Investigation into the death of a man at North Manchester General Hospital in March 2011, while in the custody of HMP Manchester

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is a report into the death of a man in March 2011, just five days after his reception into custody at HMP Manchester. The post mortem concluded that the cause of his death was methadone toxicity (a fatal level of methadone in the body). I offer my sincere condolences to his family and friends for their loss.

The investigation was carried out by one of my investigators. I am grateful to NHS Manchester for appointing the clinical reviewer and a doctor assisting the clinical reviewer to review the man's clinical care, as well as to the Governor and his staff for their co-operation during the investigation. I apologise for the delay in issuing this report.

The findings of the clinical review play an important part in this report in relation to the man's care. The review shows that, although the man's initial assessment for and referral to a detoxification programme were in line with, or even better than, expectations in the community in terms of timeliness, his management thereafter was inadequate.

Overall, the investigation found a number of failings. Following the reception process, previous community medical records were not requested to confirm the information reported by the man concerning his drug use. Staff did not adhere to the policy on the management of prisoners undergoing detoxification and did not follow the treatment plan. In addition, they failed to conduct the clinical observations specified for the man and key prescribed medication was not documented. The man had a history of self-harm and attempted suicide. In custody, he expressed ongoing thoughts of self-harm which were not acted on. I have made five recommendations regarding these findings.

This office has dealt with a number of deaths arising from medication toxicity. Together with a number of Coroners, I have raised concerns about the apparent increase in such deaths with the National Offender management Service, including issues regarding the prescription and administration of combinations of medication to those undergoing detoxification. In light of the cause death in this case, I make a further recommendation, concerning the need for increased awareness of these issues when prescribing all medications with sedative effects to prisoners detoxifying.

Notwithstanding the concerns set out above, I wish to recognise the speed and professionalism of the staff who responded to the emergency situation and the professional and sensitive approach to family liaison adopted by Manchester.

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 CBE
Prisons and Probation Ombudsman **May 2012**

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SUMMARY

1. The man was convicted of a serious offence in March 2011. He was remanded into custody at HMP Manchester and was due to return to court for sentencing. The man was a heavy smoker had a history of alcohol and drug dependency as well as self-harm. He had also been diagnosed with depression and psoriasis. He had served several custodial sentences since 1998 and had previously been in custody at Manchester on a number of occasions.

2. At Manchester, healthcare staff assessed the man. They placed him on detoxification for his alcohol and drug dependency as well as prescribing medication for his psoriasis. He also had an assessment by a member of the mental health team and the visiting psychiatrist, who prescribed additional medication. The assessment was appropriate but his subsequent care was not compliant with the drug treatment policy or the Department of Health guidelines on managing drug dependency.

3. The man had a history of self-harm which was known to staff. While at Manchester, he expressed further thoughts of self-harm. Staff did not formally monitor him in respect of these assertions and there is no evidence that he acted on them while he was at Manchester. However, it is our view that staff should have conducted a formal assessment under the suicide and self-harm procedures and a recommendation has been made in relation to this issue.

4. The staff found the man unconscious in his cell and called for emergency medical assistance. Healthcare staff carried out cardio pulmonary resuscitation (CPR) until the paramedics arrived and took over his care. The man was taken to hospital however, the hospital doctor pronounced him dead at 8.42am.

5. In the days that followed, the prison family liaison officer maintained contact with the man’s family and offered support and financial assistance towards the funeral expenses.

6. We are satisfied that the man’s assessment and referral were timely and, in that respect, was equitable to what he could have expected in the community. We recognise the speed and professionalism of the staff who responded to the emergency situation when the man was found and the professional and sensitive approach in family liaison. However, we are concerned about the management of his detoxification and the failure to put in place self-harm monitoring. Accordingly, we make recommendations concerning accurately maintaining medical records; adherence to the policy for those prisoners on a detoxification programme; obtaining community medical records; clinical risks in prescribing medication during detoxification and implementing the suicide and self-harm procedures when prisoners express current thoughts of self-harm.

THE INVESTIGATION PROCESS

7. The investigation was opened on 16 March 2011, when my initial investigator, issued notices announcing the investigation to staff and prisoners. These included an invitation to anyone with information relevant to the investigation to contact him. No one came forward as a result.

8. The investigator visited HMP Manchester on 22 March 2011. During his visit, he was given copies of all documentation relating to the man and visited where he had lived. Our investigation was suspended on 24 March, due to a pending police investigation into potential criminal offences. It was re-opened on 18 July, following confirmation that no criminal investigation would take place.

9. My other investigator took over the investigation on 27 September. He went to Manchester on 20, 21, 25 and 26 October and 9 November and interviewed 18 members of staff. My investigator also attempted to interview the man's cellmate. The man's cellmate had been released from custody and he failed to respond to written requests for an interview. Written feedback on the progress of the investigation was sent to the Governor on 10 November.

10. NHS Manchester appointed the clinical reviewer who was, assisted by a doctor, to review the man's clinical care. My investigator and the clinical reviewer discussed aspects of the man's treatment at Manchester and jointly conducted interviews with members of staff. My investigator and the clinical reviewer met the doctor who was assisting the clinical reviewer on 11 January 2012, to discuss the findings of the investigation and post mortem report.

11. This report has been delayed partly because of the requirement to suspend our investigation for four months, from March to July, pending a potential criminal investigation undertaken by Greater Manchester Police. Further delays were incurred due to workload pressures in this office.

12. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and request a copy of the post mortem report. Upon completion, the investigation report will be sent to the Coroner to assist his enquiries into the man's death.

13. Our Senior Family Liaison officer contacted the man's family to inform them about the investigation and to invite the family to ask any questions or raise any concerns. The family have made no contact at this stage. However, they will have the opportunity to comment on the draft report if they wish.

HMP MANCHESTER

14. HMP Manchester is part of the high security estate. It is located in the centre of the city. Manchester also operates as a local prison serving the courts of the Greater Manchester area. It holds up to 1,269 adult male prisoners on remand, convicted and sentenced. The E wing inner section operates as the self-contained unit for up to 53 category A and escape-list prisoners. (Category A are prisoners whose escape would be highly dangerous to the public or the police or to the security of the state.)

HM Chief Inspector of Prisons

15. HM Chief Inspector of Prisons (HMCIP) last carried out a full announced inspection of Manchester in July 2009. In the introduction to the inspection report the Chief Inspector wrote:

    "Unlike some of the other core locals, Manchester has always tried to ensure that it can meet the needs of the great majority of its prisoners, who could be found in any large local prison, while ensuring the security necessary for category A prisoners. This inspection found that still to be the case. The fact that category A prisoners were held on a separate landing meant that security arrangements for the rest of the prison did not intrude unduly on the regime."

16. In considering support for prisoners at potential risk of self-harm, the Chief Inspector found:

    "The comprehensive suicide prevention and self-harm strategy adopted a holistic approach to support … assessment, care in custody and teamwork (ACCT) documents … were reasonably well completed, but case reviews were not sufficiently multi-disciplinary …"

Independent Monitoring Board

17. Each prison in England and Wales has an Independent Monitoring Board (IMB). IMB members are volunteers from the local community who monitor day-to-day life in the prison to help ensure proper standards of care and decency are maintained. The latest report published by the IMB at Manchester for the year ending February 2011 recognised the work of the prison staff in maintaining standards despite the ongoing need for efficiency savings.

18. The IMB also commented on healthcare at Manchester as follows:

    "Healthcare continues to be provided by the Manchester Primary Care Trust (PCT). The Mental Health In-reach Team (MHIT) is provided by Manchester mental Health and Social Care Trust. Members of the team visit prisoners with such needs on their respective wings on a regular basis, assessing and providing support for a wide range of needs.

"Treatment clinics are held in the out-patients area of Healthcare centre each weekday. Prisoners can ask to see the doctor, dentist, optician and podiatrist. Dental treatment is for emergency only, not check-ups. Podiatry is mainly for elderly or diabetic prisoners.

"Also available at out-patients is a Drug Intervention Record (DIR). Offenders on methadone are offered this appointment. It is an in-depth interview and questions are very comprehensive. Physical/mental health is considered, as is drug misuse and personal and social functioning. Upon completion the prisoner receives a Comprehensive Substance Misuse Assessment (CSMS)."

Assessment, Care in Custody and Teamwork

19. At the time of the man's death, the policies that governed all aspects of running a prison were set out in a series of documents called Prison Service Orders (PSOs). PSO 2700 – 'Suicide prevention and self-harm management' details prison procedures for looking after prisoners at risk of suicide or self- harm. Assessment, Care in Custody and Teamwork (or ACCT) is the system used by prisons to identify, monitor and support prisoners at risk of self-harm. Any member of staff who is concerned about a prisoner can start the ACCT process by raising a Concern and Keep Safe form, explaining the reasons for their concern. The manager of the wing where the prisoner is located writes an Immediate Action Plan and, within 24 hours, a member of staff who must be a trained assessor carries out an ACCT assessment .

20. After the ACCT assessment has taken place, a multi-disciplinary ACCT case review is held to determine what measures can be taken to monitor and support the prisoner effectively. The prisoner attends the case review and staff should encourage him to contribute to the decisions made. An ACCT CAREMAP is drawn up with details of each of the actions required to keep the prisoner safe and identifies who is responsible for carrying out each action. Case reviews must be held at regular intervals, usually monthly, to review the actions and the prisoner's level of risk.

Integrated Drug Treatment System (IDTS)

21. 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 (Counselling, Assessement, Referral and Throughcare (CARAT) Services; and
- reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

Staff checks undertaken during the night

22. Two processes take place in the prison at night. Roll checks are a physical count of all prisoners at the start and end of every shift. For night staff, this is around 8.00pm and between 6.00 - 6.30am. Officers simply look through the observation hatch to see that the prisoner is present and do not wake prisoners if they appear to be asleep. If staff find anything out of the ordinary, they should seek help. There is then a further roll check on handover to the day staff, which takes place around 7.00am - 7.30am. Again, prisoners may appear asleep. In the morning, prisoners are unlocked from their cells between 7.30am – 7.45am. There are no exact timings made for each individual cell during any of the roll checks. In addition, prisoners can use their cell bell to call for assistance from staff at any time.

23. Staff should check prisoners subject to ACCT at the intervals specified in the ACCT document and record the checks in the ACCT document.

Use of restraints

24. On each occasion a prisoner is escorted outside of the prison to hospital a risk assessment is completed which considers the risk to the public, potential for escape and likelihood of outside assistance. The assessment informs the decision about the number of escort officers and the type of restraint to be used (single cuffs or two metre long escort chain with cuff at either end). It also determines the circumstances and the authority required for the restraints to be removed. The risk assessment is reviewed each day that a prisoner is in hospital and amended where necessary.

