PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at HMP Elmley in November 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2012

This is the report of an investigation into the death of a man, a prisoner at HMP Elmley, in November 2011. He had been on remand at Elmley since 31 October. He was 47 years old, when he died from ischaemic heart disease. I offer condolences to his family and everyone touched by his death.

An investigator was appointed. The local Primary Care Trust (PCT) commissioned a review of the man's medical care, which was completed by a clinical reviewer and I am grateful for his report. The Governor of Elmley and his staff co-operated fully with the investigation.

The man had both physical and mental health problems prior to custody and these were recorded during initial reception health screens, at both HMP Belmarsh, where he was first remanded and Elmley. During his relatively short time in custody he had regular contact with healthcare professionals, the focus of which was his medication. However, at no time did he refer to a heart condition or related complaints. Shortly before 9.00am, on a morning in November, he was discovered by an officer sitting by his bed, on the floor of his cell. He was unresponsive and it was apparent to healthcare staff who attended that he had died sometime ago. Therefore, resuscitation was not attempted and the emergency services were not called. He was pronounced dead by the prison doctor shortly after he was found.

The investigation concludes that the man's death could not have been reasonably foreseen. However, while it was unlikely to have affected the outcome, the investigation also found that there was confusion among some staff about the actions to be taken during roll checks. It was also of particular concern that a very inexperienced member of staff saw him sitting on the cell floor at 8.00pm and saw him still sitting in exactly the same position over nine hours later, without this triggering alarm or referral to other staff. A more experienced member of staff subsequently unlocked his cell but, again, did not notice him on the floor until he returned to relock the cell. Recommendations are therefore made for improved roll checks and for better training and support for inexperienced staff.

More positively, I am pleased to note that mental health nurses are routinely used to conduct reception health screens at Elmley. This enables them to identify quickly and appropriately refer prisoners who have special mental health needs. I regard this as good practice and hope that the National Offender Management Service encourages this in other prisons.

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 **July 2012**

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SUMMARY

1. The man was 47 years old and remanded into custody to HMP Belmarsh on 19 October 2011. During the initial health screen, he highlighted past and current physical and mental health problems. In the community, his doctor had prescribed various medications some were relatively high doses. He was able to provide a prescription for his medication and they were re-prescribed at the prison. One of them, nitrazepam, was subsequently stopped as he was already on similar medication that served the same purpose.

2. On 31 October, after appearing at Crown Court, the man was taken to HMP Elmley. Following a health screen, there was continuing concern about the level of medications. A prison doctor assessed him and advised a gradual detoxification. He was not happy about this and, throughout his time at Elmley, continually stated that his medication was insufficient.

3. The doctor also had concerns about the man's weight and referred him to a weight clinic. On 8 November, he attended an appointment with the same doctor, where he again spoke about his medication. She explained to him that she was not in favour of increasing them but would refer him to a pain clinic to seek advice on his management. During the consultation, he appeared the same as usual and raised no other health concerns.

4. On the evening of 8 November, all prisoners on the man's wing were locked in their cells, after collecting their evening meals, at around 5.30pm. The night officer saw him at 8.00pm, while she was conducting a count of all prisoners. At the time, he was sitting on the floor at the edge of his bed. At 5.30am the night officer conducted a further count of prisoners and saw him by his bed in the same position. She assumed he had fallen asleep. She did not consider this unusual and therefore did not mention it to any other staff.

5. The officer who unlocked the cells in the morning did not notice the man. While locking cells after breakfast, at around 8.50am, the same officer saw him sitting on the floor by his bed, with his head resting on his arm. There was no response when the officer called out and placed his hand on his shoulder, so he called to his colleague for assistance. It was apparent to both officers that he had died. Nursing staff concluded that resuscitation attempts would be futile and asked the prison doctor to certify the death. The doctor said that it was clear that he had been dead for sometime. A subsequent post mortem attributed his death to ischaemic heart disease.

6. The investigation and review of the man's medical care have concluded that while his medication was managed appropriately and his death was unforeseen, there is a need to improve the recording of medical information. Additionally, the requirements for conducting roll checks are unclear.

7. The investigation found that the man was seen sitting in the same position on his cell floor over a period of nine hours, and we are concerned that the night OSG regardless of training did not investigate further to check on his well being. Another officer unlocked his cell but, again, did not notice him on the

floor until he relocked the cell. The investigation found that staff were not given enough training before transferring to the role of a night officer and that procedures for unlocking prisoners required review. Three recommendations have been made concerning the issues highlighted in this report. We are pleased to note the routine use of mental health nurses during the reception health screen, which we regard as good practice.

THE INVESTIGATION PROCESS

8. An investigator opened the investigation on 15 November, when he visited HMP Elmley. Notices were issued informing staff and prisoners of the investigation. They asked anyone who had information, pertinent to the investigation, to contact him but no responses were received.

