INVESTIGATION INTO THE CIRCUMSTANCES SURROUNDING THE DEATH OF A MAN AT HMP FORD IN SEPTEMBER 2006

Report by the Prisons and Probation Ombudsman for England and Wales

August 2007

This report considers the circumstances surrounding the death of a man in September 2006 at HMP Ford. He was found dead in his room during the late morning roll check. The post mortem concluded that he had died as a result of fatal toxicity. The man was 31 years of age.

I extend my personal condolences to the man's family and to all those touched by his death.

My colleague undertook the investigation with the assistance of a second investigator. I would like to thank the Governor of Ford and her staff for their cooperation during this investigation. I am also grateful to Western Sussex Primary Care Trust for carrying out a thorough clinical review of the care the man received during his time in custody.

The man had misused drugs and alcohol, and had a complicated history of mental health problems, which were diagnosed shortly before he entered custody. As his mental health appeared to have stabilised by the time he went to HMP Wandsworth he did not receive his prescribed medication but was seen regularly by the mental health team. When he transferred to HMP Ford, the man's mental health was beginning to show signs of deterioration. However, this was quickly addressed by the prison's GP and primary mental healthcare nurse.

It has not been possible to ascertain whether these mental health problems contributed to his death or whether it was accidental. His mental health aside, the man was a generally fit and healthy young man. The police investigation has ruled out any suspicious circumstances. The man's death was a great shock to everyone at HMP Ford and no one has come forward with specific evidence that his death might have been intentional.

Based on the clinical review, I make five recommendations (two of which relate to the man's care at HMP Wandsworth).

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

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SUMMARY

The man was arrested in December 2005, but was not remanded into custody until March 2006 after a period as an in-patient at a private clinic in London, The Priory. Prior to custody, the man had a history of drug and alcohol abuse, gambling and suicidal ideation. He also suffered with anxiety and bipolar disorder, and had other mental health problems. These were diagnosed whilst he was at the private clinic and he was prescribed methylphenidate (for hyperactivity), semi-sodium valproate (for bipolar disorder) and venlafaxine (an antidepressant). He discharged himself and then occasionally attended as an outpatient.

During early March, the man was remanded to HMP Wandsworth and began a three week detoxification process for alcohol abuse. His mental health appeared to have stabilised following his treatment. Healthcare staff, including the dual diagnosis team, decided that he did not present as needing his prescribed medications. However, he continued to receive regular monitoring and counselling from the dual diagnosis team for the next five months. The man remained largely stable with short periods of feeling low in mood. During this time, his consultant psychiatrist at the private clinic sent two letters expressing concern that his patient was not receiving his prescribed medications. The dual diagnosis team remained firm in their judgement that he did not require them.

In June 2006, the man was sentenced to three years and eight months imprisonment. He moved from Wandsworth to HMP Ford as a category D prisoner on 24 July. On reception, the man referred to his mental health history and said he would refer himself to the Counselling Assessment Referral Advice Throughcare team (CARATS) for substance misuse support. Two appointments were made, one for the next day with the doctor, and a second with the mental health nurse the following week. On assessing the man, the doctor referred him to the psychiatric practice in Bognor Regis, The Bedale Centre, for a second opinion on the diagnoses made by The Priory.

Unfortunately, the mental health nurse was on leave until the end of August, but the man continued to have contact with healthcare during this period for complaints about ear and jaw ache. He did not present with any concerns regarding his mental health until 21 August when he saw a nurse and told her that he felt low in mood. He again explained that he had not received the medications prescribed by the private clinic in London since early March. An appointment was scheduled for the man to see the doctor the following day, but it is not clear if this took place.

Towards the end of August, he had his first appointment with the mental health nurse. The man told her that he was “not feeling right” and explained his mental health history. She suggested restarting his medications and agreed to discuss this with the doctor. His medications were resumed that day. The referral to the Bedale Centre was confirmed and an appointment was set for a date in September.

The man saw the mental health nurse again in September. During this consultation, he told her that he had stopped taking his venlafaxine as it was giving him headaches. He was also feeling tired and lethargic. The nurse noted that the

psychiatrist would review the medications. She also scheduled a follow up session for two weeks later.

A few days later, the man withdrew from CARATs. He had completed the courses relevant to him and continued to test negative for illicit substance use. The man and his counsellor agreed that he could continue without their support.

In September, the man was seen in healthcare regarding his continuing ear and jaw ache. He was prescribed seven days of painkillers.

During his appointment with the mental health nurse in September, he appeared stable, but referred to feeling emotionally cold. He complained once more about his ear and jaw ache, so she made a referral to a dentist for an x-ray. This took place the following morning.

The man attended his appointment with the psychiatrist at the Bedale Centre. He went unescorted. The psychiatrist referred to the man's documented mental health history and assessed his current presentation. He concluded that the man was not a concern and showed no self harm or suicidal ideation.

On his return to the prison, the man spent the remainder of the day associating with fellow prisoners. Both staff and prisoners who recall seeing him note that he was his usual self and did not give cause for concern. No one saw him with any contraband.

The next morning, the man was found dead during the 11.30am roll check. Although staff and prisoners had looked in on several occasions earlier in the morning, he had appeared to be sleeping. At weekends, prisoners at Ford are allowed to have a lie in and it is not unusual for some people to remain asleep until the roll check. When he was found, it was clear that he had been dead for some time and was beyond resuscitation.

A police investigation was undertaken. On searching the man's room they found a bottle of vodka (unopened), a wrap of brown powder, a small amount of cannabis resin, a mobile phone and his prescription medications. All items apart from the vodka were taken away for examination. The powder was found to be heroin based (diamorphine). There was no SIM card in the mobile phone so it was not possible to trace any calls made. In addition to a post mortem, a toxicology report was requested. The results showed high levels of morphine and ethanol, consistent with fatal toxicity. There was no evidence of him having used injecting equipment. It is not apparent whether the man's death was accidental or intentional. The police investigation has ruled out any suspicious circumstances.