Deaths at Manchester

25. The man's death was the second to have occurred at Manchester in 2011, where the recorded cause of death was methadone toxicity. However, the circumstances surrounding the other death are completely different to that of the man's death. There was one recommendation made in that investigation that is not relevant to the man's death.

KEY EVENTS

26. The man was born in August and lived in the Manchester area. He was a heavy smoker who had a history of alcohol and drug dependency, depression, self-harm and psoriasis. The man had served several custodial sentences since 1998, the majority at HMP Manchester.

27. On 11 March 2011, the man was convicted of a serious offence. He was remanded into custody at HMP Manchester until his next court appearance. The man arrived at Manchester at approximately 4.00pm and had an initial interview with Officer A. The officer recorded that the man had been in custody before and staff had previously placed him under the ACCT suicide prevention and self-harm monitoring provisions. However, the man said that he had no thoughts of harming himself or taking his own life. The officer also recorded that the man was a smoker and was happy to share a cell. The man declined the opportunity to make a phone call to inform someone that he was in prison.

28. Officer A completed a Cell Sharing Risk Assessment (CRSA) (the assessment of whether the individual is a risk to other prisoners sharing a cell). He noted on the form that the man was a smoker and that he had been subject to ACCT monitoring during previous custodial sentences but at that time had no thoughts of self-harm or suicide. The officer assessed that the risk to others was low.

29. The Healthcare Assistant (HCA) A then conducted a First Initial Healthscreen. (The healthscreens are conducted to obtain a brief confidential medical and psychiatric history from the prisoner to ensure that he receives the appropriate medical treatment and medication as required). The man told the HCA that he smoked, was an intravenous drug user and drank around 540 units of alcohol a week (The NHS guidance on safe alcohol consumption for a man is 21 to 28 units a week). He also said that he had a history of psoriasis, depression and had attempted suicide ten months before while in the community.

30. The HCA recorded the man's blood pressure as 119/69. (The normal range for blood pressure is 100/70 to 140/90, although the pressure varies throughout the day depending on the individual's activities. A blood pressure reading of greater than 140/90 is classed as high and a reading of 90/60 or below is classed as low.) The HCA referred the man to see the substance misuse specialist nurse and the prison doctor.

31. The HCA also assessed on the CSRA that the risk the man posed to others was low. In addition, the HCA assessed that there were no concerns that the man would harm himself or attempt to take his own life.

32. Nurse A, a member of the substance misuse team, saw the man to conduct an initial substance misuse assessment and completed a urine drug test, the result of which was positive for morphine (opiate medication) and benzodiazepine (for alcohol withdrawal). He told the nurse that before he came into prison he had been using heroin and methadone that he had "bought off the street". The nurse recorded that the man showed mild signs of both drug and alcohol withdrawal.

33. At 7.05pm, the man saw Dr A, prison doctor, who recorded that he had red scaly patches on his upper arms, legs, face and scalp and prescribed cetirizine (for skin allergies), Diprobase Cream (for skin conditions) and Dovonex Cream (for psoriasis). Because of his drug and alcohol dependency, the doctor also prescribed and gave him 20mg of chlorodiazepoxide (for alcohol withdrawal), diazepam (for benzodaizapine withdrawal and insomnia) and 10mls of methadone (opiate dependency substitute).

34. The man was, allocated to a cell on the specialist detoxification wing. He shared a cell with a long-standing friend. There were no concerns raised during the night.

35. The investigator was unable to interview the cellmate as he had been released from prison and did not respond to requests for contact. However, the clinical reviewer obtained information given by the cellmate, which had been passed, via the police, to the pathologist who conducted the post mortem. The cellmate alleged that the man had told him that he had been free from heroin and crack for five months before he was remanded to prison. In order to get a methadone prescription, he had asked the cellmate to provide a urine sample. The cellmate refused but assumed he had got a sample from another prisoner. (These claims have not been substantiated but the clinical reviewer considered them and was of the view that it was unlikely that the man was no longer dependent at that time.)

36. The next morning, the man saw Dr B, a prison substance misuse doctor. He told the doctor that he used either five bags of heroin or 80mls of illicit methadone on a daily basis. He also said that he used crack cocaine and injected speedballs (combination of heroin or morphine with cocaine) into his groin. The man told the doctor that his usually drank nine litres of strong lager a day. He added that he had a history of depression, had attempted suicide ten months before in the community and had been prescribed medication in the past but was not taking any prior to entering custody. The doctor made a referral for the man to see the mental health team.

37. Dr B recommended that the man undergo a drug detoxification programme of supervised methadone, to be given once a day, starting on 20mls, then increasing by 10mls a day up to a maximum of 50mls. The doctor also put the man on an alcohol detoxification programme of supervised daily decreasing amounts of chlorodiazepoxide starting at 30mg three times for the first day, reducing daily to 5mg twice a day after seven days.

38. Dr B explained, at interview, that IDTS nurses should monitor prisoners placed on a detoxification programme twice a day and that no further medication with sedative effects should be prescribed for five days. Dr B said that she was aware of the detoxification treatment that the man received when in the community and the amount of methadone he received was significantly higher than what he received in custody. The clinical review indicates that no attempts were made to obtain his records from his community GP.