9. The local PCT conducted a review of the medical care provided to the man while in custody. A clinical reviewer completed the review on their behalf.

10. The investigator wrote to the Coroner to inform him of the investigation and to request a copy of the post mortem report. This gave the cause of death as ischaemic heart disease.

11. One of our family liaison officers wrote to the man's family on 1 December and explained the purpose of the investigation. She was then contacted by his partner, who spoke with her on 7 December. The family liaison officer and the investigator visited the family on 19 December to discuss the investigation and the family's concerns.

12. The family raised questions about the man's medication and why this had been reduced. They also had concerns about the way in which they were notified of his death. Both issues have been addressed in the report. The draft report will be made available to the family if they wish to see it.

13. The investigator visited Elmley on 20/21 December and conducted interviews with nine staff. On conclusion of the investigation, he reported his initial findings to the Governor of Elmley and followed this up in writing.

14. Both the Prison Service and the man's next of kin provided a response to the draft report, and changes have been made to this final report to reflect these.

HMP ELMLEY

15. HMP Elmley is the largest of three prisons located on the Isle of Sheppey, known as the Sheppey Cluster. It opened in 1992 and is a local prison for the Kent area, with a capacity for 985 prisoners. There are five residential house blocks, including provision for vulnerable prisoners (this enables such prisoners to live away from other prisoners for their own protection), a healthcare unit and a segregation unit.

16. Eastern and Coastal PCT commission healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit, treating patients with both physical and mental health needs.

17. Every prisoner has an initial health screen, on reception, to determine if they have any immediate physical needs, such as injuries or withdrawal from alcohol or drugs. At Elmley, the reception nurse has mental health training and this enables an assessment of any mental health needs within the first few hours of a prisoner's arrival. Issues relating to the risk of the prisoners harming themselves are also recorded.

18. HM Inspectorate of Prisons conducted the most recent inspection of Elmley in April 2009. The report said of health services at the prison:

> "Health services were much improved since our last inspection. Primary care included two GP [general practitioner] clinics daily, health promotion, and access to a variety of specialist clinics. Reception procedures and the health screening of new arrivals were good, but secondary health screening was often carried out without the prisoner's complete clinical record. Primary mental health provision was more limited, but prisoners with an enduring condition received a reasonable service. Pharmacy services had improved. Staffing levels and skill mix were good, despite a reliance on agency staff. Inpatient arrangements were reasonable, and their time out of cell was satisfactory, but patients needed more activity."

19. All prisons in England and Wales have an Independent Monitoring Board (IMB). IMB members are unpaid volunteers appointed by the Secretary of State for Justice. The IMB monitors day-to-day life in the prison to help ensure proper standards of care and decency are maintained. The Board's report for the year from 2009 to 2010 does not raise any issues that are relevant to the circumstances of the man's death.

20. Since the Prisons and Probation Ombudsman took over responsibility for investigating deaths in prison custody in 2004, there have been nine deaths attributed to natural causes, up to and including that of the man. None of the issues arising in any of those cases is directly relevant to the circumstances surrounding his death.

KEY EVENTS

21. The man appeared at Magistrates' Court on 19 October, on charges of violent offences and was remanded into custody. He was 47 years old.

22. Following his court appearance, he was taken to HMP Belmarsh. On arrival, staff carried out an initial medical assessment, including a review by a doctor. All prisoners have an initial health screen completed when they arrive into custody. The purpose of this is to obtain a brief medical history, and record existing medical conditions and current medication.

23. During the medical screen, staff recorded that the man's physical problems included muscle contracture (tightening of muscles and tendons) on both hands. He also said that he had been admitted to a psychiatric hospital, for four weeks during February 2011. He was receiving medication for mental health problems and said that he had been diagnosed with a bi-polar personality disorder. A doctor also recorded that he was underweight and would require 'close follow up by healthcare staff over the coming days'. He had been receiving various medications in the community. All were represcribed, as he had brought a prescription into custody with him, which showed the levels and types of medicines he was taking. These included:

    - Diazepam 10mg – twice a day (mainly used to treat anxiety or insomnia, as well as acute alcohol withdrawal)
    - Ensure plus liquid – three times daily (a nutritional supplement, used to aid weight gain)
    - Aripiprazole 10mg – two daily (used in treatment of schizophrenia and bipolar disorder)
    - Citalopram 40mg – once daily (an anti-depressant)
    - Nitrazepam 5mg – once daily (Mainly used to treat same symptoms as Diazepam)
    - Tramadol 50mg – three times daily (an opiate based pain killer)
    - Fentanyl 100 microgram patches – one daily (used in the treatment of chronic pain)
    - Lansoprazole 30mg – once daily (used to treat gastric acid and stomach ulcers)

24. In addition to recording medical history and medication, the man was asked about any thoughts or previous attempts of self-harm or suicide. He told the nurse carrying out the health screen that he had taken an overdose of medication a month earlier, but said that he had no thoughts of harming himself and had promised his partner that he would not.