THE INVESTIGATION PROCESS

1. During the opening of the investigation, my investigator discussed with Ford's Governor the circumstances surrounding the man's death. The Governor asked for the circumstances to remain confidential at that stage to reduce the possibility of negative media attention, which could have been insensitive to the man's family. My investigator agreed the need for sensitive handling.

2. My investigator asked Western Sussex Primary Care Trust (PCT) to conduct a clinical review of the healthcare the man received in custody. My investigator and the clinical reviewer agreed to hold joint interviews with the main healthcare staff at Ford who had provided care for the man. My investigator conducted all other interviews at the prison with a colleague. These took place on 16 January 2007, with the clinical interviews the following day. On concluding the interviews, my investigator provided verbal feedback to the Governor on her findings. In addition to the interviews held at HMP Ford, the clinical reviewer also spoke with healthcare staff at HMP Wandsworth, the man's consultant psychiatrist at The Priory, and with the consultant psychiatrist from the Bedale Centre.

3. The man's family was contacted by one of my family liaison officers to explain the purpose of the investigation and to allow them the opportunity to raise any concerns they would like explored and addressed. The man's family have remained in contact with my office and have raised a number of issues:

    - How were his mental health needs monitored?
    - What medications were prescribed and how were these monitored?
    - The family were aware that he had visited the consultant psychiatrist the Bedale Centre. They were under the impression that he might have been prescribed medication twice the strength of his usual prescription following this appointment.
    - Following the man's death, the family discovered from documentation that prior to his period in custody he had been a police informant. The family believed that a relative of the person he had informed on was located at the same prison. They were concerned that he had suffered adversely because of this.

4. The first three issues are addressed in the main body of the report and the clinical review. In relation to the third point, I should say at this point that the man was not prescribed any further medication following his appointment.

5. My investigator looked into the final issue. She established that the prison was not aware that the man had been a police informant. However, the prison would not have been party to this information unless the police had raised it as a concern. There was no evidence that he had been bullied or harassed whilst at Ford.

HMP FORD

6. HMP Ford is a category D open prison with an emphasis on resettlement. It stands on the site of a former Fleet Air Arm station and was converted to an open prison in 1960.

7. Further buildings have been added including a gate complex, chapel, education and probation. There are two main sites for the accommodation blocks – A and B wing. A wing has six residential blocks of single rooms. B wing has 24 billets of single and shared rooms. The prison has an operational capacity of 541.

8. Healthcare at HMP Ford has seen significant improvement since responsibility for the delivery of services was transferred to Western Sussex Primary Care Trust in April 2005. The healthcare unit is open from 7:45am until 5:30pm, Monday to Friday. It provides a good range of nurse-led clinics, including mental health support. However, this is currently only one registered mental health nurse to 541 prisoners. This is not adequate, a matter further highlighted within the clinical review at Annex 2.

9. There are two GPs at the prison whose duties are split to provide cover five days a week. Out of hours cover, including the weekend, is provided by the Primary Care Trust. A dentist also holds weekly clinics and an optician attends once a month.

KEY FINDINGS

Chronology

10. The man was arrested in December 2005 although was not remanded into custody at this time. During January 2006 he spent time as a general psychiatric inpatient at a private clinic, The Priory, in South West London. He was admitted for assessment due to his impulsive behaviour including excessive drug and alcohol misuse, which had resulted in a suicide attempt. At the clinic, the man was the patient of a psychiatrist. He diagnosed the man as having:

    - generalised anxiety disorder
    - post traumatic stress disorder
    - pathological gambling
    - cocaine and alcohol abuse.

17. The psychiatrist offered a differential diagnosis of bipolar disorder and also attention deficit hyperactivity disorder (ADHD). He did not think that the man's mood swings were directly related to drug abuse, although he felt this possibly exacerbated his behaviour.

18. The psychiatrist prescribed methylphenidate (Ritalin), semi sodium valproate, and venlafaxine. He also referred the man to a psychologist for cognitive behavioural therapy and treatment for his post-traumatic stress disorder.

19. The man discharged himself from the clinic on two weeks later. He was not complying with group work and questioned his medication. The man went to a couple of his outpatient follow-up sessions but then stopped attending.

20. During early March, he was remanded into custody at HMP Wandsworth. This was his first time in prison. During the reception procedures, both a discipline officer and a member of the healthcare team assessed the man (this is the usual course for someone entering the prison system). The nurse who completed the first reception healthscreen noted the man's mental health and self-harm history, as well as his drug and alcohol misuse. The assessment concluded that he was "not depressed and not suicidal". He was referred for detoxification and prescribed chlordiazepoxide together with thiamine and vitamin B compound forte for acute alcohol detoxification.

21. The man did not receive a medical follow up until three weeks later on 28 March when a referral from one of the registered mental health nurses was received by the in-reach mental health team. Until this point, the man had not come to the attention of the in-reach service. They discussed his case and referred him to the dual diagnosis team for further assessment.

22. On 7 April, the dual diagnosis nurse saw the man. Notes from this assessment were made available to my investigator, but were incomplete, wrongly dated and unsigned. However, they did include a reasonably detailed clinical history and a note that information had been sought from the man's previous GP and

his psychiatrist. A symptom score and risk assessment was completed and this indicated a low suicide risk. The man was not referred to any other services, but follow-up assessment by the dual diagnosis team was arranged.

23. On 19 April, the man was seen by a consultant in dual diagnosis, who noted his history (as outlined above) but questioned the diagnosis of ADHD. The consultant found the man to be depressed and suffering from insomnia. Despite this, the man presented as being relatively optimistic. He talked about the future and returning to his wife. The consultant diagnosed 'adjustment disorder'. (An adjustment disorder is psychological disturbance that develops in response to stress or an unexpected negative event.) The medication prescribed by the psychiatrist at The Priory was not given. Instead, the man was prescribed three days of sleeping tablets and was referred to a psychologist for support.

