) and discovered that the man had been in Leicester previously. More detailed information about whether or not he had declared a drug use on previous receptions was not available on the computer database. In interview, the agency nurse described feeling suspicious and questioning why the man should want drugs given his negative result. At 4.30 pm, the agency nurse completed a Security Information Report (SIR) expressing his concerns that the man's request for medication was for questionable motives.

The wing officer encountered the man in the holding cell after the man rang the cell bell. The man was alone in the cell and asked the wing officer when they would be

going over to the wing. This was at approximately 4.45 pm. Due to the prison being in patrol state at this time, the man could not be moved until about 5.15 pm. During this time, the wing officer got him out of the cell and interviewed him for sections 1 and 2 of the Cell Sharing Risk Assessment. Part of this assessment concerns whether the man presented a risk to others, either self-declared or perceived by the officer. The officer concluded that there was 'no current evidence/assessment of risk, suitable for multi-cell occupation'.

The wing officer asked the man about how he was feeling and whether he had concerns about self-harming. The man gave him no cause for concern. He recalled that the man was, like most prisoners, keen to get over to the wing to sort out their meal, phone call and tobacco. As soon as the prison returned to operational state, the officer took him over to the First Night Centre. Once in the FNC, the man was handed to staff there.

A prison officer conducted the FNC interview with him. The purpose of this meeting was to explain what was going to happen over the first few days and to give him a reception pack containing tobacco and other things. She recalled that the man said that he had been in before and was quite uninterested. The officer said that this was a common response for some prisoners who had been in Leicester before. As a routine part of the process, the prison officer said she asked whether he had any worries or concerns. The man did not give her any cause for concern. The man was allocated cell L1-11, which was a double cell but he was the only occupant. The prison officer could not recall why he was placed in this cell and in interview stated that it was for no particular reason. The decision to place him alone in cell L1 -11 seems to have been completely random.

As part of the procedure on the FNC, the man was given a three minute phone call. Another officer put him on the telephone. At 6.08 pm, he telephoned his sister. The phone call was recorded and the transcript indicates that he asked his sister to send him some money which he would need for canteen (prison shop). He said that it needed to arrive by Monday. He also wanted her to go to his flat in order to sort some things out for him. He also told his sister he was 'rattling', a commonly used term to describe the symptoms of somebody who is withdrawing from drugs. Following the phone call, he was taken to cell L1-11 at 6.41 pm.

A wing cleaner on the FNC, recalled seeing him when he came over from reception. He described himself as a 'meeter and greeter' for all new prisoners and he was also responsible for giving out prison kit. He described him as very quiet and noted that he did not engage in any conversation.

Some time later, he was taken from his cell to see the doctor in the consultation room, also located in the FNC. The doctor saw him as part of the first night procedure for giving all new arrivals the opportunity to see a doctor. The staff nurse was present during the consultation. In advance of seeing him, the doctor had already been told by the agency nurse that the man had tested negative but was asking for medication. He completed the 'Medical Assessment' form. The man told the doctor that he had last used heroin two days before and diazepam two to three days before.

In interview, the doctor recalled saying to him that his test had been negative but the man said something like, 'you can see I need a pack, I need to have some tablets, I'm a user and I need to have something for that'. The doctor explained that the test was how they would tell if someone was a user. He recalled him saying that 'this isn't very fair, I was in the Police Station last night and the doctor refused to see me then as well, they wouldn't give me any drugs last night'. Quite coincidentally, the duty doctor had been the doctor on call for the police the night before and had not been asked to see the man, which he explained to him.

The doctor stated that the man said he had given a positive test at the police station. The doctor indicated that he had no way of checking that out. The doctor checked with the staff nurse that she was sure that she had read the test properly, which she was, and he told him that they would give him the benefit of the doubt and do another test. There was not a testing pack in the consultation room so the man was taken back to his cell so that a sample could be taken later. The staff nurse recalled that he was angry, said that he was not going to do another test and walked off.

In interview, the doctor recalled that he had told him that a friend of his had hung himself two days previously. They talked about how this made him feel and whether he felt at risk of harming himself. The man said that he did not and, although the doctor recognised that the death of his friend was a risk factor and considered opening a self-harm monitoring booklet, he decided that it was not needed. In general, the doctor's impression of him was that he was anxious, and may have been 'rattling' slightly, but not badly.

In interview, an officer recalled encountering the man as he came out of the doctor's room accompanied by a nurse. He recalled him swearing and complaining to the nurse. He thought this was about not getting medication. The officer ushered the man back to his cell. He did not speak directly to him and went off duty at 8.00 pm.

