Investigation into the circumstances surrounding the death of a man in November 2010, at outside hospital, while in the custody of HMP&YOI Doncaster

Report by the Prisons and Probation Ombudsman for England and Wales

September 2011

This is the report of my investigation into the death of a man who died at outside hospital in November 2010. He had been in custody at HMP&YOI Doncaster for less than 24 hours when he was discovered collapsed in his cell. He was 45 years old. I would like to offer my condolences to the man's family and friends for their loss.

My colleague conducted the investigation on my behalf. I commissioned a review of the man's medical care, which was undertaken by a clinical reviewer. I am grateful to him for his report and contribution to this investigation. I would also like to thank the Director of Doncaster and his staff for their co-operation. I am particularly grateful to the member of staff who provided a high level of prison liaison and ensured that the documentation was in good order.

The man was sentenced to 12 weeks in custody and arrived at Doncaster on a day in November 2010, from a magistrates' court. Nursing staff assessed him and considered that he required alcohol detoxification. He had also been prescribed methadone treatment in the community. Despite previous instances of self-harm before he went into custody, staff considered it unnecessary to put in place additional monitoring during the night.

At 4.35am the following morning, the man's cell mate called an officer and told him that he had collapsed. The officer saw the man "slumped" over his bed and immediately requested medical assistance. Staff attempted cardio pulmonary resuscitation, which was continued by emergency paramedics, who subsequently took him to outside hospital. Further attempts were made to save his life but hospital staff pronounced him dead at 5.58am.

Toxicology reports give the cause of the man's death as 'methadone toxicity'. The clinical reviewer comments on the interactions between different medications, based on his experience in this field, and these are summarised within my report.

My investigation has looked at the policies and procedures in place at Doncaster relevant to the man's circumstances as well as the medical treatment given to him. As a result, I have made five recommendations. They relate to the use and sharing of information received from external agencies, documentation used for drug and alcohol assessments, the use of medical emergency codes and medical equipment and also local procedures for entering cells in an emergency. Both the clinical reviewer and I have also commented on the delay in entering the cell and providing medical treatment. While I make no formal recommendation, I urge the Director to consider the views of the clinical reviewer in relation to joint first aid training of discipline and clinical staff. HMP Doncaster has accepted all the recommendations made in this report.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen
Prisons and Probation Ombudsman **September 2011**

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SUMMARY

1. The man was sentenced to 12 weeks in custody for breach of a community order in November 2010 and was taken to HMP&YOI Doncaster. This was not his first time in prison. He was 45 years old.

2. Court staff completed and passed to the prison a self-harm warning form due to concerns about the man's welfare. He had recently cut his wrists while under the influence of alcohol. The nurse who completed the initial healthscreen saw the form but other prison staff did not see it. The nurse was of the view that the man did not require monitoring under the suicide and self-harm procedures.

3. The man had a history of illicit drug use and was on a methadone treatment programme in the community. This information was recorded and clarified with the community pharmacy by nursing staff during his reception. He disclosed that prior to custody, he had been drinking large quantities of alcohol daily and staff identified that he required a detoxification programme. The substance misuse team assessed him and medication to treat his withdrawal symptoms was prescribed. As a precaution, he was only allowed a half dose of methadone as staff could not establish how much of his community prescription he had taken before he came into prison that day.

4. During the first night of the man's arrival into prison, a PCO was on duty and a nurse who was responsible for the prisoners on the first night/stabilisation unit. The PCO was not required to monitor the man more often than any other prisoner, but he went to his cell three times during the night. The nurse monitored him hourly as is required for any prisoner considered to be withdrawing from drugs or alcohol. She gave him medication at 11.00pm and 3.00am, and had no concerns.

5. At 4.30am, the man's cell mate summoned help and told the PCO that the man had 'wet himself'. The officer looked into the cell and saw him kneeling on the floor with the top half of his body 'slumped' over the bed. He immediately went to get the nurse and they returned to the cell together. The nurse tried to gain a response from the man outside the cell, and then told the PCO that she needed to go inside. She then went away to collect a blood pressure monitor, and the PCO went to the wing office to ask his colleague to summon the orderly officer.

6. The orderly officer heard a call over his radio asking him to attend B wing, but was not told the reason. He unlocked the cell and the nurse asked staff to move the man to the landing outside so there was more room to administer first aid. No medical equipment had been brought at this time, but the nurse attempted cardio pulmonary resuscitation (CPR). The orderly officer also asked for additional medical assistance and an ambulance to be called. A nurse heard the radio call for medical assistance and made her way to the wing. She immediately asked for other medical equipment to be collected and again asked for an ambulance to be called. The nurses continued to administer CPR until the paramedics arrived around 25 minutes after being called.

7. The paramedics took over treatment and managed to establish a pulse before transferring the man to outside hospital by emergency ambulance. He was still unconscious, and emergency treatment continued on his arrival at hospital. Despite the efforts of the medical team at outside hospital, the man was pronounced dead at 5.58am that morning.

8. Later that morning, the prison broke the news of the man's death to his family and subsequently contributed towards the funeral. They offered support to staff and held a debrief for the following day.

9. The investigation highlights concerns about the way in which information received about a prisoner is shared, documentation used during detoxification assessments and staff response to medical emergencies. I make recommendations in relation to these matters.

THE INVESTIGATION PROCESS

10. The investigation was opened by one of my investigators at HMP/YOI Doncaster on 23 November, where he was provided with all documentation relating to the man. Notices were issued informing both staff and prisoners of my investigation. They asked anyone who had information pertinent to my investigation to contact the investigator, but no responses were received.