24. The dual diagnosis nurse next saw the man on 26 April. An entry in his medical records states, "[the man] says he's been much improved without being on medication. Appears very calm and relaxed." Despite his calm presentation, it appears that the man had been worried that his medication prescribed at the private clinic in London had been discontinued. His psychiatrist from The Priory wrote to the man on 26 April, expressing concern that he was not receiving the treatment needed. The psychiatrist copied this letter to the man's solicitor and the chief medical officer at HMP Wandsworth. There is no record of any subsequent action taken by healthcare or the dual diagnosis team.

25. In spite of not receiving this medication, the man continued to remain stable at Wandsworth. He received regular assessments by a dual diagnosis nurse and was given zoplicone (sleeping tablets) as and when required. During these months, the man actively participated in the prison's regime and made an application for employment. There were no concerns about his behaviour or demeanour.

26. There is an entry in the man's medical record on 14 June that alludes to a visit with the psychiatrist from The Priory on 13 June, but there is no actual record of such a meeting. The man told his dual diagnosis nurse on 14 June that the psychiatrist he had seen the previous day was concerned that he was not receiving the medications prescribed he had prescribed in January. The dual diagnosis nurse notes a 'plan of care' in the man's medical record which would consist of meetings with a dual diagnosis nurse every three weeks and monthly meetings with the consultant psychiatrist.

27. The man appeared at court on 23 June and was sentenced to three years and eight months in prison. He then returned to Wandsworth.

28. At his dual diagnosis check up on 10 July, the man was still noted to be coping "fairly well" without his medication. However, during this session the man said that his solicitors were still writing to him asking why he was not taking his previously prescribed medications. The dual diagnosis nurse told him that his current physical and mental state did not warrant any of his previous medications.

29. On 24 July, the man was transferred to HMP Ford as a category D prisoner. He was allocated a room in billet R2 on B wing. The man's full medical record was transferred with him. A cursory healthscreen was undertaken on reception to establish whether there were any concerns requiring immediate medical attention. The note in the medical record simply says "HMP Ford. Labour 1" and is unsigned. My investigator spoke to the Head of Healthcare to see if this was an acceptable entry for a cursory healthscreen. The Head of Healthcare confirmed that it was not satisfactory and she would expect the entry to reflect that there were no concerns raised. As the man was not seen for a full healthscreen until the following day, it is assumed that he was stable and well during this assessment.

30. A nurse performed the full reception healthscreen on 25 July. During this assessment, the man referred to his mental health history. It was noted that a mental health nurse would see him the following week. A doctor's appointment was made for the following day as the man was complaining of earache. The man said he would also like to be referred to the Counselling, Assessment, Referral, Advice, Throughcare team (CARATS) and also take part in voluntary drug testing.

31. On 26 July, one of the prison's GPs saw the man. They discussed his mental health, including his previous diagnoses. The man raised concerns that he had not received the medications prescribed by The Priory whilst he was at Wandsworth. He said that over the last five months he had experienced a few lows, but had mostly felt stable. The GP decided to refer him to a psychiatrist for further assessment. The following day, he wrote to a consultant psychiatrist at the Bedale Centre, asking him to see the man and offer a second opinion on the diagnoses given at The Priory.

32. The man quickly settled at Ford. He made friends with other prisoners and gained employment in the induction workshop. The man had a couple of appointments with the doctor regarding continuing earache and jaw pain, but had no contact with healthcare regarding his mental health until 21 August. On that day, he told a nurse that he felt low in mood. He again explained that he had not received any medications for his diagnosed bi-polar disorder since March. The nurse made an appointment for the man to see the doctor the following morning and referred him to the registered mental health nurse. There is no record of him seeing a GP the following day. His next contact with healthcare was on 29 August when he saw the mental health nurse.

33. During his session with the mental health nurse, he said that he was "not feeling right". He felt his mood had become unstable and this was of concern to him. The nurse suggested restarting his medications and said she would discuss this with the GP. An entry was made in the man's medical record to monitor him and reiterated that an appointment had already been scheduled for him to see the psychiatrist at the Bedale Centre at 10.00am on a date in September. After discussing the issue of restarting medications with a GP it was agreed to this course of action and the man was given venaflaxine and semi sodium valproate.

34. The mental health nurse next saw the man in September. During this session, he told her that he had stopped taking the venaflaxine, believing it was giving him headaches. The nurse noted that psychiatrist would advise on this during the man's appointment. The man also explained that he was feeling tired and lethargic. In addition, he was having difficulty dealing with the unresolved nature of the relationship with his wife with whom he had no contact in the previous six months. This left him feeling "bitter, angry and hurt". The nurse scheduled a follow up session to take place in two weeks.

35. A few days later, the man ended his contact with his CARATS worker as he felt he no longer needed the support. The man had a history of negative voluntary drug tests and there was no evidence of any ongoing substance misuse issues. He had also successfully completed a cocaine awareness workshop during August. The CARATS worker agreed with his request and his file was closed.

36. A member of healthcare saw the man for his continuing earache in September. He also complained of left eye pain and was prescribed 400mg of ibuprofen for seven days.

37. The mental health nurse saw the man for a follow up session. They discussed how he was feeling emotionally "cold" and how he seemed to be "cutting off". Despite these feelings, his mood appeared stable. The nurse noted that he would be seeing a psychiatrist in two days. She also suggested a referral to the dentist for an x-ray to establish the cause of his ear and jaw pain. This appointment was made for 8:30am the following day.

