PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man whilst in the custody of HMP High Down in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

February 2013

This is the report of an investigation into the death of a man at HMP High Down. He died in December 2011, four days after his arrival at the prison. A post-mortem recorded his death as being due to cardio respiratory collapse and heart disease due to the addictive effects of methadone and diazepam. The report suggested that the heart problem was linked to use of cocaine. I extend my condolences to his family and friends.

The investigation was carried out by one of my investigators. A clinical reviewer was appointed to conduct a review of the clinical care the man received while in custody. Staff at High Down cooperated fully with the investigation. I apologise that the report has been delayed.

The man had a history of alcohol and drug abuse and had been in prison a number of times before. When he arrived in High Down on 29 November, he asked to be held apart from others, because of a previous incident at the prison. As there was no room in the vulnerable prisoner unit, he was held in the segregation unit. In December, when unlocking prisoners in the morning, an officer discovered the man unresponsive. Healthcare staff attempted resuscitation, but it was confirmed he had died.

The clinical review concludes that the man received appropriate support and medication for his detoxification from drugs and alcohol. Overall, his clinical care was satisfactory. However, I am concerned that the man's vulnerable prisoner status denied him the opportunity to be admitted to the stabilisation unit where he would have received 24 hour nursing cover and support, nor was he admitted to the healthcare unit as an alternative. The investigation also identified some areas for improvement including: more effective sharing of information from the police, better use of the computerised medical record system and a need for better guidance on when not to attempt resuscitation when death is apparent.

The recommendations made in the draft report has been mostly accepted by HMP High Down. I have included the response to the recommendations at the end of this report.

The 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 **February 2013**

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SUMMARY

1. The man died in December 2011, at HMP High Down, from cardiopulmonary failure and myocardial fibrosis (heart disease) caused by his use of drugs.

2. The man was arrested on 29 November 2011. While in police custody, he was prescribed dihydrocodeine (a strong pain relief) and diazepam (also known as valium which is used to treat alcohol withdrawal, anxiety and insomnia). On the 30 November, he was remanded into custody at High Down.

3. During the reception process, the man asked to be treated as a vulnerable prisoner[1] as he was concerned for his safety because of incidents during his previous time in prison. The vulnerable prisoner unit (VPU) had no room and he was given a cell in the segregation unit (or separation and reintegration unit (SRU) as it is known at High Down. (The SRU is a small, separate unit for prisoners who cannot be managed on the main wings, usually for disciplinary reasons or for their own protection.) It was intended to move him to the VPU once space became available.

4. During his reception health screening, it was recorded that the man had history of drug and alcohol dependency. He was referred to the prison doctor who prescribed methadone (a synthetic opiate based medication used as a painkiller and as substitute for heroin in the treatment of heroin addiction) and diazepam to support his withdrawal from alcohol.

5. On 2 December, the man declined his evening meal but did not appear to be unwell. During the night he was checked by staff and again no concerns were recorded.

6. Around 8.25am the next day, an officer unlocked the man's cell and found him unresponsive. Emergency assistance was requested and healthcare staff attempted to resuscitate the man, although it was evident he was dead. An ambulance was called and paramedics pronounced him dead at 8.44am.

7. The clinical review carried out by a clinical reviewer, considered both the care provided for the man throughout his time in prison and the emergency response when he was discovered. In his view, the general standard of care given to the man was comparable to that he could have expected in the community. We make five recommendations about transferring information between police custody and the prison, the use of computerised medical records, arrangements for vulnerable prisoners who are detoxifying and about resuscitation procedures.

[1] A prisoner who is separated from the general population of the prison. This can be due to a number of reasons including: the nature of their offence, publicity surrounding their case and trouble coping with being in prison.

THE INVESTIGATION PROCESS

8. The Ombudsman's office was notified of the man's death on 5 December 2011. The investigator issued notices at High Down informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No responses were received.

9. A clinical reviewer was commissioned to review the clinical care provided for the man during his time in custody. The clinical reviewer's report was received on 28 May 2012.

10. The investigator visited HMP High Down on 6 December. He met the Governor and a member of the Independent Monitoring Board, and spoke to staff involved in the man's care. He also spoke to the prisoners who were in the cells next to the man's, prisoner A and prisoner B. The investigator examined the man's relevant prison records, including his medical records.

11. The investigator returned to High Down on 31 January 2012 to interview Officers A and B. He returned again on 23 February and 22 March with the clinical reviewer, when they carried out joint interviews with Healthcare Assistant, Nurse A and the prison doctor. The investigator interviewed Officer C and Operational Support Grade[2] A. Initial feedback was given to the prison on 22 March, and subsequently confirmed in writing. We are sorry this report is late, due to work pressures in the Ombudsman's office.