11. A clinical reviewer conducted a review of the medical care given to the man while in custody, on behalf of my office. I would like to thank him for his assistance in the investigation.

12. My investigator wrote to the Coroner to inform them of the investigation and requested a copy of the post mortem report.

13. One of my family liaison officers (FLO), contacted the man's parents on 10 December 2010. She explained the role of my office and offered them the opportunity to be involved in the investigation process. The family raised no concerns and a copy of my final report will be made available to them, as they have requested.

14. My investigator visited Doncaster on 13 and 14 December to conduct interviews with staff. After completing the interviews, he wrote to the Director of Doncaster and explained the issues that had emerged as a result of my investigation.

HMP/YOI DONCASTER

15. HMP & YOI Doncaster is a privately run prison operated under contract by Serco. It opened in 1994 as a local prison, originally graded to hold the most dangerous of prisoners (category A). It was reclassified to a category B prison in May 2003. Prisoners are risk assessed when they come into prison and given a category based on their offence and the risk that they pose to the public should they escape. There are four levels of category: A, B, C and D, with category A prisoners being the most dangerous. Category B are prisoners for whom the highest security conditions are not necessary but for who escape must be made very difficult.

16. The Governor of a private prison is known as a Director. In prisons managed by the private sector, there is also a controller, equivalent to a governor grade, employed by the Ministry of Justice to ensure that the terms of the private company's contract with the government are adhered to. If the contract is breached, fines can be levied on the company.

17. Healthcare is provided by Serco Health and is based on two floors. A 19 bed in-patient unit is located on the upper floor with primary healthcare services on the lower floor.

18. The prison is certified to hold up to 771 prisoners, but has recently been enlarged and has an operational capacity of 1,145. It consists of three houseblocks, each made up of four separate two level wings. In addition to the residential units and healthcare unit, the prison also has a segregation unit.

HM Chief Inspector of Prisons

19. HM Chief Inspector of Prisons carried out an unannounced inspection at Doncaster in November 2010, just before the man died. Commenting on healthcare and drug and alcohol detoxification provision the report said:

> '… Drug- or alcohol-dependent prisoners received treatment immediately and were located on a designated stabilisation unit, which offered a safe environment. GP cover was insufficient regularly to review all but the most complex cases. Prisoners could access a good level of counselling, assessment, referral, advice and throughcare (CARAT) support but this was not fully integrated with clinical services. Proactive security measures were in place to reduce illicit drug supply and the mandatory drug testing rate was well within the annual target ... '
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> '… Partnership working between the prison and health providers was good. Clinical governance structures were robust. Prisoners expressed dissatisfaction with several aspects of their care, although their concerns and complaints were handled appropriately. Primary care services were good but prisoners waited too long to see an optician. The pharmacy service was functional but some aspects of medicines management were poor. Dental services were satisfactory but had

insufficient capacity to address waiting lists. The inpatient unit was utilitarian but there was good joint care planning. There were no mental health group support opportunities ...'

Independent Monitoring Board

20. The Prisons Act 1952 and the Immigration and Asylum Act 1999 require every prison and immigration centre to be monitored by an independent board. The members are appointed by the Secretary of State for Justice from members of the community in which the prison is situated. The Independent Monitoring Board (IMB) at Doncaster published their last annual report in September 2010. The report says about healthcare:

> "… During the past year there have again been a number of changes made to the way that healthcare services are delivered at Doncaster. In October 2009 a new Clinical Manager joined the team and she has made significant changes in the delivery of core services. In January 2010 on-wing nursing was introduced with dedicated nurses and nursing assistants allocated to work on each residential unit providing medication, wound care and clinics, which include phlebotomy, asthma and diabetes. This service has proved very successful and reduced the amount of waiting time for prisoners to see a healthcare professional and also improved partnership working with nurses and custodial staff. Focus groups are held on each unit on a weekly basis involving prisoners, custody staff and nurses and once a month a joint meeting is held with healthcare management also being involved."

Cell Sharing Risk Assessment (CSRA)

21. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners, which includes taking into account the situational context of any previous violence or mental health issues. An assessment takes place before a prisoner spends their first night in custody (with the exception of open prisons) and triggers a plan to minimise risk for those identified as high or medium risk which is reviewed at regular intervals.

Counselling, Assessment, Referral, Advice and Throughcare (CARATS)

22. Organisations specialising in the treatment of substance abuse have drugs workers based in most prisons. CARATS workers run programmes, and can offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary, by application.

Critical debrief

23. A critical debrief takes place after a serious incident. It gives the staff the opportunity to understand the incident in detail, review their feelings and normalise the reactions that some people experience after a traumatic incident. Benefits include being able to discuss their experiences in a safe and confidential environment.

Cut-down tools

24. Cut-down tools are used to cut ligatures. All staff in closed and semi-open prisons that have contact with prisoners must be provided with and carry, when on duty, their own personal issue tool.

Emergency response

25. Emergency codes are used to summon staff to deal with a prisoner who requires immediate attention cannot be taken to the healthcare centre for treatment. Generally the codes used in emergency situations are 'red' and 'blue'. Blue indicates that a person has breathing/respiratory problems and red that the person is bleeding. The codes allow the medical staff to respond with appropriate equipment.

26. The general alarms are linked to the control room. When the button on a wing landing is pressed it registers in the control room and is broadcast over the radios throughout the establishment so that staff from other areas can respond to the alarm in that location.