38. The man travelled, unescorted, by train to Bognor Regis for his appointment at the Bedale Centre. After his appointment he returned to the prison, arriving at reception at approximately 1.00pm. An officer was on reception duty that afternoon and performed a rub down search on the man. (All prisoners leaving and entering the prison are subjected to a search to make sure they have no contraband.) In interview, he recalled the man asking if he could go back to the train station as he had left his jumper there. The officer explained to the man that he could not leave the establishment again as his temporary release licence had expired. A prisoner who was in reception and about to leave the establishment offered to pick up the man's jumper and bring it back later that afternoon.

39. The man left reception and returned to his billet where he saw his friend, a fellow prisoner in billet R2. The man told his friend that he had been to hospital regarding the pain in his ear and jaw. He said that he had been prescribed painkillers which he had with him. His friend next saw the man at approximately 4:45pm when they went to dinner together. After dinner they returned to their own rooms until the 6.00pm roll check. At 6:25pm, his friend went to the gym. The friend saw the man there with one of their mutual friends (who occupied the room opposite the man's in billet R2). An hour later, both friends left the gym together without the man and returned to the billet. After making a drink, the first friend noticed that the man had also returned. The friend remained in his room until the 8:45pm roll check. Meanwhile, another

prisoner and friend of the man, visited him at the billet. The visitor told my investigator that he spoke with the man and he seemed fine. The man told his visitor that he had been to the doctor earlier that day and had been given antibiotics. He did not reveal the real nature of his appointment to either any of his friends.

40. After the evening roll check, the man watched television with one of his friends. The other friend who occupied the room opposite the man told my investigator that the man and his friend watched the evening film with the door open. He could clearly see the open door from his own room. At approximately 11:30pm, the man's friend returned to his own room and the man went to bed and closed his door. In his statement to the police, the friend who watched television with the man said that he had no concerns about him that night and he appeared to be his normal self. He did not see the man take any medication.

41. During the night, operational support grade staff (OSGs) made random checks on all the billets. There were two OSGs responsible for making checks that night. A check was carried out between midnight and 1.00am. One of the OSGs told my investigator that he noticed nothing unusual about any of the prisoners in billet R2. The OSG recalls that he did not have to use a torch to shine through the observation panel to check on the man. He remembers that the television was on and this gave enough light to see into the room. The man was on his bed. Two further checks were performed during the night, one at approximately 2.00am and another at around 5.00am. On both occasions there was nothing noteworthy about the man; he just appeared to be asleep.

42. At 7:30am on the day the man died, an officer performed the morning roll check in billet R2. This was the first check performed by day staff after the night OSGs went off duty. At the weekend, the check at this time of day is visual. Officers are not required to obtain a verbal response from the prisoners as they are entitled to get up later on weekend mornings. The officer recalls seeing the man and he appeared to be sleeping.

43. Later in the morning, prisoners are allowed to leave their rooms and go to breakfast. During interviews with officers, my investigator was told that it is not unusual for prisoners to take this opportunity to have a lie in and miss breakfast. At around 8.00am, the friend in the room opposite to the man's left his room and went to the communal washrooms. On his return, he looked into the man's room through the observation panel. He saw that the man appeared to be asleep. He was lying on his bed in his underwear.

44. After breakfast, the visitor from the previous evening went to billet R2 to see the man again. He saw that the man's door was closed, so he looked through the observation panel to see if he was in there. The visitor told my investigator that the man appeared to be asleep. He knocked on the door to try and wake him, but the other residents in the billet asked him to stop and keep the noise down. The visitor left the billet and went round to the man's window to try and get his attention. The visitor called to him through the open window. On getting no response, he decided to try and wake the man by throwing some clothes pegs that happened to be nearby. At this stage, the bell was rung for the 11:30 roll

check and visitor had to return to his own billet. He believed that the man was sound asleep and he would speak to him later.

45. At around 11:32am, the officer performed a second roll check in billet R2. He instructed all prisoners to stand by their doors to be counted. On reaching room 2, he noticed that the door was still shut and the man had not come out. At this point friend who lived opposite said “he’s fast asleep in there”. The officer then unlocked the man’s door and entered the room. He found the man lying on his bed in his underwear, with the window open. The officer tried to rouse the man by raising the foot of his bed slightly and shaking it, at the same time talking to him to try and get a response. The man did not stir so he tried again to get a response. On failing to wake him, the officer placed his hand on the man’s upper right arm. He immediately the man’s cold temperature and that he was very stiff. The officer checked his wrist for a pulse but found none. It appeared that the man had been dead for some time and was beyond resuscitation.

46. Using his radio, the officer placed a call for urgent assistance. In a matter of seconds, six officers arrived at the hut, one of whom was senior officer (SO). The SO requested (via radio) that the duty governor attend and that the communications room call for an ambulance. He also requested that the police attend. Approximately two minutes later, a principal officer (PO), who was acting as orderly officer that day, arrived and instructed the first officer to retrieve the scenes of crime kit bag. The decision was made to leave the room and wait for the police. Prisoners were moved out of the billet and the chaplain attended to provide support.

47. The ambulance arrived at the prison at 11:45am, shortly followed by the police. After the ma had been pronounced dead, the police took over the enquiries. Statements were taken from prisoners and staff who had recent contact with the man or who had been present after he was discovered. On searching the man’s room the police found a bottle of vodka (unopened), a wrap of brown powder, a small amount of cannabis resin, a mobile phone and his prescription medication – venlafaxine, valproic acid and ibuprofen. All items apart from the vodka were taken away for examination.

48. The police also said that they would inform the man’s next of kin and the coroner’s officer. The man’s wife had been listed as his next of kin and the police experienced some difficulty in contacting her during the afternoon.