25. A secondary health screen was carried out with the man the following day, to obtain further medical history. The nurse who carried out the screening recorded that an assessment was completed for his suitability to have medication in his possession (ie retained in his cell). All prisoners who are receiving medication have such an assessment to record any identified risks. He was assessed as being suitable to have some medications in his

possession, but those containing opiates or benzodiazepines and that could be misused, would be prescribed daily.

26. The secondary screen recorded the man's weight as 9st and his pulse rate as 79 beats per minute (bpm). A normal pulse rate for an adult is considered to be between 60-100bpm. The nurse noted that during the assessment he was cheerful, co-operative, and communicative. The clinical observations did not indicate a need for further tests in relation to heart or circulatory problems and he reported no previous problems or health concerns in these areas.

27. Over the next week, the man took part in a full induction, which involved being told about the prison regime and how to access various services. He was also spoken to by the prison disability liaison officer. He recorded that the man had a progressive condition, affecting his mobility. It was agreed that he would collect meals from the 'bottom' gate, which was more accessible, and have a lower bunk (bed) in his cell; a referral for remedial gym was also made to assist his condition.

28. On 24 October, the nitrazepam that the man had been prescribed in the community and re-prescribed on arrival at Belmarsh was stopped by the prison doctor. He recorded that the medication was not required as the man was already in receipt of diazepam.

29. His court case was transferred to Crown Court and he appeared there on 31 October. To facilitate future court appearances, he was taken to HMP Elmley, after appearing in court.

30. A mental health nurse conducted a health screen with the man on his arrival at Elmley. She recorded that when spoken to he was calm, relaxed and displayed no overt psychotic symptoms. The investigator was told that Elmley uses nurses trained in mental health to conduct the reception health screens, as it enables prisoners who may have mental health needs to be identified on arrival into custody.

31. The man shared the same information with the nurse as he had on his reception at Belmarsh. However, he also said that he suffered from plantar fascitis in his left foot. (Plantar fascitis is the inflammation of tissue on the sole of the foot.) This had not been recorded at Belmarsh. She referred him to the doctor as well as the drug treatment and the mental health teams.

32. The investigator asked the nurse the reasons for the referrals she had made. She said that when interviewed, he had mentioned previous use of illicit drugs and, therefore, she made the referral to the Integrated Drug Treatment Service (IDTS). IDTS started in prisons in 2006 and aims to improve drug treatment services while in custody, offering an equivalent level to that in the community.

33. The nurse said that it would be usual practice to refer someone with his previous mental health history to the mental health team. She said that when she spoke to him, he was calm and relaxed but did stress the fact that he had

been diagnosed with a mental health condition. He also emphasized that he needed his medication.

34. The investigator asked the nurse whether the amount of medication the man had been prescribed was unusual. She replied that it was common for prisoners to arrive in custody with large amounts of prescribed medication. Given the conditions that he had mentioned during the screening, the nurse had no concerns about his medication.

35. The day after arriving at Elmley, the man was assessed by a prison general practitioner (GP). The doctor told the investigator that the consultation with him was 'very difficult'. She said that he asked for a lot of medication that he had been prescribed, but she wanted to know more about his history, so had asked him for consent to contact his community GP.

36. When asked to explain why she had found it difficult, she said that he was asking about diazepam, nitrazepam and increasing his fentanyl. She said that although the doses had been recorded at Belmarsh, he believed that he should have been on a higher dose. She explained that she was unhappy to re-prescribe the nitrazepam, which had already been stopped at Belmarsh, as she considered it was too risky. She explained to him that because he was underweight and had been on a high dose of various medicines for a long time, she would probably be looking to start him on a detoxification programme.

37. During her consultation with the man, she found no psychotic symptoms. He was only willing to talk about his medication and, when asked about his other physical problems, would not discuss them, or agree to an examination. She recalled that he was moving around well when she assessed him and was not using a walking stick as an aid. Following the consultation, the doctor made referrals to the mental health in-reach team (MHIRT), and the weight clinic. The medical record does not show that his weight was recorded, despite it being a concern for her. When interviewed, she said that he was insistent that she could not physically examine him during her assessment. It is therefore possible that this was the reason why there was no record of his weight.

38. A member of the MHIRT carried out an assessment with the man the same day. She said that she spoke to him about his contact with mental health services in the community. She knew that he had a history of mental health problems and her aim was to find out what treatment he had been receiving, so that this could be continued while in custody. To enable her to do this, she asked him for his consent to obtain his previous history, from his community mental health team.