27. Emergency bags are located around the prison. They contain life support equipment, which includes airways, ambu bags (breathing aid), oxygen, needles and syringes. There are 12 defibrillators located around the prison. Defibrillators are portable devices that can be attached to a patient who is suspected of having a cardiac arrest, and will deliver a controlled electric shock to put the heart back into a normal rhythm. A defibrillator cannot restart a heart that has stopped.

Person Escort Record (PER)

28. This is a form that accompanies prisoners on all journeys from and between prisons. It serves as a communication tool about risks a prisoner poses on escort or transfer. It also provides a chronological record of the escort, eg meals served, times journey started etc. Further information is in PSO 1025. It is essential that when a prisoner is moved between a police station, court, prison, hospital or other destination, those responsible for the prisoner are made aware of any risks or vulnerabilities. In particular, it is essential that known risks of escape, assault, suicide/self harm or harassment are communicated to protect prisoners, staff and the public.

Reception and induction

29. Reception staff do not routinely have access to a prisoner's past records, so the prisoner is the main source of information. If a prisoner has transferred from another prison, his previous record would arrive with him. All prisoners will also have a PER form.

30. During reception, a prisoner has an initial healthcare screen to assess his immediate well-being, mental health, risk of self-harm or suicide and any drug or alcohol withdrawal or detoxification issues.

31. All prisoners also have an induction. Induction is the process of introducing new prisoners or newly sentenced prisoners into custody. It is designed to:

    - explain the immediate consequences of being in custody
    - explain the routines of the prison
    - explain the rules and regulations they must observe
    - explain the procedures governing certain processes, such as obtaining visits
    - offer practical advice on obtaining goods and services; and
    - help prisoners understand how to navigate their way around issues of imprisonment.

32. Staff should check that prisoners understand what is going to happen to them and attempt to deal with any immediate problems. The induction includes a further assessment, medical screening, and input from the education and offender management units. Prisoners are also provided with (personal identification number) PIN numbers to enable them to use the telephone system and visiting arrangements are explained.

Roll check

33. The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks take place on a number of specified occasions during the day and night, and staff sign that the roll is correct. Staff must ensure the prisoner is in his cell by seeing the prisoner's face or getting a response from him and prove the cell door is locked. If the prisoner cannot be seen, staff must open the door to investigate further until satisfied.

Suicide prevention and self-harm management procedures

34. The Assessment, Care in Custody and Teamwork (ACCT) procedures aim to help and monitor prisoners at risk of harming themselves. The key aims of ACCT are to create a safe and caring environment, identify prisoners' individual needs, and provide individualised care and support before, during and after a period of crisis. Once an ACCT is closed a post closure review should take place within seven days.

Integrated Drug Treatment System (IDTS)

35. The integrated drug treatment system (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:
    - early custody
    - improving the integration between clinical and CARAT Services
    - reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Previous deaths at Doncaster

36. My office took over the responsibility for investigating all deaths in prison, in 2004. Since then, there have been 17 deaths at Doncaster, 14 of these occurred before the death of this man. Recommendations made as a result of my earlier investigations have been about quality of communication, healthcare provision, and I have also highlighted good practice in family liaison.

KEY EVENTS

37. The man arrived at HMP&YOI Doncaster in November 2010, after being sentenced to 12 weeks custody at a magistrates' court. He was 45 years old. He had served three and a half years in custody previously, and released from HMP Kirklevington in 1990.

38. While at court in Wakefield, court staff had completed a form indicating that the man was considered to be at risk of suicide or self-harm. (Staff complete a suicide and self-harm warning form if there is concern about a prisoner's welfare before they arrive into custody. The form is then handed to reception staff at the receiving prison so that further information can be obtained from the prisoner and a decision made on the level of care required.) It was recorded on the form that he had cut his wrists two weeks earlier and was depressed. In addition, an urgent fax was also sent to the probation department at Doncaster indicating the concerns about him.

39. On his arrival at Doncaster the man was taken through the reception procedures. A Prison Custody Officer (PCO) completed the cell sharing risk assessment (CSRA) with him. My investigator asked the PCO about the entries he had made on the CSRA and whether he had sight of the self-harm warning form. He said that most of the information on the CSRA is obtained by asking the prisoner a series of questions. On the form the PCO wrote, "previous self-harm – self-harm warning form, openly stated that he was attention seeking with recent self-harm. No thoughts of self-harm at present." The PCO was asked to clarify the comment that he had written, as it was not consistent with the information on the self-harm warning form. He said that the man had given the information in response to a question that he had asked.

40. The investigator asked the PCO whether he had seen the self-harm warning form when he completed the CSRA. He said that he could not recall seeing it, but had seen the person escort record (PER), where it was recorded that a self-harm warning form had been completed. He also said that he based his questioning on the information that had already been recorded in section three of the CSRA by the nurse. The investigator asked whether it was normal for the reception nurse to complete their part of the CSRA before the other information had been completed, the PCO said, " it is normal procedure at Doncaster".

41. The PCO said that all warning forms go straight to the nurse and, as a reception officer, he would only be required to obtain basic details from the man and allocate him a prison number. (All prisoners on reception are given a unique number, which is generated by the computer when their details are put into the system.)

42. A nurse assessed the man and completed the CSRA. The nurse signed the self-harm warning form to indicate that he had seen it and decided that monitoring under the suicide and self-harm prevention procedures was not required. In section three of the CSRA, the nurse wrote "no concerns at this time. Recent self-harm while under the influence of alcohol. No thoughts of

self-harm at this time." He also completed the reception health screen with the man and recorded that he was on a methadone prescription in the community. (Methadone is one of a number of synthetic opiates (also called opioids) that are manufactured for medical use and have similar effects to heroin. It is used mainly to wean people off their addiction to stronger opioids.) When asked about any previous injuries, the man told the nurse that he had cut his left wrist two weeks earlier.