49. The coroner’s officer and undertaker removed the man’s body from the prison at 7:35pm that evening.

50. A Detective Sergeant telephoned the prison the day after the man died to let the Governor know that the man’s wife had been contacted. She had recommended that they contact his brother and sister. The police passed the family’s details to the prison and the prison’s family liaison officer spoke with the man’s brother later that day. The Governor personally telephoned the man’s brother and offered her condolences the following day. She offered full support in assisting with funeral arrangements (including a financial

contribution), the return of his belongings and a visit to the prison should he and his sister so wish. (They visited the prison a few days later.)

51. During this time, the police continued with their enquiries before ruling out any suspicious circumstances surrounding the man's death. Test results on the brown powder found in the man's room proved the substance to be heroin based (diamorphine). Efforts were made to try and trace any telephone calls made, however no SIM card could be found.

52. A toxicology report was requested and the police tried to establish where else the man had been on the day he died. Unfortunately, the enquiries proved fruitless and it was not possible to determine what had happened to him. A toxicology report completed in October revealed that he had levels of morphine and ethanol in his body consistent with heroin use and a high level of alcohol consumption. The combination at these levels is consistent with fatal toxicity.

53. The man's funeral took place on 26 October and a memorial service was held at the prison on 29 October.

Clinical findings

54. The Clinical Governance Lead for the Western Sussex PCT (which has since merged with other organisations to become West Sussex PCT) conducted a clinical review. Western Sussex PCT assumed responsibility for medical services in HMP Ford in 2002.

55. The full report of the clinical review is at Annex 2. This is an account of the key findings and conclusions.

Medical history

56. The man's psychological and psychiatric histories are of major significance in this case. In late 2005, prior to his arrest, the man tried to take an overdose of alcohol, cocaine and amitriptyline but survived. Intermittently over the year before his death, he had had recurrent suicidal ideation, but does not appear to have been assessed as a high suicide risk.

57. He was admitted to The Priory in January 2006, prior to being remanded into custody, for assessment of his impulsive behaviour, which had led to the suicide attempt. A medical report by his psychiatrist at the clinic lists his diagnoses as:

- generalised anxiety disorder,
- post traumatic stress disorder,
- pathological gambling,
- cocaine and alcohol abuse.

58. The man had a long history of symptoms of anxiety and pathological gambling. The alcohol and drug abuse started after the death of his mother, closely followed by that of his father. The post-traumatic stress symptoms related to

these events. In particular, he had discovered his mother's body following her suicide.

59. The man's psychiatrist offered a differential diagnosis of bipolar disorder, particularly in view of rapid mood swings, and also attention deficit hyperactivity disorder (ADHD), which in the past had responded to methylphenidate (Ritalin). He did not think that the man's mood swings were directly related to drug abuse, although they were possibly exacerbated by this behaviour.

60. The man was prescribed methylphenidate (Ritalin), semi sodium valproate (for bipolar disorder), and venlafaxine (an antidepressant). He was also referred to a psychologist for cognitive behavioural therapy and treatment for his post-traumatic stress disorder.

61. The clinical reviewer interviewed the psychiatrist by telephone on 4 December 2006. He confirmed the details in his report, adding that he thought the man had a borderline psychopathic personality but also had the diagnoses listed.

62. Prior to his period in custody, the man had also been under the care of an NHS GP, whose report notes that his binge drinking dated back to at least the year 2000, and that he had received treatment in the past from the community drug and alcohol team in Richmond. The clinical reviewer did not interview this GP.

Issues

63. On entry to HMP Wandsworth in March 2006, the man was prescribed chlordiazepoxide, together with thiamine and vitamin B compound forte for acute alcohol detoxification. No medical follow up note was made for three weeks, but on 28 March referrals were made to the dual diagnosis and substance misuse teams. The gap of three weeks in record keeping is of some concern, particularly as his alcohol detoxification had not been followed up.

64. The notes made available from the man's first session with the dual diagnosis nurse in HMP Wandsworth were incomplete, wrongly dated and unsigned. However, they did include a reasonably detailed clinical history and noted that the man's GP and psychiatric records had been requested. It appears that an appropriate symptom score and risk assessment was made by the dual diagnosis nurse at this time and indicated a low risk of suicide or self-harm.

65. The man was further assessed 19 April 2006 by a consultant in dual diagnosis. The consultant questioned the diagnosis of ADHD and did not prescribe the medications suggested by the man's previous consultant psychiatrist. He felt that the man had an 'adjustment disorder'. He prescribed three days of sleeping tablets and referred him to a 'psychologist for psychological support'.

66. Despite the man's view (in a meeting with his dual diagnosis nurse on 26 April) that he was "much improved without being on medication" and his appearance of being calm and relaxed, it seems that the man continued to be concerned about not receiving his previous prescriptions. A letter from the consultant psychiatrist at The Priory to the man on 26 April suggests that he had contacted

him, or someone else had on his behalf, regarding his medications. Neither my investigator, nor the clinical reviewer, had sight of any initiating correspondence. The consultant psychiatrist's reply expressed concern that the man was not receiving treatment needed for his bipolar disorder, attention deficit disorder and pathological gambling. This letter was copied to the man's solicitor and to the Chief Medical Officer at Wandsworth, but there is no record of any subsequent action.

67. Despite the letter, the medication was not prescribed, but it appears that the man remained quite stable at Wandsworth during May and June until his court case on 23 June. An entry on 14 June describes him as "feeling very well and looking forward to going to court next Thursday".

68. On transfer to HMP Ford, the man received timely contact with a GP (to discuss his medical and psychiatric history. Appropriate referrals were made at this stage for follow-up support with the mental health nurse and to seek a second opinion on his diagnoses with the local psychiatric services, historically provided by the Sussex Partnership Trust in the Bedale Centre, based in Bognor Regis.

69. The clinical reviewer and my investigator interviewed the GP on 17 January 2007. The GP confirmed the details of his initial consultation with the man, and also mentioned that at that time the mental health care worker at the prison was on holiday. The appointment at the Bedale Centre was booked for a date in September, two months after referral. This is a fairly typical waiting time for a non-urgent outpatient appointment for NHS psychiatric services in West Sussex.