39. Later the same day, Nurse A saw the man. She recorded his blood pressure as 127/74 (within normal limits) and that he said he smoked 20 to 39 cigarettes a day.

40. Officer B made an entry in the man's prison computer record that he was the man's personal officer. The officer added in the record that he knew the man from previous custodial sentences. Officer B said at interview that the man had been in custody on the detoxification wing in Manchester on numerous occasions and that he had not caused any problems with the officers or nursing staff.

41. One of the chaplains also saw the man that afternoon as part of the reception process. The chaplain recorded in the prison computer record that the man had told him that he was registered as a Roman Catholic, had been in prison before and had no thoughts of harming himself. The man also said that he was aware of the chaplaincy and other support services that were available to him in prison.

42. During interviews with the discipline and medical staff who dealt with the man in the reception process, the investigator and clinical reviewer asked about the suicide and self-harm procedures and their impressions of the man. Each of them indicated that they were aware that he had previously attempted to take his life, but that he had no thoughts of doing so at that time. They confirmed that they would have placed him on monitoring under the ACCT procedures if they considered that he was at risk.

43. Nurses issued the man's oral medication and this was detailed in his prescription charts. They gave him 30mg of chlordiazepoxide in the morning, afternoon and at night, 20mls of methadone at noon and 10mg of cetirizine at night. Each entry on the prescription chart is signed by the initials of the nurse that dispensed the medication.

44. On 13 March, there were no recorded entries made in the man's clinical record. However, the prescription charts show that the man was issued with 20mg of chlordiazepoxide in the morning, afternoon and at night, 30mls of methadone at noon and 10mg of cetirizine at night.

45. In the afternoon of 14 March, the man saw Nurse B a member of the mental health team, who conducted an initial mental health assessment. At the outset, Nurse B asked if the man was subject to ACCT monitoring and the officers replied yes. After the meeting, when he went to make an entry in the ACCT document, he found this was not the case.

46. Nurse B recorded that the man was agitated, restless and had booked appointments with the prison doctor and the visiting psychiatrist the following day. The man told the nurse that he had tried to throw himself under a train six months previously and that he was having difficulty coping with the highs and lows of his mental state. He said that he had constant thoughts of suicide, but rather than take his own life, it was his wish for someone else to end his life. The man also told the nurse that he had sought help from his community doctor

who had prescribed fluoxetine (an antidepressant) in the past. Nurse B confirmed to the investigator that he would have started the suicide and self-harm monitoring process if he had considered it necessary.

47. Later that afternoon, Nurse C took the man's his blood pressure, which he recorded as 124/83 (within normal limits). The man told the nurse that his skin was getting worse and he replied that he had an appointment with the doctor the next morning.

48. The prescription charts show that the man was issued with 15mg of chlordiazepoxide in the morning, afternoon and at night, 40mls of methadone at noon and 10mg of cetirizine at night.

49. The man saw Dr C, another prison doctor, the next morning as arranged. The doctor recorded that the man was argumentative and confrontational and was unhappy to spend a lot of his time applying the prescribed creams for his skin condition. At interview, Dr C said the man wanted to be referred to the hospital for specialist treatment and was not happy just to be prescribed skin creams.

50. HCA B saw the man later in the morning to take his blood pressure, which he recorded as 148/88 (slightly higher than the normal range). There were no other concerns recorded at that time.

51. In the afternoon, a visiting psychiatrist saw the man as a result of the referral made by Nurse B. The man told the visiting psychiatrist that he had suffered from depression and low moods for a number of years as well as multiple-substance and alcohol misuse. He also gave details of his suicide attempts from the age of 15, including the suicidal intention and event that had led to his most recent conviction and imprisonment a few days earlier. The doctor recorded that the man was a thinly built, poorly nourished young man who harboured thoughts of self-harm and suicide and was anxious and tearful throughout the consultation.

52. The visiting psychiatrist's assessment was that the man had no psychotic symptoms but did experience panic attacks. The doctor noted that it was difficult to predict the risk that the man posed to himself as he was prone to impulsive behaviour. However, given his willingness to co-operate with treatment, the doctor's assessment was that the short-term risk was low. The visiting psychiatrist recorded that a nurse from the mental health team would be allocated to see the man on the wing and he would review the man in three to four weeks time. The visiting psychiatrist prescribed 15mg mirtazapine (antidepressant) but did not record it in the man's medical record.

53. At interview, the visiting psychiatrist said he was unsure why he had not documented the prescribed medication on the man's record as this would have been his normal practice. He examined the man before he had prescribed mirtazapine and had no concerns about the treatment. The visiting psychiatrist also explained that he was aware that the man was undergoing a drug detoxification programme but it was his professional opinion that the low dosage of mirtazapine would not have had any effect on methadone or the

other medication the man had been prescribed. In respect of self-harm, the visiting psychiatrist clarified that the man always had thoughts of suicide. However, he did not consider him to be at risk of suicide as he was thinking about the future.

54. The prescription charts again show that the man was issued with 10mg of chlordiazepoxide in the morning and afternoon with 15mg issued at night. He was also issued 50mls of methadone at noon, 15 mg mirtazapine in the evening and 10mg of cetirzine at night.

55. There were no recorded concerns regarding the man during either the evening or morning roll checks on 15 and 16 March.