39. The records indicate that mental health worker made this request the same day, but although the information was promised, she had to request it on a number of occasions. She said that it was not until 7 November that she finally received confirmation that he had been receiving treatment from the community mental health team. This meant that he would automatically come under the secondary care of the MHIRT.

40. An entry in the man's medical notes, on 2 November, indicates that he had failed to attend the healthcare centre for a blood test. However, there is no earlier entry regarding the reason for the test. During the investigation, all medical staff interviewed were asked for their views on this and whether they could provide a reason why the test had been requested. No one was able to provide an explanation for the test, or who had requested it.

41. There is little information recorded about the man's interactions on the residential wing but staff said that he presented no problems. He did have further contact with nursing staff, when he complained that he felt his medication was not strong enough and the liquid diazepam upset his stomach. An appointment was made for him to be seen by the prison GP on 8 November.

42. When the GP assessed him on the afternoon of 8 November, he told her the fentanyl was not working for him and asked to be given tramadol, as he felt it 'worked for his head'. She explained to him that his existing dose was high and she was reluctant to add further opiate-based medication.

43. The GP said that during the consultation the man appeared to be fine and expressed no other health concerns, other than about his medication. He asked about being located in a single cell and told her that he was finding it difficult to cope with his medical conditions sharing with another prisoner. She completed an F35 form, requesting that he be located in a single cell for medical reasons, with a review in 3 months. An F35 form is a medical request, normally completed by a GP. It indicates that a prisoner requires something for medical reasons. This could be a particular cell location, diet, or medical equipment in his cell. Such requests must be dealt with by prison staff.

44. The GP also explained to him that she wanted to refer him to the pain clinic, in order to get advice on his management. However, she agreed to prescribe a short term, low dose of tramadol, which he would receive daily for a week.

45. After the appointment with the GP, the man returned to his cell in houseblock 6. At some point during the late afternoon, he moved into a single cell as per the F35 instruction, completed by the GP.

46. The man collected his evening meal and returned to his cell where he was locked in at around 5.30pm. Prisoners remained in their cells that evening, as there was no association. (Association is the term used for the time that prisoners are given out of their cells to associate with one another or make telephone calls.)

47. At 7.30pm, an Operational Support Grade (OSG) arrived on houseblock 6 to take over from the day staff and begin her night shift. The investigator interviewed the OSG, who has worked at Elmley for five years.

48. The night of 8 November was only the OSG's second, as she was formerly part of the day shift. Her duties during the day did not require her to have any prisoner contact, or responsibility for prisoners. On night duty, her responsibilities included checking prisoners subject to Assessment Care in

Custody and Teamwork (ACCT) monitoring. (ACCT is used in prisons to monitor and support prisoners assessed as at risk of suicide or self-harm. Once placed on ACCT, the prisoner will be subject to regular case reviews that will direct observations/conversations to be carried out at intervals determined by their perceived level of risk. The observations continue during the day and the night.)

49. In addition to checking prisoners on ACCT monitoring, the OSG was also required to carry out a count of every prisoner on the houseblock spur where she was based, twice during her shift. This is known as a roll check. Once at the start of her shift, around 8.00pm and a further count the following morning between 5.30am and 6.00am. She said that on her first night, she had shadowed a fellow officer, but on 8 November, she carried out her duties alone on B spur.

50. When the OSG counted prisoners on B spur of Houseblock 6 at 8.00pm, she saw the man sitting on the floor of his cell, leaning against his bed. She told the investigator that she was unable to say what he was doing at that time or even if he had moved or acknowledged her, as she just continued with her count.

51. During the night, the OSG and an officer, who was responsible for another spur on houseblock 6, continued to patrol the houseblock between them and neither officer had reason to go to the man's cell. At 5.30am on 9 November, the OSG carried out her second count of all prisoners on the spur. She reported nothing unusual.

52. At 7.30am, another officer relieved the OSG and the officer. This officer was responsible for printing of the lists of prisoners on each landing. There is no requirement for a further count of prisoners by the day staff when they arrive on duty. During the investigation, there appeared to be some confusion about this amongst staff, with some believing that they were still required to conduct a count.

53. The investigator was told that it had previously been a requirement but this had changed recently. However, the revised requirement has yet to be updated in the prison's local security strategy (LSS). (All prisons have an LSS, which details the security requirements for that particular prison.)

54. The remainder of staff arrived onto houseblock 6 at around 7.55am and at 8.15am they began unlocking prisoners to collect their breakfast. An officer on duty on B spur said that as he unlocked the cells he would have a quick look through the observation panel to ensure there was no obvious threat to staff or other prisoners, before unlocking the door. He would then push the door slightly open before moving on to the next cell. When asked, the officer said that he did not see the man while he was unlocking.