70. The mental health nurse was asked to see the man on 29 August, following her return from annual leave. At this stage, his mood was thought to be "unstable". The man apparently said that he was "not feeling right". The decision was made to restart some of his medication, and the following day he started semi sodium valproate and venlafaxine. When he was next seen he had stopped the venlafaxine because he thought it was giving him bad headaches. The man was feeling down due to the breakdown of his relationship with his wife, whom he said had not contacted him in six months. The notes show he was feeling "bitter and angry and hurt". Two weeks later, the mental health nurse saw him again and observed that his mood was stable, although he described himself as "cold" emotionally. The nurse thought he was "cutting off emotionally", and noted that he was due to see the psychiatrist in three days. The next entry in the medical notes records the man's death the previous night.

71. My investigator and the clinical reviewer interviewed the mental health nurse on 17 January 2007. The nurse confirmed that the clinical details recorded in the notes were accurate. She explained that she was the sole mental health care worker at Ford, and had only started her job full-time in July 2006. It had become clear that her predecessor had struggled with the role, and there had been a lot to sort out after she arrived.

72. When asked about links with secondary care and other NHS psychiatric services, she felt that the links were far from perfect. There was no formal service level agreement (SLA) with the Sussex Partnership Trust for provision of consultant cover, and it appeared that the referrals to the Bedale Centre were made on a goodwill basis. Consequently, there were no regular visits to the prison by a psychiatrist or psychologist, and there was difficulty in accessing drugs and substance misuse services.

73. As the only registered mental health nurse, there was no cover when she took annual leave. This aside, she found the pressure of work quite intense. The nurse suggested that having two mental health nurses would be both practical and realistic for a prison the size of Ford, particularly as a large number of prisoners suffer from psychiatric and/or drug and alcohol problems. The nurse also felt isolated from her peers, having no links with other primary mental healthcare workers or community mental health care teams. Moreover, both she and the GP felt that the links with the Bedale Centre were far from ideal. Communication and follow-up was often difficult and no collaborative plans were usually put in place.

74. Notes from the man's outpatient appointment made by psychiatrist show that he had considered the reports provided about the man's psychiatric history over the last few years. During the appointment, the psychiatrist found the man to present with no evidence of current depressive, hypomanic or psychotic illness. He considered previously documented features of his personality, and when discussing his view of long-term interpersonal relationships noted that the man said: "If I don't get the right reaction, I would want to kill myself."

75. It was the psychiatrist's opinion that the man presented with a pattern that fitted the borderline personality disorder, but felt that at this point other disorders could not be ruled out. Despite the man's comment, he did not think he presented a risk to himself or to others, or that it was reasonable to commence psychotropic medication. The man was not given a follow-up appointment and no action plan was suggested other than re-referral if any other psychiatric disorders developed.

76. The clinical reviewer interviewed the psychiatrist from the Bedale centre by telephone on 22 November 2006. The psychiatrist confirmed that he had had access to the psychiatric report from The Priory prepared in January 2006. He said that, after his consultation with the man in September, he did not feel that he had any ongoing psychiatric illness, and that the predominant problem was a borderline personality disorder. He therefore discharged him to the care of the medical team at Ford.

77. The man was found dead, having apparently taken an overdose of morphine and alcohol the evening after his appointment at the Bedale Centre.

78. On speaking to officers who responded to the discovery of the man's body, it became clear that some discussion had taken place as to whether resuscitation should have been attempted. An officer who was fully conversant in first aid and cardio pulmonary resuscitation had been concerned that no attempt had

been made. However, it was clear that rigor mortis had set in and that the man had been dead for some time. In this instance, it is correct that CPR was not initiated.

Post mortem results

79. Post-mortem results dated 24 November 2006 recorded the cause of death as toxic effects of alcohol and drugs, specifically there was a blood ethanol level of 264 mg per decilitre and blood morphine level of 0.392 mg per litre. There was no evidence of injection marks on the man's body.

Concerns

80. On reception to Wandsworth, the man was placed on an alcohol detoxification medication. It seems that there had been no obvious planned follow-up for three weeks. The guidance for alcohol detoxification in a custodial setting requires the prisoner to have their blood pressure and pulse monitored throughout the first 72 hours. There is no documented evidence that this took place. Indeed, the next entry in the man's medical record is 28 March, some 20 days after his detoxification started. However, the prescription chart for his detox medication is complete.

The Head of Healthcare at HMP Wandsworth should instruct staff to correctly record and monitor the detoxification process, in line with the guidelines for alcohol detoxification in a custodial setting.

81. The first reception healthscreen form used by Wandsworth specifies that if "acute mental health problem suspected, or any recent/current deliberate self harm, then refer to a medical officer". The man was not referred to a medical officer at this stage. Even though he had said that he did not feel like harming himself, given the diagnosis and list of prescriptions that followed him from the Priory, the clinical reviewer and I would have expected him to have been referred to the GP sooner.

82. The overriding concern emerging from this investigation and clinical review is the link between the prison mental health care service and that of the NHS. Although reports were received from NHS services prior to the man's admission to Wandsworth, medication was not continued. In this case it may not have affected the outcome, but the ramifications in other cases could be serious.

The Head of Healthcare at Wandsworth should try to ensure continuity of care for any prisoner entering prison. Where there are differences in opinion, particularly concerning mental health, a second opinion should be sought and discussion held with the previous responsible clinician to make sure that reasoned and informed judgements are made.

83. Equally in Ford, the lack of a service level agreement between the prison and the mental health care trust is a serious deficiency. On a clinical level, communication has been historically poor and closer collaboration between consultant/specialist services and primary mental health care workers at Ford is

recommended. Specifically, regular visits to Ford by a consultant psychiatrist (and possibly a psychologist) should be considered, as well as more support for the primary mental healthcare worker. This should include cover for holiday and other absences. The mental health care worker should also be engaged in peer support through links with local NHS community mental health care teams.