43. The health screen is divided into sections covering different areas of a person's current and previous medical history. When asked about his substance use, the man said that he drank about one and a half litres of vodka a day, which helped him cope with his "agitation". He told the nurse that he had used drugs in the past month and clarified that this was daily use of methadone. In respect of his mental health, the man said that he had not previously received any treatment from a psychiatrist, but had been prescribed citalopram in the past. (Citalopram is used to treat anxiety.)

44. When the nurse enquired further about the man's recent self-harm, he replied that he tended to cut his wrists when drunk. He said that his most recent self-harm occurred while under the influence of alcohol and he had no current thoughts of self-harm. The healthscreen is completed in two parts, with a secondary screening either two or three days after the prisoner goes into custody. However, due to time constraints on nursing staff, both parts are often completed at the same time. As part of the secondary screen, the nurse recorded the man's blood pressure as 151 over 106, which indicated that it was high, and his pulse 126 beats per minute (BPM), again indicating that this was raised. Both readings are in keeping with the man saying that he suffered from anxiety. He said that he had no other concerns about his physical health.

45. Once the man had completed the health screen and reception procedures, he was considered suitable to share a cell. Due to his substance misuse history, he moved to the first night/stabilisation unit. A PCO was on duty the evening the man was brought onto the unit by reception staff. He explained that when the man arrived he sat down with him and asked him questions as part of the induction process. He said that he asks about the offence for which the person has been either sentenced or remanded and enquires about what drugs or alcohol they have been using. He added that the prisoner's medical record is also handed over to IDTS nursing staff. Once he has finished and the prisoner has been provided with information and signed various documents, they are given a cell and wait to be seen by the IDTS nurse.

46. The PCO was asked whether he had noticed anything unusual about the man when he arrived on the unit, and whether he had any concerns. He said that in his opinion as soon as the man came onto the unit there were "warning signals". He could see he was a "poorly chap" who was not very talkative. He said that despite trying to engage the man in conversation he just replied, "I don't want to talk at the moment, because I am not very well".

47. My investigator asked the PCO to clarify what he meant by "poorly chap". He replied that he was referring to the man clearly withdrawing from either drugs or

alcohol. He had seen prisoners withdrawing a lot worse, but this man looked as though he was in pain. He recalled that the man came onto the unit at around 4.00pm. Once he had completed the initial induction and shown him to a cell, he spoke to the IDTS nurses, as he was concerned about him.

48. The nurses contacted the pharmacy where the man collected his prescription of methadone in the community, as this is normal practice to clarify the dose and the last time it had been dispensed. The pharmacy confirmed that he was receiving 52mls daily and had last collected his prescription on 17 November.

49. At 6.30pm, a nurse went to see the man. In the medical record, the nurse wrote that he was known to drink one and a half litres of vodka daily and he had been drinking at these levels for the past eight months. She also recorded that he had "acute objective alcohol withdrawal signs, sweating, tremors, anxious and was agitated". She also noted the blood pressure and pulse taken in reception and that a healthcare assistant had rechecked them. The new readings were blood pressure 160 over 112 and pulse was 137bpm. The nurse telephoned the duty IDTS doctor and left a message on his answer phone as he was en route to the prison to begin his evening surgery. She recorded that the man should be observed regularly until seen by the doctor.

50. The duty doctor returned the nurse's call and she explained the situation with the man. The duty doctor advised that he should be given 15mg of diazepam and 20mg of buscopan, until he could see him later. The nurse said that the diazepam would have "settled" him and helped prevent any seizures because of his withdrawal and the buscopan would help alleviate the stomach cramps that he had also mentioned.

51. At interview, the nurse spoke about her interaction with the man. She said that she had been shown the blood pressure and pulse readings completed on reception and it was decided that he should be seen before the rest of the new prisoners. She had asked her colleague, a healthcare assistant, to recheck the man's blood pressure and pulse so that the doctor would have a fresh reading when he saw him later.

52. The nurse also said that the healthcare assistant completed an alcohol withdrawal chart, and described this as "a scale". The investigator asked the nurse about the withdrawal "scale" and whether this was the only document available to the nursing staff. She explained that there are others relating to other types of withdrawal, but essentially the format is the same. The scale referred to is completed over five days by the IDTS nurses and gives a list of possible symptoms that may be exhibited by someone withdrawing. The nurse then allocates either zero or one to each. Zero indicates that the prisoner does not have this symptom and one that he does. However, there is no sliding scale to indicate the level of a particular symptom. The nurse was asked whether she found the current documentation useful, and she replied "no".

53. The nurse was asked whether, as part of her assessment, she had knowledge of the man's previous self-harm and whether questions about self-harm were asked. She said that if a prisoner mentions self-harm or the nurses are made

aware of concerns and an ACCT document is not already open, then this would be done. However, the man had not mentioned any concerns relating to this.

54. The duty doctor told the investigator that he is contracted to provide services at the prison on a sessional basis starting at 7.00pm. He said that it is his practice to telephone the prison before he leaves home to let them know he is on his way, and it was during such a telephone call that he spoke to the nurse. He said that this would have been between 6.40pm and 6.50pm, and the nurse explained her concerns about the man. He confirmed that he authorised the nurse to give diazepam and Buscopan prior to his arrival. The doctor assessed him at 7.20pm and said that he had full access to the man's medical records.