56. At approximately 7.35am, Officer C was unlocking the cells on I wing when the man's cellmate told him that there was something wrong with the man. He looked through the cell hatch and saw both men in bed, so assumed they were all right. He continued unlocking other cells on the landing but was called back by the man's cellmate who asked him to check on the man, as he appeared to be unwell. Officer C then went into the cell and checked the man. He was not breathing and appeared to be dead. The officer called down to Officer D, who was on a different landing and had a radio and telephone.

57. Officer D used his radio to make a 'Priority 1' call (emergency call for healthcare staff to attend when there is an immediate threat to life) and immediately went upstairs to the cell. He said, at interview, that when he entered the cell he found the man on the top bunk in a sitting position with his head up against the frame of the bed. The man was unconscious and unresponsive. Both officers checked for a pulse.

58. When the emergency call was made, healthcare staff were on the wings giving treatments. Nurses D and Nurse E responded immediately, joined moments later by Nurses F and Nurse G. Officer C estimated that it took the nurses around three minutes to arrive. Nurse E felt for a pulse and found the man cold to the touch. The nurses, with the help of Officer D, moved the man on his mattress from the top bunk to the floor. They checked his airway, breathing and circulation and then started cardio pulmonary resuscitation (CPR), using an airway bag and an automated external defibrillator (AED). (A defibrillator monitors the heart rhythm and administers electrical shocks to the heart to restore the normal rhythm when necessary.) As there was no cardiac rhythm, no shock was given and the staff continued with CPR until the paramedics arrived.

59. The clinical review shows that the call for assistance was passed to the ambulance crew at 7.40am. Paramedics arrived at 7.47am and took over the man's care. Following further treatment, they took him to North Manchester General Hospital (NMGH) at 8.17am. Two prison officers accompanied the man but no restraints were used. At 8.42am, doctors at the NMGH pronounced that the man had died and the news was conveyed to the prison at 9.10.

60. A hot debrief was held for staff involved in the emergency incident that morning, chaired by Governor A, with the services of the care team available for staff. (A hot debrief is a meeting for staff to discuss issues and any lessons learned following serious events.) The healthcare staff were due to attend a training course, but prison managers ensured that they were able to participate in the debrief before doing so. Staff and the chaplaincy were available to offer support to the man's cellmate and any other prisoners affected by the man's death.

61. The man had named his partner as his next of kin. At around 10.00am that morning, Prison family liaison officer, Officer D and the chaplain, set off to visit his partner to break the news of the man's death. They went to her address and, after two visits over a period of time and some persistence, they were able to talk to her. They then obtained contact details for the man's parents and visited each of them, in turn, that morning. The actions taken during that day are fully detailed in the transcript of the chaplain's interview. He explained that although the usual risk assessments had not been completed for visiting the additional addresses, he felt it important to tell the family face to face and he believed that his status and clerical clothing reduced the risk of harm.

62. During the visit to the man's mother, the chaplain and Officer E offered support and financial assistance towards funeral expenses, in accordance with Prison Service Order (PSO) 2710 'Follow up to deaths in custody'. In the days that followed, Officer D and the chaplain maintained contact with the man's family and, at their request, the chaplain conducted the man's funeral service.

ISSUES

Clinical care and record keeping

63. The clinical reviewer has carefully considered the overall clinical care given to the man. As part of this, the doctor, a consultant psychiatrist who is a specialist in the diagnosis and treatment of mental disorder and the management of substance misuse, assisted her. The clinical reviewer identified several aspects of his care which were good:

    "The man received appropriate and timely care from health care staff. He received a Medical appointment within a matter of days for assessment and treatment of his skin condition. This is better than could be expected for a non-urgent problem within a community general practice setting.

    "The man was seen and assessed in an appropriate and timely manner by the nurse from the Mental Health Team and a referral was made to the psychiatrist who saw the man the next day. It is unlikely that in the community, he would have been seen so quickly.

    "The treatment for drug and alcohol misuse in prison differs from the treatment in the community. It is a much more cautious approach in custody. In the community the man would have probably received a higher dose of methadone at the start of treatment and would have seen a nurse after four days and not been reviewed by a doctor for a week."

64. In spite of the clinical reviewer's general conclusion that the man was, appropriately assessed and given timely care, the investigation and the clinical review has identified a number of failings in record keeping and adherence to clinical guidelines. The clinical reviewer highlighted the following:

    "As part of the monitoring process Dr B requested that the man's blood pressure be recorded twice daily. As far as the records show, this did not happen. His blood pressure was only recorded on three separate occasions. It is unclear why the man's blood pressure was not recorded as requested.

    "The psychiatrist prescribed medication for the man but this was not documented"

65. Given that good record keeping is essential to support the proper administration of treatment and prescription of medication, this lack of full and accurate documentation is a clear weakness. We, therefore, endorse the following recommendation made in the clinical review:

    The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

66. The clinical reviewer additionally found:

> "There was no attempt to request the man's GP records which is advisable for some one who has attempted suicide or self-harm in the previous twelve months.

67. The clinical reviewer's statement is set in the context of best practice in respect of suicide and self-harm and she has made a recommendation in this regard. However, there is also guidance about the necessity of such records in treating substance misuse. Department of Health guidance "Clinical Management of Drug Dependence in the Adult Prison Setting" highlights the following in respect of methadone toxicity:

> "Methadone deaths tend to occur on the second or third day of treatment as a result of cumulative toxicity. These deaths occur as a consequence of inadequate assessment, failure to confirm previous opiate use by clinical testing for drugs, failure to confirm dependence (such as treatment in the absence of withdrawal symptoms) and a lack of monitoring."