The Governor and Head of Healthcare should work with Western Sussex Primary Care Trust and Sussex Partnership Trust to establish a service level agreement to formalise links between prison healthcare and external consultant and specialist services.

The Head of Healthcare should consider employing an additional primary mental healthcare worker to support the existing post and provide cover in their absence.

The Head of Healthcare should ensure that the primary mental health care worker receives peer support though links with local NHS community mental health care teams.

Findings relating to policy and procedure

84. I have no concerns about the response of the discipline staff to finding the man. He had evidently been dead for some time before being discovered. The nature of the checks performed on weekend mornings (only visual checks are required at the 8.00am roll check) were such that staff on duty were confident that he just appeared to be sleeping. Indeed, fellow prisoners have also confirmed that, when they saw the man through the observation panel in the door, or through his window, he seemed to be asleep. The decision not to resuscitate was correct as rigor mortis had clearly set in. This is in line with the prison's suicide and self-harm policy which states that resuscitation should not be initiated in such instances. To begin resuscitation under such circumstances would be disrespectful to the deceased and an unreasonable expectation of staff.

85. In making enquiries about how discipline staff responded to discovering the man, my investigator asked whether officers had current first aid training. The majority did not. I have concerns about this as Ford does not have 24 hour healthcare cover and therefore staff, who may not feel confident in their first aid skills, would rely on the arrival of paramedics. My investigator discussed this with Governor. She confirmed that refresher first aid training was in planning and an in-house training course would be rolled out when the physical education instructor had completed her training instructor course. The Governor also told my investigator that resuscitation aids are available to all officers to be carried on their belts.

86. The clinical reviewer has recommended in his clinical review that consideration should be given to having at least one staff member with up-to-date certification in CPR training on every shift. While I agree that this would be ideal, I appreciate that in practice it might be impractical unless there were high numbers of staff trained in CPR. Ford has low staffing levels and few staff have

current first aid training. I believe that Governor's approach of having in-house training is the most practical and effective way of addressing the situation. To maximise the probability of having trained officers on each shift, it would be sensible to prioritise training for senior officers as there is always one on duty.

87. As the post mortem results have indicated, the man died from excessive amounts of alcohol and morphine. Levels in his blood stream are consistent with that of fatal toxicity. It has not been possible to identify where he obtained either substance, but interviews and police witness statements indicate that he consumed them after going to bed on the night before he died. This seems confirmed by what the police found in his room.

88. The availability of drugs and alcohol in prisons is a matter both of professional and public concern. To a greater or lesser extent, it is a problem that affects every establishment in the Prison Service. Clearly, it is particularly challenging for an open prison where prisoners can leave the establishment, on licence, and unaccompanied. My investigator discussed this with the security governor at Ford to understand more about how the prison tackles this issue.

89. The security governor explained that the security department largely relies on intelligence, coupled with staff patrols, to identify when and where contraband is brought into the establishment. If staff suspect a prisoner is carrying or hiding contraband, they would be challenged and the findings removed. HM Chief Inspector of Prisons' report on Ford in November 2005 notes a "good intelligence system, with reasonably effective security for an open prison". The system is based on information provided by staff, prisoners and the police. The security team have had some success in finding contraband left for prisoners outside the prison grounds, but the size of the site can mean that much is missed.

90. The security governor added that voluntary and mandatory drug test results are also used as a guide for identifying what kind of drugs might have been brought into the prison. Breathalyser tests can also be used by staff working on reception if they suspect that a returning prisoner is intoxicated. Any prisoner found to be under the influence of alcohol or drugs is moved back to a closed prison. Ford used to have access to an area team of dogs for detecting drugs, but expenditure on drugs dogs is no longer considered a priority for the area. This was a decision taken by the Surrey and Sussex Area Office, which pre-dates the current Kent and Sussex Area.

91. My investigator discussed the weakness in physical security with the Governor of Ford. I am pleased to learn that this is being addressed in line with recommendations in the Chief Inspector's report, and that additional outside lighting has been installed as well as a hedge of pyracantha (a thorny plant often used to deter intruders) planted around the perimeter. There are a number of identified 'hot spots' around the perimeter for leaving contraband that is later smuggled into the prison.

92. In addition, as part of the resettlement programme, CARATS programme and drug reduction strategy, prisoners have access to a relapse prevention course

and short-duration drugs programme (specifically for short term prisoners). These courses address the dangers of using drugs when the user has reduced tolerance levels. Unfortunately, there are no dedicated alcohol programmes. Prisoners who need alcohol related treatment are referred to community drug and alcohol centres for specific support for alcohol misuse. An Alcoholics Anonymous group is held weekly at the prison.

93. The day before he died was the man's first opportunity since sentencing to return to the community. During the period that he was released on temporary licence, he would have had the opportunity to obtain both drugs and alcohol, although in doing so he would have been in breach of the conditions of his temporary release.

94. Prior to this, it is likely that the man had five to six months with no alcohol or drugs. His tolerance levels to these intoxicating agents would have reduced considerably. The levels of alcohol and morphine in his bloodstream on 30 September seem to have been fatal. He may well have misjudged what he could safely take after five to six months abstinence.

CONCLUSION

95. The man appears to have received good mental health care prior to his admission to HMP Wandsworth. It is also apparent that, at each stage of his care in custody, a genuine attempt at assessing his mental state and suicide risk was made. Past documentation and medical records of his mental health history were available on admission to both prisons.

96. It is the opinion of the clinical reviewer that appropriate questions were asked about the man's medication when mental health care workers saw him, and he received prompt and appropriate psychiatric assessment and referral to specialist services at HMP Ford.