55. In explaining the effects of alcohol withdrawal, the duty doctor said:

> "… acute withdrawal of alcohol can lead to neuropsychiatric (neurological and psychiatric) complications, hallucinations, which may be auditory, visual, and fitting. Also, there are other complications of alcohol withdrawal, for example cardio vascular complications, tachycardia [fast or irregular heart beat] hypertension. Generally speaking these are unpleasant but not generally life threatening."

56. The duty doctor was asked about his impressions of the man when he assessed him. He said:

> "clearly [the man] was unwell. From the records [the man] had a tachycardia and he had a wide pulse pressure and he was hypertensive. These are signs that I would expect on a prisoner who has stated that he's been consuming over one and a half litres of vodka a day. However when I saw [the man] at 7.20pm, he expressed an opinion that he was somewhat more settled and the tachycardia and the wide pulse pressure of hypertension did not give me overall undue concern."

The duty doctor also said that he was aware that the man was being prescribed 52mls of methadone daily. He explained that because the man's methadone was unsupervised there was no way of verifying what dose he was taking. He added that the methadone protocol errs on the side of extreme caution and because of this only 10mls of methadone was prescribed that evening.

57. The duty doctor explained the major problems with methadone, and the facts that must be considered. He said that one of the concerns, as with any opiates, is of respiratory depression (insufficient breaths), so it has to be approached with extreme caution. He said that the effects of methadone decreases by half in 25 hours, so if a prisoner on supervised methadone comes into custody and it is confirmed that they have received their dose within the last 72 hours, they can be slightly more "relaxed" in terms of the dose of methadone prescribed. However, he would always err on the side of caution and give a half dose on the first evening followed by a half dose twice daily, ie divided doses, for a few days until absolutely certain that a prisoner is tolerant and his condition is satisfactory.

58. In relation to concerns about self-harm, the investigator asked the duty doctor whether this formed part of his assessment with the man. He said that he would always ask a patient about feelings of self-harm or depression and any other physical problems. The man did not tell him that he was thinking about harming himself and did not complain of depression or anxiety other than his withdrawal. After the assessment, the man returned to his cell.

59. On the night of the man's arrival, a PCO and nurse were both on duty on B wing. The investigator asked both members of staff about the requirements for monitoring a new prisoner identified as withdrawing from either drugs or alcohol. The PCO said that he was not required to make any additional observations unless a prisoner had alerted him by pressing their cell call bell, which he would answer. (All cells are fitted with a cell call bell that can be pressed by a prisoner to alert a member of staff that they require help or assistance. The officer is alerted by a light on the outside of the cell and a buzzer sounding in the wing office.) He said that prisoners who were detoxifying would be monitored by the nursing staff.

60. When the nurse was asked the same question, she explained that nursing staff monitor prisoners detoxifying or withdrawing from drugs and or alcohol. She said that the man was considered to be one of these prisoners and she monitored him hourly. My investigator asked the nurse about how the observations are recorded and she said that in the past 'observation logs' had been used, but these were not in use at the time and she recorded her observations in the man's medical record.

61. The man was unlocked from his cell at 9.00pm to allow him to go to the treatment room on the unit to be given his methadone. A nurse was dispensing medication and, when the man came to collect his, it was evident to her that he was withdrawing from alcohol. He was shaking, which she explained is an indication of withdrawal. The nurse gave him 10mls of methadone in liquid form that he took in front of her. He also asked for Buscopan tablets as he had stomach cramps, but she said that because he had already been given some at 7.00pm, she was unable to prescribe anymore at that time.

62. The PCO has to conduct three full checks of all the prisoners on the unit during the night duty. He said that they have to be done between 11.00pm and 5.00am, and he is required to account for every prisoner.

63. The nurse conducted her observations on the man hourly until 3.00am. She was asked about the purpose of her observations and whether they were physical or visual. She replied that she does not have access to cells at night so her observations are visual and made by looking through the hatch on the cell door. As the man had been assessed as having raised blood pressure and pulse, the investigator asked the nurse how this could be monitored visually. She said that not having access to a prisoner at night to conduct physical observations is something that "hindered" her conducting her job. However, if she had particular concerns about a prisoner, she would contact the orderly

officer, who is in overall charge of the prison at night, who would be able to provide access to the cell.

64. When asked why her observations had stopped at 3.00am, the nurse said that this happens every night. She has to leave the wing to deliver medication to other areas of the prison. She added that this is customary and furthermore, when she returns to the wing after delivering the medication, she writes up medical notes which means that no further observations are made. The investigator asked how many prisoners on average she would be required to monitor on the wing and she said that it would be about six. She said that when she leaves the wing no one else continues to conduct her checks and, although there is an officer on the wing, they will be making their own checks.

65. The man was in a shared cell. During the night, the PCO went to see him on three separate occasions after he pressed his cell call bell. The officer said that on one of these occasions the man had requested some painkillers for a headache. The nurse also gave him some Buscopan at 11.00pm and again at 3.00am, which was her last check, before leaving the wing.

66. At 4.00am, the PCO had just completed his check of all the prisoners when he heard shouting coming from the man's cell. When interviewed, he had difficulty recalling what he had done, but said that he remembered going to the cell and being told by the man's cell mate that he was shouting and making no sense. He then went to the nurse and told her that she should see the man. The investigator asked the nurse why there was no entry on the medical record about this. She explained that the PCO had said "[The man] has been calling again" and she replied "oh yes I have been and I gave him some Buscopan earlier, I will go when I finish". The investigator clarified with the nurse that her intention was to go and see the man again when she had completed what she was doing, which she confirmed.