55. The officer said that it was each prisoner's choice whether they collected their breakfast and there is no requirement for them to do so. Once all the cells had been unlocked, he began collecting applications from prisoners and recording them in the application book. (A prisoner must submit an application for various

requests, such as to see a doctor, have items from their property, or speak to someone from a certain department. These applications are then recorded and sent to the relevant areas for action.)

56. At 8.50am, all prisoners were instructed to return to their cells and the officer began walking around the landing securing the cell doors. When he arrived at cell 29, occupied by the man, he saw him sitting on the floor by his bed, with his head resting on his arm, which was across the bed. He said that when he first saw him he thought that he was upset, because of the position he was in, so he called to him and asked if he was all right. When he got no response, he checked his landing sheet for him and called to him again, using his name.

57. The officer said that he was aware that there was the possibility that the man might have been trying to get him into the cell, so he approached him cautiously. He then gently shook his shoulder, but he was 'very cold and stiff.' He then called to his colleague, who also checked him. The officer went to the office and told a Senior Officer (SO) that he believed the man was dead.

58. The SO said that when he entered the man's cell he could see that he had a grey appearance. He immediately requested healthcare assistance via his radio.

59. The nurse who attended carried the emergency response radio on 9 November, which meant that she was required to respond to any medical emergency. She said that she was alerted to a problem on houseblock 6 by a code blue being called over the radio. (Prisons use a coding system for medical emergencies to alert medical staff to the nature of the emergency. Code red indicates that a prisoner may be bleeding and code blue indicates breathing or respiratory problems.)

60. The nurse said that she had emergency equipment, which she carried to all medical emergencies. On her arrival at houseblock 6, she was directed to the man's cell. She told the investigator that when she entered the cell, "you wouldn't have thought that there had been an incident. You would have thought there was a man leaning on his bed to write a letter. The letter was on the floor, slightly underneath the bed and a pen and a cup of tea or coffee was on his right hand side. It was almost as though he had just been resting on his bed to write this letter and then something had happened and he had just put his head down".

61. She said that she called out to him, then bent down and placed her hand on his shoulder and noticed that he was very cold and stiff. She then checked his carotid pulse (neck) and radial pulse (wrist) but could not feel anything. She gently lifted his head and there were no signs of breathing. The nurse said that she had been with him for around two minutes when her senior colleague and another nurse arrived. She told her senior colleague she had checked for a pulse and breathing and that none were present. She also explained that, in her opinion, rigor mortis was present. (Rigor mortis is one of the recognisable signs of death, caused by a chemical change in the muscles, which causes the limbs to become stiff or difficult to move.)

62. The senior colleague said that having been provided with the information from the nurse and her own experience as a clinician, she made the decision that any attempts at resuscitation would be futile. She explained that in view of the man's apparent death, they decided not to request paramedics. She was aware that the prison doctor was due in the prison at 9.00am and immediately asked an officer to go to the gate and tell him to attend the houseblock immediately.

63. The doctor arrived at the cell at 9.05am. He said that he found the man in a seated position beside his bed. He asked the nursing staff and officers present to lay him down so that he could examine him and a pillow was placed under his head. He described the man's left elbow as flexed, with his left fist resting on his forehead. His eyes were closed and when the doctor opened them, there were no pupil reflexes. There were no chest movements or respiratory sounds.

64. The doctor said that he had been called to certify the man's death and from his examination, the presence of both rigor mortis and liver mortis (discolouration of the skin), he concluded that CPR would have been futile and he had been dead for some time. He pronounced death at 9.10am.

Actions following the man's death

65. Prison Service Order (PSO) 2700, provides guidance to ensure that families, staff and prisoners are supported following a death in custody.

66. All officers involved were spoken to by members of the staff care team, and a de-brief was held later that morning, to give staff the chance to raise any issues or concerns. The senior nurse spoke with the healthcare staff involved to offer support and provide them the opportunity to raise issues or concerns.

67. The Governor published notices that were displayed around the prison, informing both staff and prisoners about the man's death. The chaplaincy team were also available to speak with prisoners affected by the death.

68. The Governor and a chaplain, appointed as the prison's family liaison officer (FLO), arranged to visit the man's partner who had been nominated as his next of kin. They arrived at her home at 12.05pm. However, her mother informed them that her daughter was not at home and enquired whether it was about the man. The Governor confirmed this but said that he needed to speak with her daughter. She told them that she expected her daughter home around 6.00pm but she would try to contact her.

69. In his record of the visit to the family home, the Governor says that the partner's daughter, who was also present, immediately suspected that the man was dead. She telephoned her mother to return home and became distressed. He said that he did not confirm the death at this stage but told the partner's mother that they needed to speak directly to his elected next of kin. They were told

that she was expected to be home within 30 minutes, so they waited in their car.