Although the man's death from methadone toxicity did not occur within the timeframe indicated above, the principles of assessment, confirmation and monitoring apply to his circumstances.

68. In addition, PSO 3550, Clinical Services for Substance Misusers sets out a number of mandatory tasks to be carried out in managing prisoners subject to the detoxification process. This includes, "corroboration of information from GP, local substance misuse service or dispensing pharmacist.

69. Medication was therefore issued to the man and his detoxification managed without any confirmation from his community GP or other prescribing service as the relevant records were neither requested nor obtained. In view of this, we make the following recommendation:

The Head of Healthcare should ensure that during the reception process, staff request consent to release community medical records from prisoners who have attempted suicide or exhibited self-harming behaviours in the previous twelve months or have been placed on a detoxification. Staff should then request the records, within one day and follow up any delays in receipt.

Integrated Drug Treatment System (IDTS)

70. During the reception process, the man reported that he was a substance misuser. Subsequent tests showed traces of morphine and benzodiazepines and the nurse said she observed mild withdrawal symptoms. As mentioned above, prison staff did not obtain community medical records. Evidence from the police to the pathologist indicates that the man told a fellow prisoner that he had not taken illicit drugs for several months. It was said that he had also asked the other prisoner to give him urine to enable him to be prescribed methadone. The investigation has not been able substantiate the information

from the prisoner, but the clinical review concludes that it was unlikely that the man was no longer dependent on heroin.

71. The doctor assisting the clinical reviewer has carefully considered the man's medical history, his clinical records, detoxification programme and toxicological results and makes the following comments:

> "The man had taken or been administered methadone which he was prescribed whilst in prison. The concentration in his post mortem blood specimen is within the range of levels that have been reported in fatalities in non-tolerant individuals. However, a regular methadone user could have potentially survived the level found. The results indicate that the man could have consumed additional methadone besides his prescribed dosages. The man had also taken or been administered chlordiazepoxide and mirtazapine which he was also prescribed. The results are consistent with therapeutic usage.
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> "Toxicological testing revealed the presence of methadone. The level detected fell within the range associated with fatality but this is a very wide range since considerable tolerance can be developed to methadone. Tolerance can diminish after periods of abstinence and I note that the man had alleged that he had been free from heroin and cocaine for several months prior to his admission to prison. If he had really been opiate free for several months he may have lost some tolerance to the effects opiate based compounds. In addition the findings do not allow the exclusion of the possibility that the man had actually consumed more methadone than was prescribed.
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> "Chlordiazepoxide was also detected. The level detected was not within the toxic range but chlordiazepoxide has sedative properties and it could have interacted with the methadone.
>
> "Mirtazapine was detected. Mirtazapine does have sedative properties and so could have enhanced the depressant effect of the methadone.

72. When considering the local detoxification policies at Manchester, the doctor assisting the clinical reviewer's opinion was as follows:

> "Whilst then I would not say that the methadone induction scheme was of itself patently excessively fast, local guidelines and the specific treatment plan do not appear to have been followed in this case.
>
> "The treatment plan indicates that the man will have clinical observations completed twice a day for the next 5 days by IDTS nurses. These appear to have been once on 12.03.11, once on 14.03.11 and once on 15.03.11.
>
> "This difficult and tragic case then seems to reinforce the need for strict adherence to the cautious induction protocol adopted by the service most especially where there is a need for combined alcohol and drug detoxification."

73. In conclusion, the doctor has commented on the man's cause of death as follows:

> "The man also had additional risk factors in that he had a history of extremely heavy alcohol use and was undergoing detoxification for alcohol dependence and had past history of epilepsy. Mirtazapine can cause additional sedation.
>
> "Despite this, it still does seem surprising that a man such as the man who has previously been prescribed methadone at a dose of 80mgs should have died suddenly when prescribed only 50mgs titrated up over the period of a few days. Any suggestion that he took extra illicit methadone is however speculative. He had a significant past history of self-harm and current thoughts of suicide and thus there must remain a possibility that he took additional methadone in a deliberate attempt to kill himself. If however he was now taking and tolerating 50mgs of prescribed methadone then he would have needed to consume a considerable amount of illicit methadone (perhaps an additional 100mgs or 20 x 5mg methadone tablets. at absolute minimum) to push him into the toxic range. This seems to me to be an unlikely scenario unless new information comes to hand.
>
> "Overall in my opinion the principle reason for the man's death was that he had a level of methadone in his blood which caused toxic symptoms. This would have caused respiratory depression and may have caused him to aspirate stomach content into his lungs, although judging by the appearances this aspiration happened only very shortly before he died. On the balance of probability the toxic effects of the methadone were enhanced by the sedative effects of mirtazapine and chlordiazepoxide. Whether or not he had actually taken illicit methadone in addition cannot be ascertained although it is a reasonable possibility.
>
> The man's death does seem likely in my view to have been related to his prescribed medication."

74. We are satisfied that, given the man's history of drug and alcohol dependence, that the levels of prescribed detoxification medication were consistent with his detoxification needs. However, it is the doctor's view that the prescribed mirtazapine enhanced the toxic effects of the methadone. In addition, Dr B, at interview, explained that it was her expectation that no other sedative medication should be prescribed for the first five days of a detoxification programme.