67. The PCO was alerted by a cell call bell from the man's cell again at 4.35am. When he answered it, the man's cell mate was standing behind the door and told him that the man had "wet himself". The PCO looked into the cell via the hatch and saw the man kneeling beside his bed with his top half "slumped" across the bed. He then left the cell to get the nurse. The investigator asked why he did not use his radio to summon medical assistance rather than leaving the cell, and he said that as the nurse was on the wing he thought that this would be a quicker option.

68. When both the PCO and the nurse returned to the cell, they tried to get a response from the man by calling out to him through the hatch, but he did not respond. The nurse then told the PCO that she needed to go into the cell and he should contact the orderly officer. The nurse then went upstairs to get a blood pressure monitor. She confirmed to the investigator that this was the only equipment that she collected at that time. While she was doing this, the PCO went to ask a fellow officer to come onto the wing and also radioed for the orderly officer to attend.

69. The PCO was asked why he did not use his emergency key and go straight into the cell when he first arrived with the nurse, and then radioed for assistance. (At night keys are only carried by the orderly officer, but officers patrolling wings carry a single cell key in a sealed pouch to be used in the case of an emergency.) He explained that to go into a cell at night or while in a 'patrol state' is a matter of judgement, particularly a double occupancy cell. He was not sure whether the man was alright and, although he could have gone into the cell, he decided that it was better to wait for additional staff assistance.

70. The night orderly officer is responsible for the running of the prison during the night. He told the investigator that he was called over his radio at around 4.40am and asked to attend B wing with a patrol officer. The investigator asked whether any emergency code was given and the officer said that at that time it was not and he was just asked to attend. The night orderly officer said that he reached B wing about three minutes after receiving the radio call. The PCO alerted him to the problem and he made his way straight to the man's cell. At that point, five minutes had passed since the man's cell mate had pressed the cell call bell.

71. The night orderly officer said that he looked in and on seeing the man 'slumped' across the bed, immediately went into the cell. He said that when he arrived the PCO was the only other person there and no nurse was present. The officers checked the man's pulse. The nurse then returned and she also tried to find a pulse. She asked the officers to move the man on to the landing outside so that there would be more room to administer treatment. The night orderly officer told the investigator that at this point an emergency 'code blue' was called via his radio.

72. Once outside the cell, they laid the man on his back and the nurse applied cardio pulmonary resuscitation (CPR). Another nurse was in the healthcare wing when she heard the code blue call over the radio requesting medical assistance on B wing. Along with her colleague, a further nurse, they made their way there, which she said took about two minutes. On her arrival, she saw that her colleague was administering CPR with the help of an officer, but no equipment was available. The nurse who had just arrived said that, because she knew that there was oxygen and a defibrillator located on B wing she had not brought them from healthcare, and was surprised when she arrived to find that they had not already been collected. She checked the man's pulse and asked for an ambulance to be called, which again she would have expected to have already been done, and she asked for both the defibrillator and oxygen to be collected.

73. There appears to have been some confusion about collecting the medical equipment caused by staff not knowing exactly where items were located. However, the night orderly officer said that all the equipment was collected and accessible to the nursing staff within about five minutes. The nurses continued CPR but the defibrillator did not indicate the presence of a heart beat which could be stimulated by delivering an electric shock.

74. The night orderly officer said that the paramedics arrived in B wing at around 5.10am, about 25 minutes after being called and 35 minutes after the man had first been discovered collapsed. The nurse who arrived to help with her colleague also recalled it was around 30 minutes before paramedics arrived. She said that they had mentioned that they had been 'stood down' by their control room after the original call. However, this has not been confirmed and no records from the ambulance service have been made available.

75. The paramedics took over treating the man and managed to establish a faint pulse. They then took him by emergency ambulance to outside hospital where an emergency team continued attempts to resuscitate him. Despite the efforts of nursing staff at outside hospital, the man was pronounced dead at 5.58am.

76. The night orderly officer said that after the man was taken to outside hospital he remained on B wing with his cell mate and put in place monitoring for him under the suicide prevention and self-harm management procedures by opening an ACCT document. He also arranged for another prisoner who was trained to be a 'buddy' to stay with him. (A 'buddy' is a prisoner who has volunteered to provide support to fellow prisoners. They have no formal training and receive no financial or other reward for providing their services.)

Actions following the man's death

77. Later that morning, the prison's family liaison officer (FLO) and senior manager travelled to the man's parent's home to inform them of their son's death. They gave the family support and details of what had happened after discovering him as well as advising them of my investigation.

78. The following day, a debrief was held. The staff involved were given the opportunity to discuss what had happened and were offered support from members of the staff care team. All staff interviewed during the investigation said that the support that they had received following the man's death was good.

79. The prison offered the family support towards funeral costs as required by PSO 2710. The man's funeral was held on 2 December.

ISSUES

Sharing information

80. While the man was in court, staff completed a self-harm warning form which accompanied him to Doncaster. The form was raised initially due to recent self-harm and concern by court staff about his welfare. It was also faxed to the prison to make staff aware of the concerns before his arrival into custody. However, there is no indication that the faxed copy was ever seen by reception staff or any other person who would be dealing with him on his arrival.

81. The hand written copy was handed to reception staff. Despite this, the staff that interviewed the man said that they did not have sight of the document. The nurse who completed the initial health screen did see the form and made the decision that monitoring under the ACCT suicide and self-harm prevention provisions was not required.

82. When the man moved to the first night wing, he was again interviewed by staff. The PCO said that there were "warning signals" in his opinion as soon as the man came onto the wing, but described this as him being a 'poorly chap'. The officer did not see the self-harm warning form. Following his interview with the PCO, IDTS nursing staff assessed the man and they did not see the self-harm warning form either.