70. The man's partner arrived home at 12.40pm and the Governor and chaplain introduced themselves. The Governor says that the man's partner was insistent that she was told what had happened straight away, but as they were in the middle of the street, he explained that it would perhaps be better if they went inside and spoke in private. However, he said that she was adamant that she would not go inside without knowing and, reluctantly, he quietly informed her of her partner's death. Once the family had been told, they agreed to go inside the house. He and the chaplain explained what had happened. He told them that there would be further enquiries made by the coroner, but early indications were that her partner had died from natural causes.

71. The Governor said that the man's partner was concerned that the facts about her partner's death would be 'swept under the carpet'. He reassured her that this would not be the case, and invited her to visit the prison the following day, which she accepted. He also told the family that the prison would meet the funeral costs, for which the family were grateful. He and the chaplain left the family home at 12.50pm.

ISSUES

Medical care

72. The man's family raised concerns that healthcare staff reduced his medication at both Elmley and Belmarsh. He had spoken to his partner about this and from evidence provided to the investigator it is clear that he continued to seek clarification on this matter from the prison GP.

73. The investigator and clinical reviewer addressed this issue with the prison GP at Elmley. The clinical reviewer explains that the difficulties with prescribing multiple doses of opiates and benzodiazepines is that dependence and tolerance can occur, making it difficult to withdraw this type of medication after a patient has been taking it regularly for more than a few weeks. Additionally, prescribing these types of medications in a prison setting is difficult as they have a 'currency' with some prisoners trading their prescribed medication.

74. The clinical reviewer says that because of the problems mentioned, it is understandable that prison doctors are very cautious about prescribing these classes of drugs. He endorses the GP's decision to only prescribe them together if the man had a severe psychiatric problem, which he evidently did not, or if they had originally been prescribed by a psychiatrist. He was placed appropriately on a gradual detoxification and continued to receive diazepam and fentanyl. A referral to the pain clinic, for advice on his pain management was also appropriately made.

75. The GP had concerns about the man's weight, which would also have informed her decision regarding amounts and types of medication that he should be prescribed. She referred him to the weight clinic, to assess his malnutrition status and stopped the nutritional supplement he had been receiving until this had taken place. The clinical reviewer considers these actions appropriate and refers to the NHS guidelines, which state, "patients must be assessed using a formal malnutrition screening tool and only if they are judged to be in a high risk category can they be prescribed a supplementary feed such as Ensure Plus".

76. A further concern regarding the man's weight was the absence of any investigation into the reasons for his weight loss. Although the GP said that he had refused a physical examination, this is not recorded and therefore does not represent best medical practice. The clinical reviewer feels that such an omission could lead to medical legal problems in the future.

77. The lack of recording correctly on SystmOne and the absence of an auditable path also led to confusion over the reasons that blood tests had been requested. Of all the medical staff interviewed, no one was able to confirm that they had requested them or give reason why they were needed. The investigator was told that there should be a pathological form completed to request a blood test and this would provide information on why it had been requested and who by. Such a form was not found or given to the investigator.

78. Both of these issues raise concerns about the quality of the medical records and the recording of essential medical information. The following recommendation is made:

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. An audit of record keeping should be undertaken to check compliance with professional standards and the outcomes acted on.

Roll checks

79. Elmley recently changed the requirements for roll checks (count of all prisoners). The investigator was told that staff arriving for duty in the mornings are no longer required to complete such a check. However, there was some confusion amongst staff interviewed, with some believing that this was still a requirement. The investigator was told that although the new requirements had been put in place, the Local Security Strategy (LSS) had yet to be updated to reflect these changes. The following recommendation is made:

The Governor should ensure that staff carry out roll checks in accordance with the current requirements and that the Local Security Strategy is updated to reflect requirements for each roll check.

Emergency response

80. The OSG was told of the man's death when she attended for her shift on the evening of 9 November. She wrote a statement in which she said that she had seen him sitting by his bed when she had completed her count that morning, around 5.30am and had thought that he must have fallen asleep in that position. When asked to clarify this during interview, she confirmed that she had also seen him the previous night, in the same position, but could not confirm what he had been doing.

81. The investigator asked the OSG whether she thought it unusual that the man was in the same position in the morning. She said that she was 'surprised', but she did not think it was unusual. The investigator also asked whether she had considered trying to get a response from him to check that he was all right, or whether she had mentioned anything to the officer. She said that she had not tried to get a response, and 'maybe due to her inexperience' did not mention it to the officer as she was not concerned.

82. The OSG had only completed one night shift prior to 8 November and on that first night she had shadowed the officer. Previously, she had only ever worked at the prison during the day and in areas that required minimal or no prisoner contact.