75. The visiting psychiatrist prescribed mirtazapine, having been aware that the man was on a drug detoxification programme. However, he omitted to document the prescription on the medical record. He could not account for why he did not record it on that occasion but said that he was satisfied that the combination of drugs would be all right and that the man could cope with them physically. As mentioned above, the doctor concludes that it is likely that the

prescribed medication had a bearing on the man's death. A recommendation has already been made about record keeping in this report. We cannot dispute the clinical judgement in prescribing sedatives in this case but it is essential that doctors are aware of the risks. Accordingly, we make the following recommendation:

The Head of Healthcare should ensure that prison and visiting clinicians are aware of the clinical risks associated with prescribing sedatives in combination with detoxification medication and that a considered judgement is made regarding prescribing in each case.

76. We are concerned that in spite of a clear policy in place at Manchester for the treatment and monitoring of prisoners who are placed on drug and alcohol detoxification programmes, this policy was not adhered to in the man's case and expected practice in the clinical management of drug dependence set out by the Department of Health was not followed. From the evidence collected during the investigation, it is apparent that the man's death arose from the combination of drugs prescribed and that staff did not follow clinical guidelines. The following recommendations are therefore added to those above:

    The Head of Healthcare should ensure that all IDTS staff fully comply with the local IDTS policy. In particular, staff should conduct clinical observations in accordance with the specified frequency for each patient.

Management of the risk of suicide or self-harm

77. During the reception process, staff asked the man about self-harm. He told the officer who completed the CSRA, the healthcare assistant, IDTS reception nurse and IDTS GP that he had no thoughts of suicide or self-harm at that time but disclosed that he had attempted suicide within the previous year.

78. A mental health nurse from the MHIT held a review three days later, on 14 March. The man told him that he did not want to live anymore but he didn't want to kill myself, he wanted someone else to do it for him. He added that he always had fleeting thoughts of self-harm but had no active thoughts of actually harming himself. It is noteworthy that at the beginning of the interview, the mental health nurse had asked if the man was subject to ACCT monitoring and the accompanying officers said yes. He subsequently found out that this was not the case. Nevertheless, he considered whether he should implement such monitoring and decided it was not necessary.

79. A visiting psychiatrist assessed the man on 15 March, the day before he died. During the consultation, he disclosed that he always felt depressed and had constant thoughts of self-harm. He described various instances when he had attempted suicide.

80. PSO 2700, "Suicide Prevention and Self-harm Management", states, "Remand and the early period of custody is a time of high risk of suicide and self-harm for the majority of prisoners. It also lists a number of groups/categories of

prisoners who might be at a higher risk of self-harm. They include prisoners who have been accused of violent offences, particularly against a family member; those with a history of self-harm or attempted suicide; mental disorder; dependency on drugs/alcohol; or on remand; have been in care; and potential category A prisoners. The man fell into most of these categories. The PSO also states, “There is a significant relationship between drug and/or alcohol withdrawal and suicide”.

81. In addition, the Department of Health guidance mentioned above says, “Opiate-dependent prisoners remain at a raised risk of suicide and self-injury throughout the first 28 days and, in particular, during the first 7 days of custody”. The recommended management for this risk is, “joint working between clinical teams and residential staff”.

82. Taking account of the information given to them, the various staff members involved in the reception process had no concerns and assessed the man as at low risk of self-harm. They confirmed to the investigator that if they had such concerns about a prisoner they would implement the ACCT suicide and self-harm monitoring process. Those judgements were made with the full knowledge of the procedures and having observed and questioned the man.

83. Without wishing to second-guess their decisions, we have considered whether the reception staff who were aware of his history should have arranged for monitoring under the suicide prevention and self-harm provisions. The man fell into the category of a number of the risk factors known to increase risk of suicide and self-harm. However, on balance, given they actively considered the man’s risk of self-harm on the basis of his presentation to them and there was no indication of immediate intentions of self-harm, we are satisfied that their decision not to implement the suicide prevention measures, at that point, was reasonable.

84. The man subsequently told the mental health nurse and the psychiatrist that he had constant thoughts of self-harm. There was plenty of evidence of previous attempts of self-harm and we believe that this, together with his active thoughts of suicide, should have led to the implementation of the ACCT process. This would have provided an opportunity for a full, explicit and considered assessment of whether the man required additional support to prevent self-harm.

85. There is no evidence that the omission of such action had a bearing on the man’s death, albeit that the clinical reviewer says:

> “…a significant past history of self-harm and current thoughts of suicide and thus there must remain a possibility that he took additional methadone in a deliberate attempt to kill himself…an unlikely scenario unless new information comes to hand.”

However, in relation to the prison’s general duty of care, it is imperative that staff comply with the provisions of the suicide and self-harm strategy to prevent

future deaths arising from self-harm. We therefore make the following recommendation:

The Governor should ensure that staff start ACCT suicide and self-harm prevention measures when prisoners are at high risk and/or state active or current thoughts of self-harm.

Emergency response and hot debrief

86. When the man's cellmate alerted staff to the problem with the man, the officer unlocking the cells asked another officer to call an emergency code. This enabled healthcare staff, who were already on the wing, to attend within around three minutes.