83. The evidence suggests that the nurse who had signed the self-harm warning form was the only member of staff who actually saw the self-harm warning form during the man's reception process. The document is designed to provide information and highlight a potential risk. While the nurse had made his assessment that self-harm monitoring was not required in his opinion, he was just one part of a process. The information should have been available to all staff who dealt with the man as their assessment of his well-being and potential risk may have been different. While there is no indication that the man's death was self-inflicted, the process for the correct sharing of such information should be considered by the prison in all future cases when a self-harm warning or other information highlighting concerns is received.

The Director should make all staff aware of the correct procedures to be followed when a self-harm warning form is received from an outside source. This should include verifying that there is an auditable process to ensure that when such a form is faxed, it is handed to and acted on by the relevant staff. Regardless of the action taken, the form must be placed within a prisoner's wing history file and handed to first night staff.

Drug and alcohol detoxification assessment

84. I consider that the assessments conducted by the IDTS team were carried out efficiently. The man was seen by appropriately trained nursing staff and a doctor and necessary medication prescribed. However, the investigation found that the withdrawal assessment paperwork used by nursing staff does not include a sliding scale which would help to indicate whether a patient has

improved or become worse. The nursing staff interviewed agreed that the introduction of such a document would make assessing a patient easier.

The manager responsible for IDTS should review the current assessment documentation and introduce a sliding scale that can be used by the IDTS team to assess a patient's level of withdrawal while they are in the stabilisation unit.

Medication

85. The cause of the man's death, following toxicology tests, is recorded as 'methadone toxicity'. The clinical reviewer comments on these findings:

> "The dose of methadone, diazepam and buscopan administered to [the man] was within national guidelines pertaining to the management of drug dependence in prison settings. I could not find any evidence of unsafe prescribing practice. From my clinical experience, extensive medico-legal work in this field, and the fact that the autopsy was negative for other findings, I am of the view that it is probable that [the man] had taken other medication in the period prior to his death which was undetected at post mortem toxicology. There is an extensive market for the diversion of both prescribed and illicit drugs in prison settings and there are commonly rapid fluctuations in availability. Common drugs of abuse currently are Pregabalin, Gabapentin, tramadol, Promethasine and mirtazapine. Therefore it is probable that the cause of death was methadone and diazepam acting synergistically with a medication undetected at post mortem toxicology."

Emergency response

86. From my investigation, it is quite clear that there was a delay before staff went into the cell to treat the man as well as the delay obtaining essential medical equipment. All prisons use an emergency coding system for medical emergencies. Staff use the codes to summon assistance and provide medical staff and others with an idea of the type of emergency, and therefore what equipment may be required. However, the evidence provided by staff in interview would indicate that the codes were not used by staff after being alerted to the man's situation. My investigator was told by staff that a coding system is in place at Doncaster, but I consider that there is a need for staff to be reminded of this and the importance of their use. I therefore make the following recommendations:

The Director should issue a notice to all staff reminding them of the current medical emergency coding system in place at Doncaster, and reiterate the importance of the correct use in all medical emergencies.

The Director and the head of healthcare should remind staff of the importance of immediately taking medical equipment to an emergency.

87. As mentioned above, there was a delay before staff went into the cell. The PCO explained his reasons for not doing do immediately, as an officer on his own attending a double occupancy cell he had to ensure his own safety and the security of the prison. During a number of previous investigations, I have found confusion amongst members of prison staff concerning when they can enter a cell alone, particularly during the night.

88. In January 2010, ten months before the man took his life, the Chief Operating Officer of the National Offender Management Service (NOMS), issued guidance to all prisons about this issue. He explained that all prisons must have a local security strategy (LSS, an instruction from the governing Governor relating to a policy at a particular prison) which clearly states what members of staff should do "if faced with a potentially life-threatening situation when there are no other staff in the immediate vicinity". The sample LSS included in the Chief Operating Officer's guidance stated the following:

> "Where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own."

89. It goes on to state that:

> "Staff have a duty of care to prisoners and to themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger."

90. When the man became unwell, the PCO was not alone as he had a nurse with him and he could also clearly see that the man was in need of medical assistance. However, I appreciate that the immediate concerns of the two members of staff would have been slightly different. The PCO would have considered the security implications of opening a double cell without support and the nurse would have focussed on the medical concerns.

91. The clinical reviewer considered this issue in his review and commented on how the delay affected the effectiveness of the emergency treatment:

> "There appears to be a delay of approximately five minutes between the decision being made to open the cell door and the door actually being opened. During that time the duty officer made a call through the Oscar 1 system for additional staff prior to opening the door. [A nurse] went to obtain a blood pressure cuff. The critical question in this scenario is whether it is ever appropriate for a single officer to open the door without additional support. From my experience of working for eight years as a clinical director in prisons it is often a source of disagreement between security and clinical staff. Security staff are understandably concerned about the inherent security risk in opening a door without support staff present. [The PCO] alludes to this concern in the transcript of his interview. However in cases of a clinical emergency there is an imperative to open the door without delay to

prevent risk of death. In this scenario I would argue that there were legitimate grounds to open the door without delay. First the patient had been receiving additional medication throughout the night and was being observed hourly. Second at 4.00am the officer noted a noise coming from the cell. The noise reminded him of a previous incident of when he had heard a similar noise expressed by an individual who had found his cell-mate hanging. Third if there is reasonable suspicion that an individual is unconscious and behind locked doors then there would be grounds for immediate opening of the cell door with a view to starting CPR.