83. In his report the clinical reviewer comments that it is possible that the man had been dead for up to 18 hours before death was confirmed, based on the information provided by the staff who attended the emergency response, which

is very troubling. However, he points out that the timing mentioned in his report is only approximate as it would depend on other factors such as the temperature of the cell.

84. It is accepted that the OSG had only one night's training prior to 8 November. It is however, of considerable concern that the man was seen sitting on the cell floor and then seen still sitting in exactly the same position over nine hours later, without this triggering alarm or referral to a more experienced member of staff. At the very least, this suggests the need for better training and support for inexperienced staff. The following recommendation is made on this issue:

The Governor should ensure that staff who are required to take on duties in areas of greater prisoner contact and responsibility are given appropriate and thorough induction and training.

85. The officer who unlocked the cells, including the man's, said that he would always look into the cell before opening the cell door which is the local instruction to staff at Elmley. The guidance set out in The Prison Officer Entry Level Training (POELT) manual says "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead".

86. As the officer did not as a routine check on the welfare of those prisoners he was unlocking, by way of conversing with them or obtaining a response, the man went unnoticed for a further 30 to 35 minutes. The investigation has heard that earlier intervention would not have prevented his death, but in other cases such routine safety precautions may prevent an ill or dying prisoner going unnoticed in the future. We therefore make the following recommendation:

The Governor of HMP Elmley should review the procedures for unlocking prisoners and ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention

87. When the officer finally noticed the man while locking up prisoners, and identified that there was a problem, the response of medical staff was quick, with evidence of medical coding systems working effectively. Despite not being used, medical equipment was available.

88. We consider the decision by staff not to attempt resuscitation appropriate in the circumstances. National guidance says that resuscitation should be attempted and continued until the arrival of paramedics, unless there are clear signs of rigor mortis present. From the description given by all the staff involved, it is clear that this was the case with the man.

Family Liaison

89. The man's family raised concerns at the beginning of the investigation process about the way they were notified of his death. Notifying family and friends of such terrible news is difficult and devastating for the family. Although it is clearly important that the prison should notify the nominated next of kin as soon as possible, the guidance does not say that no other person should be informed before the next of kin and it 'allows governors discretion in decision and local practice'. This is clearly right and allows individual circumstances to be taken into consideration. When the Governor and chaplain arrived at the home of the man's partner, her daughter concluded that the reason for the visit was his death, but the Governor and chaplain felt unable to confirm this until they spoke to the partner.

90. When the man's partner arrived home, she was understandably upset and desperate to know what had happened. She was allegedly insistent that she was told before going into the house. The Governor said that he was not keen to do this in full view of the neighbours, but reluctantly told her in the street, at her request.

91. The man's partner said that she was not told that her partner was found beside his bed, but that he was in bed when discovered. When asked about this, the Governor said that he had provided the family with as much information as he was able to at the time, and did not recall saying that the man was found in his bed.

92. While we have seen no evidence to suggest that there were unnecessary delays in informing the nominated next of kin, the decision to wait until the man's partner arrived home before confirming the news to her and the rest of his family is likely to have added to his family's distress. However, it should be recognised that under such circumstances the very presence of a Governor from a prison is likely to indicate bad news to the family group and decisions as to who to inform if the named next of kin is not available will be a difficult decision to take.

93. The Governor said that the decision he made is one that he took in good faith but has attracted subsequent criticism from the family which cannot be ignored. There are clear lessons and considerations for all Governors having to deal with such tragic events given the experience that occurred on this particular occasion.

94. An offer of financial support towards funeral costs was made and an invitation offered to the family to visit the prison, which they did the following day.

Good practice

95. The investigator was told that Elmley uses nurses trained in mental health to conduct the reception health screens, as it enables prisoners who may have mental health needs, to be identified on arrival into custody. This is good

practice and we encourage the National Offender Management service to share this with other establishments.

CONCLUSION

96. The man was 47 years old and had a long history of mental health problems. He had been receiving treatment in the community for some time and been in receipt of varied medications at relatively high doses for a long period. On his reception into prison, he also disclosed physical problems, but at no time did he give any history of heart problems or complain of any related condition. Although only in custody for a relatively short time, he had quite regular contact with healthcare professionals, the focus of which was medication.

97. There was no requirement for staff to observe him frequently. On the night of his death he was seen at 8.00pm by an inexperienced night officer who observed him sitting on the floor beside his bed. The same officer then saw him in the same position around ten hours later at 5.30am, when she conducted a further roll check, but said that she had not found this unusual. Another officer unlocked him without noticing him lying on the floor until he returned to relock the door. The approach of the night officer, and the consequent lack of any alarm being raised or referral to a more experienced member of staff, is troubling. At the very least, this suggests the need for better training and support for night staff. The lack of safety checks when unlocking cells also requires review. While the clinical reviewer has said that it is unlikely that any earlier intervention would have prevented his death, it would obviously have been preferable.