The night duty officer came on duty for 8.00 pm and recalled doing the roll count for landing L1. He thought this would have been between 8.10 – 8.20 pm. In interview, he said that when he checked his cell he was lying on the bed and the officer thought he was watching television.

At approximately 8.10 pm, the prison officer unlocked the man's door at the request of the night duty nurse. She had been asked by the doctor to take another sample from the man. There were not any testing kits left in the FNC and the nurse said that she rang through to the agency nurse in reception and asked him to bring one over. She said that she was given the strips by the agency nurse. She went to the cell and asked him to 'put a drop of urine on each of the strips'. The night duty nurse did not use a specimen jar to collect the sample and was not wearing gloves. She turned her back to the man and stood by the door in order to give him a degree of privacy. She said that he took the strips and went to the toilet but did not urinate onto the strips. She said that when she asked him for the strips, he just pointed to the toilet bowl. She recalled that he was asking for 'meds' but did not specifically say what. She described him as being very angry. The nurse said she told him that the doctor would be back in the morning and he replied 'well I don't want it in the morning, I want it now'.

The senior officer (SO) was also in attendance outside cell L1-11. She was not present when the man was given the strips but witnessed him giving them back to the night duty nurse and heard her saying that 'you haven't done it properly, you are not going to get any meds'. She said that the man just shrugged his shoulders in response. His cell door was then locked and staff carried on with their other duties.

In interview, the duty doctor recalled that the nurse came and told him that the man had not done the test properly and was mucking about. He asked her if the test had been dry and he recalled the nurse saying, 'oh no, he just didn't do it, just mucked about and threw it back, and that was it'. From this, the doctor assumed that the man had known the test was going to be negative so he had not bothered to do it properly, and that he may have been asking for medication for another motive. However, the doctor was not aware of how the man had been asked to perform the second test.

A second wing officer attended the man's cell in response to him ringing his cell bell at 8.12 pm. He recalled that he was asking to see a doctor. The officer left the cell and went to speak with the night duty nurse and the doctor. In interview, he recalled that the nurse told him that he had failed to produce a second test. Following the advice of the nurse, the officer said he returned to the cell and told him that he would not be getting any medication and would not be seeing the doctor that night. He said that at this point the man was lying on his bed and simply shrugged his shoulders in response. This was the last time that the man was seen alive. The officer told my investigators that he recognised the man from a previous time in Leicester which he thought was a couple of years before.

The doctor said that he had one more conversation about the man with the night duty nurse. He thought it was about 8.30 pm as it was when he had completed all his work and was leaving. He said that he heard some banging and that the nurse had said that it was 'the man wanting some medication'. The doctor said that he had had a negative test so could not be prescribed. The night duty nurse does not recall having this conversation with the doctor and none of the officers interviewed could recall hearing any banging at that time.

All the officers on duty that night described it as relatively quiet. When they had come on duty all the prisoners had been processed through reception, and although the nurse and doctor were still there, they were just finishing up and were finished by 9.00 pm. At 3.30 am, a prisoner in the neighbouring cell did make a self-harm attempt by cutting his arm, and staff had entered his cell to treat the wound. However, given that he was not on suicide monitoring, they did not have any reason to attend his cell or check him regularly through the night. Prisoners are not routinely checked hourly unless they are deemed to be at risk of self-harm or for security reasons. Two prisoners who were located in nearby cells did not recall hearing anything that night.

At approximately 6.30am on 18 February, during the morning roll check, the duty officer looked through the cell hatch into his cell and saw him hanging from the window bars. She ran a few feet to the bottom of the stairs and called 'staff L1', before returning to the cell. She then pressed the general alarm. Very quickly, she was joined by the second senior officer (SO) and the second wing officer. The duty

officer was unable to undo her sealed pouch which contained a cell key to be used at night time in an emergency. The SO was the night orderly officer and in charge of the establishment during the night. As such, he had a set of keys and unlocked the cell door. The second wing officer used his fish knife to cut the ligature from the bars and the officers placed him on a mattress which had been laid out on the floor. The mattress was on the floor when the officers entered which suggests that the man had placed it there before he died. A pulse could not be found and he was not breathing. The duty officer described him as being cold to touch and pale. The second wing officer said that it was clear to him that the man was dead.

The incident logs taken at the scene, and in the control room, indicate that the man was found at 6.24 am, an ambulance called at 6.28 am and a paramedic arrived at 6.31 am, followed by an ambulance at 6.40 am. The paramedics pronounced the man dead at 6.45 am.

The Death in Custody contingency plans were complied with by staff. The care team spoke to all those involved. Those prisoners who were subject to regular monitoring to prevent self-harm were reviewed and monitored.