97. All staff and prisoners interviewed confirmed that they did not have any concerns about the man on the evening before he died. His demeanour did not appear any different that day. My investigator spoke on the telephone with the prisoner who last saw the man that night he died, and he confirmed that he had no concerns about him that day or on any other occasion. They were good friends and could talk freely with each other. The friend said that the man often spoke about his uncertainty regarding his marriage, but he never said he was depressed or felt like harming himself. Both of the man's friends also confirmed that they had never seen or heard of him consuming alcohol or using illegal substances whilst at Ford. The trigger for his death therefore remains inconclusive.

Response to comments on the draft report

98. In response to my draft report the Prison Service and the man's family submitted further comments for further clarification.

- The Prison Service asked for clarification on whether the man had been an inpatient at the Priory Hospital up until being remanded into custody at HMP Wandsworth. If this was the case then it would have been unusual to require an alcohol detoxification programme as the Priory would operate a policy of abstinence for inpatients. The Priory Hospital confirmed that the man was only an inpatient for a short period and discharged himself on 7 February. Therefore the man would have been able to access both alcohol and illegal substances during the period between his discharge and being remanded into custody.

- The Prison Service consulted the Drug Strategy Unit (DSU) for advice on the draft report. In the initial draft, my investigator stated that the powder found in the man's room was white. The DSU commented that if the powder was white and heroin based then it would be a rare form of heroin and therefore easier to trace the source. My investigator sought clarification from the police on evidence removed from the man's room. The Detective Sergeant stated that the wrap of powder found in his room was brown and not white. On testing the substance it was found to be heroin based (diamorphine). The level of purity was not tested.

- In addition, the DSU asked whether there were any injection marks found on the man's body or any injecting equipment found. Neither marks nor injecting equipment were found or any other kind of paraphernalia to indicate that the powder may have been snorted. This indicates that he must have ingested the substance. The DSU commented that ingestion may have been indicative of the intent to take his life based on a comment that "it takes larger quantities of a drug administered orally to achieve toxic blood levels. The apparent absence of any paraphernalia to take drugs would tend to indicate that ingestion for 'recreational' use is less likely." I am reluctant to comment either way on whether the man used the substance for recreational or self-harm purposes as this would be speculation and not based on evidence considered by my investigator.

- The police found an unopened bottle of vodka in the man's room. No empty bottles were found, however from the toxicology report he would found to have high blood/alcohol consumption. The DSU comment that the lack of a used bottle does not provide an adequate explanation for the toxicology findings nor support the contention that he must have consumed the drugs and alcohol after going to his room. During the investigation all parties spoken to confirm that the man did not behave suspiciously or appear under the influence of intoxicating substances prior to going to bed that evening. The evidence suggests that he consumed the alcohol and drugs during that night. The lack of an empty bottle may mean that it was either removed by another prisoner to conceal the fact that it had been consumed during that night by the man and potentially other prisoners, or indeed that he had drank some alcohol beforehand and simply did not appear intoxicated. The police investigation found no foul play in connection to his death and therefore my statement still stands on the fact that it is not possible to tell whether his death was simply an accident or intentional on his part.

- The man's family raised concerns about the connection with the visitor to his billet on both the night before and the morning he was found dead. Both my investigator and the police spoke to the visitor. Both parties were told that the visitor was a friend. The man's family have subsequently told my family liaison officer that the visitor is the relation of a man that the man who died allegedly informed on to the police. The family believe that as a result of this the visitor would not have been a friend as suggested in the report. My investigator found no reason to disbelieve the visitor's statement and the police found no evidence to be concerned about his involvement.

- The family wanted a further explanation as to why the prison staff that they have subsequently spoken to believed that the man had a dental appointment on the day before his death and not an appointment with a psychiatrist. Prison staff would not be aware of the nature of any prisoner's medical appointment. This is a matter of medical confidence. The man told several people different stories about the nature of his outside appointment that day. It seems that he did not want his mental health issues publicised.

RECOMMENDATIONS

- **The Head of Healthcare at HMP Wandsworth should instruct staff to correctly record and monitor the detoxification process, in line with the guidelines for alcohol detoxification in a custodial setting.**

The Prison Service has partially accepted this recommendation stating:

"HMP Wandsworth does follow the guidelines as stated for alcohol detoxification in a custodial setting, however, the practice needs to be made more consistent, with all practitioners being aware of the policy and adhering to it. As of 1st June 2007, the new providers, Secure Healthcare, will take over the Health Services of HMP Wandsworth and this procedure will be reviewed."

- **The Head of Healthcare at Wandsworth should try to ensure continuity of care for any prisoner entering prison. Where there are differences in opinion, particularly concerning mental health, a second opinion should be sought and discussion held with the previous responsible clinician to make sure that reasoned and informed judgements are made.**

The Prison Service has partially accepted this recommendation stating:

"All new reception prisoners are seen by a primary case nurses on reception, a GP and a detoxification nurse, they complete full first night procedures and again are Health Screened and any concerns are referred to the In Reach team and/or an appropriate person for on-going care. Currently the In Reach services and Primary Care come under different management, but from 1st June all health services will be managed by Secure Health. This should ensure that all requirements for prisoner care are within one function and this should improve the consistency and the timeliness of interventions, with particular reference to second opinions."

- **The Governor and Head of Healthcare should work with Western Sussex Primary Care Trust and Sussex Partnership Trust to establish a service level agreement to formalise links between prison healthcare and external consultant and specialist services.**

- **The Head of Healthcare should consider employing an additional primary mental healthcare worker to support the existing post and provide cover in their absence.**

- **The Head of Healthcare should ensure that the primary mental health care worker receives peer support though links with local NHS community mental health care teams.**

The Prison Service has said that these three recommendations "will be discussed with the Primary Care Trust and a position then taken."