98. Recommendations have been made in respect of staff training, roll checks and record keeping. With the exception of the weaknesses identified in those areas, we believe that staff managed his care adequately and that his death could not have been foreseen, although more discretion could have been used in informing his family of his death.

FAMILY RESPONSE TO DRAFT REPORT

99. The man's family responded to the draft report and provided feedback to the issues raised as part of the investigation.

100. Firstly, the family have said that they hope the recommendations that have been made will bring about changes, which will result in events such as those that occurred within Elmley on the 8th/9th of November 2011, not happening again.

101. The man's partner was concerned by the lack of care afforded to him, which resulted in him being undiscovered for possibly up to 18 hours. The family have said they feel this situation provided him with no dignity and they viewed this as 'disgusting and deplorable' and demonstrated in their view a failure to care for him appropriately. However, the family have also commented on the positive actions of the nursing staff, particularly the response nurse. They have said that knowing he was treated with dignity by nurses after he had been discovered was a comfort.

102. As with the issues raised in the draft report and the report produced by the clinical reviewer, the man's partner expressed her concerns about the management of his medication, and the lack of medical records to document this. His concerns in particular were regarding the progressive detox. She said that the removal of Nitrazepam caused insomnia, anxiety and paranoia for him. She said that she agreed with the clinical reviewer that his serious weight concerns should have been examined not only in Belmarsh but during his assessment on arrival at Elmley, and hopes this is something that will be changed for the future.

103. The man's partner commented on the lack of training provided to the OSG. Recommendations made on all issues have since been accepted by the prison.

104. The family remain dissatisfied with the way in which they were informed of the man's death and feel that the prison could have dealt with better and with more compassion.

RECOMMENDATIONS AND GOOD PRACTICE

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. An audit of record keeping should be undertaken to check compliance with professional standards and the outcomes acted on.

   The Prison Service accepted this recommendation and said:

   In the prison the issue with patients who do not attend their appointments is one that the Healthcare department has been working to resolve for a considerable time.

   The resolutions put in place subsequent to regular audit comprise the following:

   - A treatment list (without clinic information) accessible by all Houseblocks with instructions sent out for them to put this list on display, thereby offering prisoners the opportunity to see if they are due to visit healthcare that day. This was due to the audit showing the biggest reason for non-attendance was 'I was not aware'.
   - Patients to be added to the next available clinic if their reason for non-attendance is reasonable.
   - Patients to be added to the bottom of the waiting list if they decline to attend.
   - Bloods clinic patients to be followed up the same day by the Nurse despite reason for non-attendance.
   - Working in conjunction with the prison Governors as a result of recent audit whereby they implemented a communication system enabling their Wing Officers to communicate non-attendees and reasons for this on a daily basis.
   - Patients who DNA and cannot be called up are replaced by calling up other patients on the waiting list to maximise efficient use of the clinician's time and improve patient care.
   - Triage clinics now issue a slip on the spot with the time and date of the patient's GP appointment as audit showed that there was a relationship between the appointment being made and the length of time between this and the appointment itself; the shorter the time in between the more likely the patient was to attend. This is due for re-audit soon.
   - This audit is ongoing and shall remain so, particularly as it is an indicator in many areas such as QOF (Quality and Outcomes Framework).
   - All nurses are governed by the NMC Code of Professional Conduct and Record Keeping Guidance. A sample of documentation and care planning is audited weekly.

2. The Governor should ensure that staff carry out roll checks in accordance with the current requirements and that the Local Security Strategy is updated to reflect requirements for each roll check.

   The Prison Service accepted this recommendation and said:

   The local Security Strategy has been reviewed, updated and clarified and a Notice to Staff has been published to staff to inform them of this clarification

3. The Governor should ensure that staff who are required to take on duties in areas of greater prisoner contact and responsibility are given appropriate and thorough induction and training.

   The Prison Service accepted this recommendation and said:

   All staff undertaking night duty for the first time undergo a planned period of induction and supervision. A Principal Officer is currently reviewing training and support requirement for night duty staff. All recommendations will be actioned. The target date for this has been given as 31 August 2012.

4. The Governor of HMP Elmley should review the procedures for unlocking prisoners and ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   The Prison Service accepted this recommendation and said:

   Staff have been reminded of the need to undertake visual roll checks in order to check the safety of prisoners in their care.

Good practice

The investigator was told that Elmley uses nurses trained in mental health to conduct the reception health screens, as it enables prisoners who may have mental health needs, to be identified on arrival into custody. This is good practice and we encourage the National Offender Management service to share this with other establishments.