The man had not given any next of kin details upon reception. Staff were able to locate details of his sister from the phone call he had made the evening before. The prison chaplain, accompanied by a police officer went to break the news to his sister later that morning. At the sister's request, they then went to see the man's mother. Two days later, his family visited the prison and met with the Governor. A number of staff attended the man's funeral.

Issues Considered

According to the agency nurse, the man was not displaying any signs of drug withdrawal and had tested negative. He did not view his requests for medication as a sign of withdrawing. He perceived that his behaviour was suspicious and viewed this as a matter of prison security. The nurse checked the database and discovered that he had been held at Leicester twice before which appeared to arouse the nurse's suspicions further. However, in interview, he was not able to explain this in any more detail. Exploration of his previous IMRs would have shown that he had undergone detoxification on at least two previous occasions at Leicester. These documents were not readily to hand but were available within the prison. However, the nurse did not seek these out or make further enquiries with staff on the detox wing. Instead, he completed a security report.

Without wanting to undermine the importance of staff providing information to combat the illegal use of drugs in prison, I am somewhat surprised by the actions of the agency nurse. Furthermore, the nurse said in interview that the man had told him that he had tested positive at the Police Station. Whilst the agency nurse had no documentary evidence to support this, it gives further validity to his claims that he was withdrawing.

It is difficult for healthcare staff working in a prison environment to balance the needs of security with care. However, on this occasion it is clear with hindsight that the nurse's judgement was poor. The time he spent preparing a SIR could have been more usefully spent trying to check his medical history. This may indicate a more general training need.

All healthcare staff, including agency staff, working in reception should undergo training in drug awareness and suicide awareness.

The PER highlighted his risk areas as 'drugs/alcohol' and, under the section concerning additional information about risk, stated that 'the man took heroin yesterday'. The man himself also told the nurse that he had taken heroin the day before. In these circumstances, where the medical staff doubted the extent of his drug use, the PER would have provided further information which supported his claim. However, medical staff do not routinely see the PER in reception, and, specifically in this case, the staff nurse said in interview that she did not see the PER.

I recommend that, as a matter of routine, the PER form should be seen by healthcare staff undertaking reception health screens.

The duty doctor, in interview, said that had he had complete knowledge of the man's circumstances - previous detoxifications, a positive test result at the Police Station - and if he had seen him at the Police Station, it would have made a difference to whether he gave him a blister pack. The result of his drug test result was not communicated on the PER form.

Interestingly, a toxicology examination undertaken as part of the post mortem indicates that morphine and cocaine were detected in urine but only traces were

detectable in blood. The report concludes that they were of trace amounts and could not be quantified. I am unable to draw any conclusion from this.

I recommend that the Governor shares this report with Leicestershire Constabulary so that arrangements can be made to improve the quality and quantity of information on the PER form.

Given the man's insistence that he needed some medication for drug withdrawal, the doctor asked the nursing staff to conduct a second test to give him the benefit of doubt. I am very concerned about the manner in which the second test was conducted. The man was asked to provide a 'drop of urine' directly onto the strip. This was not in line with the manufacturer's recommendations and would, in any event, be a difficult act to perform. Furthermore, there was a lack of dignity afforded him by being asked to do this. For whatever reason, the man did not do as he was asked.

I also note that the nurse carrying out the test did not protect herself by wearing gloves.

Staff must always conduct diagnostic drug testing in accordance with instructions. All new staff should be fully inducted in the correct use of testing kits.

The doctor, an experienced doctor both within the prison and in other forensic settings, said that he assumed that all prisoners in the First Night Centre, a high risk area, were observed hourly at night. This has highlighted the need for all visiting and part-time medical staff to have general training about the prison regime. The first recommendation in the Clinical Review is about such training. I endorse his recommendation.

The man was the sole occupant of a double cell. Since his death, Leicester have introduced a protocol for the First Night Centre outlining that prisoners should, wherever possible, share a cell. If this is not possible, prisoners must be given priority to be located in a Safer Cell. I welcome this development.

After the staff nurse saw the man in reception, she completed an entry in the Inmate Medical Record (IMR) summarising her consultation and recorded the result of the test. The agency nurse, who was supervising the staff nurse through her induction, did not add anything to the record.

Of all the medical staff who saw the man on the wing, none recorded any account in the IMR. The doctor completed his assessment but did not write an entry in the IMR. Neither the night duty nurse nor the agency nurse, who were both involved in the second drug test, wrote an entry in the IMR.

All relevant staff should be reminded that they must record entries in the IMR, including at times when they act in a supervisory role.

The duty officer was unable to open her pouch to get the emergency key to gain entry into the man's cell. It was fortunate that the SO was nearby and able to unlock

the cell door. Having uncovered a problem with the pouches, I was impressed that the Governor acquired a new set of properly working pouches that same afternoon and replaced the entire prison stock. The Governor's prompt action reflects very well upon him and should be noted by his area manager.