"On the other hand individuals can feign unconsciousness and this could pose a security risk if the door is opened without support staff present. Therefore this is a difficult area and the fact that in this scenario there was a delay in the door being opened highlights a dilemma that is widespread throughout the prison estate. My recommendation would be that ideally annual CPR training should be delivered in co-training events to both discipline and healthcare staff working together to consider these issues. Where that is not possible clinical scenarios could be developed for CPR training. Scenarios could cover circumstances in which it is imperative that a door is opened immediately and circumstances in which it would be prudent to wait for support staff before opening the door. For example where the patient is clearly conscious it would usually be reasonable to wait for support staff. Also if there had been a recent altercation between the patient and security staff then more caution should be exercised. However where there were reasonable grounds to suspect a medical emergency then the door should be opened immediately. For reasons outlined above I would argue that there were reasonable grounds to suspect an emergency and that the door should have been opened without delay and CPR commenced on [the man]. The delay possibly increased the likelihood of death …"

92. Like the clinical reviewer, I have found that staff quickly entering cells during a medical emergency and the conflict of ensuring security while addressing the medical needs of the patient is an issue in many prisons. I agree with the clinical reviewer's views that discipline and medical staff would benefit from having the opportunity to complete CPR training together, with scenarios such as those mentioned being developed. I would therefore urge the Director and healthcare manager to consider the issues raised by the clinical reviewer, with a view to developing training that can be delivered to all staff grades along the lines suggested. By doing so all staff will have a better understanding of the issues that each must consider in emergency situations. I also make the following recommendation:

The Director should review the Local Security Strategy to ensure that it reflects the guidance issued by the Chief Operating Officer, and ensure that the guidance is available and known to all staff.

CONCLUSION

93. The man had harmed himself while under the influence of alcohol, shortly before he went into custody. As a result of this, staff at the court had raised concerns about his welfare which they shared with the prison. While it appears that this information was not seen by the staff who dealt with him during his reception he was asked on a number of occasions about any thoughts he may have about harming himself. When asked about this, he said he had no such thoughts, and apart from his obvious symptoms of withdrawal, staff had no other concerns. Although there was no adverse effect on the man as a result of staff not seeing the form, it is imperative that procedures are improved to ensure there is not a similar oversight in future.

94. During his initial health assessments, the man disclosed that he was on a methadone programme in the community and drank large quantities of alcohol on a regular basis. As per prison protocol, this was verified with his local pharmacy and his dose was adjusted by the prison doctor as it was unclear how much he had actually taken before he arrived. In addition, he was also given medication to treat other symptoms of his withdrawal. Staff observed him hourly throughout the night and on two occasions gave him further medication to treat stomach cramps, but there is no record of him complaining of any other problems.

95. When the man's condition worsened and his cell mate called for help, there appears to have been a delay of at least five minutes before staff went into his cell to give treatment and even at this point they did not have access to potentially life saving medical equipment. This was not made available until a further five minutes after staff first entered the cell.

96. The clinical reviewer is satisfied that prison staff prescribed the man's medication appropriately and safely. However, from previous experience he considers it likely that he had taken other medication before his death which was undetected during the post mortem toxicology tests.

97. The clinical reviewer concludes that the man's death was 'possibly preventable' if staff had gone into the cell and started CPR sooner. He says that while resuscitation does not guarantee a full recovery, he considers that immediately starting treatment would have possibly (rather than definitely) reduced the likelihood of death. On the evidence available, I concur with his views and urge the Director to consider ways of empowering staff to feel confident about going into cells when it is clear that there is a serious medical emergency.

RECOMMENDATIONS

1. The Director should make all staff aware of the correct procedures to be followed when a self-harm warning form is received from an outside source. This should include verifying that there is an auditable process to ensure that when such a form is faxed, it is handed to and acted on by the relevant staff. Regardless of the action taken, the form must be placed within a prisoners wing history file and handed to first night staff.

   Accepted by HMP Doncaster: Comprehensive review to be undertaken by Safer Custody Lead and Head of Security and Operations concerning the receipt, processing and sharing of the Self-Harm Warning Form and other relevant documentation. To be completed by end August 2011.

2. The manager responsible for IDTS should review the current assessment documentation and introduce a sliding scale that can be used by the IDTS team to assess a patient's level of withdrawal while they are in the stabilisation unit.

   Accepted by HMP Doncaster: Acting Head of Healthcare at Notts Healthcare Trust to conduct a comprehensive review of withdrawal assessment procedure. To be completed by end September 2011.

3. The Director should issue a notice to all staff reminding them of the current medical emergency coding system in place at Doncaster, and reiterate the importance of the correct use in all medical emergencies.

   Accepted by HMP Doncaster: All staff to be informed via management briefings of the importance of using the emergency coding system. Notices also to be displayed throughout the prison. Communications room staff to ensure that they request an appropriate code when an emergency request is made. Emergency coding procedure to be reinforced in staff training. To be completed by end July 2011.

4. The Director and the head of healthcare should remind staff of the importance of immediately taking medical equipment to an emergency.

   Accepted by HMP Doncaster: In conjunction with establishing the correct emergency codes, all nursing staff to be reminded that all appropriate medical equipment must be taken to each emergency. To be completed by end July 2011.

5. The Director should review the Local Security Strategy to ensure that it reflects the guidance issued by the Chief Operating Officer, and ensure that the guidance is available and known to all staff.

   Accepted by HMP Doncaster: LSS to be reviewed to ensure that it contains clear guidance (relative to HMP Doncaster) on what staff should do if they are faced with a potentially life threatening situation when there are no other staff in immediate vicinity. Guidance to be issued to all staff. To be completed by end July 2011.