87. The staff response to the man's need for assistance was swift and professional. Staff commenced CPR and the AED was attached, however in the absence of any cardiac rhythm, there was no instruction to shock him during the CPR. Paramedics took over the man's care and subsequently transferred him to hospital but he was pronounced dead by a hospital doctor.

88. Although the first officer did not have a radio or access to a telephone, we are satisfied that medical assistance was summoned and arrived with no unreasonable delay. We recognise the actions and professionalism of all the staff who responded to the emergency situation endeavouring to give the man the best possible chance of a positive outcome.

89. A hot debrief was held very shortly after the emergency. Healthcare staff were due to attend an important training event that morning. However, prison managers prioritised the debrief meeting so that staff could participate before their training. We are pleased that the managers placed appropriate importance on the benefits of debriefing staff.

Restraints and security

90. Unfortunately, there have been too many reports in which we have criticised the level of restraints used when prisoners are taken to outside hospital even in circumstances such as this where the prisoner is unconscious and poses no threat. In this instance, restraints were not used. It is pleasing to recognise the decision taken by Manchester. This ensured that the man was treated with dignity and respect on his transfer to hospital on the day of his death.

Family Liaison

91. Within an hour of notification of the man's death, the prison's family liaison officer and a chaplain went to visit the family to break the news. They first went to his nominated next of kin and, after more than one trip and a great deal of tenacity, were able to speak to his partner. They sought and obtained the contact details of his parents and visited both their homes in spite of a number of barriers in their attempts to make contact.

92. We recognise the professional and sensitive approach of the staff who acted as family liaison officers and the lengths they went to in order to make contact with all the key members of his family. This approach ensured his family had support available that continued in the days that followed his death and included the offer of financial assistance towards funeral expenses in accordance with PSO 2710.

CONCLUSION

93. It is clear from this investigation that the man had a significant history of drug and alcohol dependence, self-harm and depression. On entering custody, his needs were appropriately assessed and he was placed on a detoxification programme. However, the IDTS policy was not followed as staff did not obtain his medical records from the community; the correct number of clinical observations were not undertaken; and he was prescribed antidepressant medication that enhanced the sedative effects of the detoxification medication and contributed to his death.

94. The clinical reviewer concludes that the man's assessment and placement on the program was timely. We agree. However, the subsequent clinical management of his detoxification and his potential to self-harm was deficient.

95. When the man was found unconscious, staff responded swiftly and with professionalism. Resuscitation attempts by staff and paramedics were unsuccessful and the man's death was pronounced at the hospital. We recognise the professionalism of the staff who responded to the emergency incident and the professional and sensitive approach in family liaison. We are satisfied that Manchester appropriately followed the guidance given in PSO 2710, 'Follow up to death in custody'.

96. We make five recommendations. In particular, we are concerned that staff at Manchester did not adhere to the requirements of the IDTS policy and the guidelines on record keeping. In addition, no formal action was taken to assess the man under the provisions of the suicide and self-harm prevention measures when he expressed constant thoughts of harming himself.

The man's family, having had the opportunity of reading the report at the consultation stage of the process, wish to make the following comments:

The family expresses concern as to why the man's cellmate was not interviewed earlier given that the man died in March and the cellmate was not released until the September.

It is the family's opinion that the prison did not maintain positive liaison with them and that communication was poor.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff accurately and contemporaneously record actions, in accordance with the required standards of the General Medical Council and the Nursing and Midwifery Council.

   Accepted

   Guidance will be sent to all clinician from relevant regulatory bodies. A records audit will be conducted to ensure that they are accurate and contemporaneous.

2. The Head of Healthcare should ensure that during the reception process, staff request consent to release community medical records from prisoners who have attempted suicide or exhibited self-harming behaviours in the previous twelve months or have been placed on a detoxification. Staff should then request the records, within one day and follow up any delays in receipt.

   Partially accepted

   Staff will contact GP's in the community of all patients with relevant clinical history. The prison will aim to do this within one working day.

   For any patient who has accessed services within GMW, there is read only access via ICIS within the prison for past history. If they are still in substance misuse services out of area, GMW will contact them for clinical data.

3. The Head of Healthcare should ensure that prison and visiting clinicians are aware of the clinical risks associated with prescribing sedatives in combination with detoxification medication and that a considered judgement is made regarding prescribing in each case.

   Not accepted

   All doctors are expected to adhere to the standards of practise set out in GMC guidance, good medical practise. This states that in providing care a doctor must:

   1.Prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patients health and are satisfied that the drugs or treatment serves the patients need

   2. Provides effective treatments based on the best available evidence.

   Also system one has an automatic warning system for medication interactions, such as those which may result in increased sedation, which is activated when prescribed.

4. The Head of Healthcare should ensure that all IDTS staff fully comply with the local IDTS policy. In particular, staff should conduct clinical observations in accordance with the specified frequency for each patient.

   Accepted

   Monthly audits will be completed to check for compliance. If there is any variance from policy then the reasons will be recorded.

5. The Governor should ensure that staff start ACCT suicide and self-harm prevention measures when prisoners are at high risk and/or state active or current thoughts of self-harm.

   Accepted

   During the ongoing Safer Custody Refresher training staff are being reminded of the triggers and risk factors of suicide and self harm. If a prisoner is at high risk of suicide or self harm, and / or states active or current thoughts of self harm or suicide he will be placed on the ACCT processes.