I would also like to commend the quality and appropriateness of the contact with the man's family. His sister was visited in person by the chaplain to break the news and the chaplain then visited the man's mother at the sister's request. Very promptly the family were invited to visit the prison and meet the Governor. The family also had a named family liaison officer. The man's mother later sent a card to the Governor to thank him and his staff for their kindness.

The Clinical Review

The clinical reviewer makes one national and seven local recommendations, all of which I support. Four of these concern the drug testing procedure. However, as noted above, I have also made a recommendation of my own regarding the training of staff in the use of drug testing kits. This reflects the serious view I have taken of this aspect of the man's medical care, which I consider to have been unacceptable.

Recommendations

All healthcare staff, including agency staff, working in reception should undergo training in drug awareness and suicide awareness.

Partially Accepted. All Healthcare staff will receive refresher suicide awareness training and drug awareness training will be built into HMP Leicester's healthcare training plan.

I recommend that, as a matter of routine, the PER form should be seen by healthcare staff undertaking reception health screens.

Accepted. Healthcare staff undertaking reception health screens have access to the PER form, but will now be required to sign and date the PER form for each prisoner seen in reception

I recommend that the Governor shares this report with Leicestershire Constabulary so that arrangements can be made to improve the quality and quantity of information on the PER form.

Accepted. Security Policy Unit within HMPS are reviewing the PER from on behalf of NOMS and Police Leadership and Powers Unit. The forms and guidance notes are to be revised to improve the quality and quantity of the information on the PER form. It is planned that piloting of the new arrangements will start in May 2007 with implementation across England and Wales by January 2008.

Staff must always conduct diagnostic drug testing in accordance with instructions. All new staff should be fully inducted in the correct use of testing kits.

Accepted. An on-going certificated training programme is already underway for current staff with a completion date of April 2007. The training is carried out by Surescreen, the drug test supplier. All new staff will be trained by Surescreen as part of their Induction.

All relevant staff should be reminded that they must record entries in the IMR, including at times when they act in a supervisory role.

Accepted. Staff Information Notice to be issues as reminder to staff. Each member of staff will evidence that they understand this requirement. Healthcare manager will carry out management checks on IMR's as part of Post-Induction checks.

Recommendations from the Clinical Review

<u>National</u>

Attention should be given to communication systems between police, courts and prisons that ensure the transmission of relevant information to minimise risks as individuals move rapidly within the system. Specifically in this case to ensure the onward transmission of drug testing results.

See response to recommendation 3

Local

Medical staff should be made aware of the level and type of supervision and review that applies on the First Night Centre.

Accepted Medical staff, including doctors, will be made aware of the levels of supervision on FNC as part of their Induction process

Robust stock control system should be established to ensure the availability of urine testing equipment to ensure compliance with manufacturers' recommendations.

Accepted. This applies to the testing carried out on the FNC. As of February 2007, no routine testing will be carried out on FNC, it will all be completed in reception. Reception have robust stock control in place, currently managed by DSRT but to be transferred to SERCO under new management. Procedures for stock control will be reviewed by SERCO and any necessary adjustments made.

The forms available from Surescreen Diagnostics which indicate the appearance of the test should be used and kept as part of the medical note.

Accepted. Forms will be kept in the IMR as record of test. This will form part of the management checks.

All healthcare staff should be reminded about need to use gloves when there is the potential for contact with body fluids. Practice should be consistent with current NICE Guidance[1] and involve appropriate Health and Safety risk assessments.

Accepted. A nominated healthcare staff member will take up role of Infection Control Liaison. Links have already been made with Infection Control Unit at PCT. Staff Information Notice will be issued as initial reminder.

When staff are being supervised the supervisor should sign notes and test interpretations to confirm satisfactory completion.

Accepted. Staff Information Notice as initial reminder to current staff. A staff mentoring scheme will be introduced and maintained and will include supervisory guidance for staff. This will form part of the Healthcare Manager's management checks

HMP Leicester should avail itself of the competency based training available free of charge from Surescreen Diagnostics on the use of their products.

[1] Infection control Prevention of healthcare-associated infection in primary and community care Clinical Guideline 2 June 2003

Accepted. See Recommendation 4

The PCT as commissioners should ensure that the standards for training use of clinical protocols and supervision are consistent with those applied with the Community Drugs Team. A direct link to this consultant service should be considered.

Accepted. Healthcare Manager is member of the local Drug and Alcohol Team and attends quarterly Board meetings. Links have also been established with the local DAWN Centre to improve communication with outside agencies and teams. Detox clinical protocols are already approved by the Prison Health Substance Misuse Team.