12. HM Coroner for Surrey was informed of the investigation and provided the results of the post-mortem examination. The Coroner will be sent a copy of this investigation report.

13. One of the Ombudsman's family liaison officers contacted the man's mother. She was informed about the purpose of the investigation and offered the chance to raise any concerns about the man's care at High Down. The man's mother did not raise any concerns or matters she wished the investigation to consider. The man's mother received a copy of the draft report. No further representations were made in response to the findings.

[2] An Operational Support Grade (OSG) is a member of prison staff at a grade below prison officer. They work in many areas of the prison, normally where there is little or no contact with prisoners.

HMP HIGH DOWN

14. HMP High Down is a local prison for adult males, and takes prisoners from Croydon and Guildford Crown Courts and surrounding magistrates' Courts. At the time of the investigation High Down could hold up to 1,103 sentenced and remand prisoners.

15. Healthcare services at the prison are commissioned by Surrey NHS and provided by Surrey Community Health. There is a 23 bed inpatient unit, plus a 12 bed "step down" unit for prisoners requiring a less intensive level of care.

HM Inspectorate of Prisons (HMIP)

16. The last inspection of High Down was in July 2011. The Inspectorate judged that that healthcare was excellent. However, inspectors noted that arrangements for newly arrived vulnerable prisoners were inadequate and that vulnerable prisoners were held in the segregation unit for up to a week as there was insufficient space on the dedicated wing. Inspectors said that vulnerable prisoners in the segregation unit had an unnecessarily restricted regime. One of the inspection report's main recommendations was that "the prison should implement a specific safeguarding strategy that ensures vulnerable prisoners are appropriately located and have access to a purposeful regime that is free from harm and abuse and includes formal reintegration planning."

17. With regard to support for prisoners with alcohol or drug problems, the report said:

> "The quality of IDTS care was good, and prisoners had a high level of satisfaction with their treatment and support. Prisoners were initially assessed in reception by nurses and a GP with a special interest. Those subject to dual diagnosis were referred to the mental health in-reach team. There was appropriate first night prescribing. The stabilisation/detoxification unit was a well-run therapeutic environment. Prescribing regimes were flexible."

However, the man was not held on the stabilisation/detoxification unit but instead was held in the segregation unit.

Independent Monitoring Board (IMB)

18. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for High Down covers the year to November 2011.

19. The IMB expressed concern about the situation of vulnerable prisoners at the prison:

> "Both the SRU and the HCC [healthcare centre] are used to house overflow VPs when, as has happened frequently, there is no space in the dedicated unit. This decision is taken for the men's safety but is far from ideal. The SRU is intended mainly as a punishment area. New

arrivals will include men facing their first time in prison; some will be on remand and found guilty of no crime and in SRU they will be subject to long periods of isolation."

Previous deaths at High Down

20. Since 2009, the Ombudsman has investigated seven deaths through natural causes at High Down. None of the previous investigations raised any issues which are pertinent to the man's death.

KEY EVENTS

21. The man was born in 1975. He died in December 2011.

22. On 23 September 2011, the man was released from prison custody. Just over two months later, on 29 November was taken to Streatham Police Station. In police custody at around 2.12pm, a doctor, saw the man and noted that he was "drug and alcohol dependent and needs medication". He prescribed him 30 milligrams of dihydrocodeine and 10 milligrams of diazepam.

23. On 30 November, the man was remanded into custody and arrived at HMP High Down that day.

24. During his first reception health screening interview (which identifies any immediate mental or physical health problems requiring referral to the doctor or other specialist service), Healthcare Assistant (HCA) A recorded that the man had a history of drug and alcohol dependency. The HCA referred the man to the prison doctor. At the second health screen, on the same day, Nurse A recorded that the man told her that he smoked £70 worth of heroin and £40 worth of crack cocaine a day and that he drank 15 cans of strong lager or cider daily. The man said he had used heroin for the past 15 years and that he had stopped taking methadone three months previously. The nurse recorded that he was showing signs of withdrawal. She also referred him to the prison doctor in relation to his substance abuse.

25. A prison doctor saw the man later on 30 November, and recorded that the man said he suffered from paranoid schizophrenia but had not taken medication for this for a number of years. He repeated his history of heroin, crack cocaine and alcohol use, and also told the doctor that he had been using illicit diazepam. The man asked for methadone treatment and alcohol detoxification. The doctor prescribed 20 milligrams of methadone for opiate withdrawal, which could be adjusted as required by the substance misuse team to stabilise the man. He also prescribed diazepam for his alcohol withdrawal. He recorded that the man would be followed up by the substance misuse team.

26. The man was recognised as a vulnerable prisoner (VP) as he was concerned for his own safety. (It is not clear from the records what the risk was but he been granted this status during a previous period in custody). As the vulnerable prisoner unit (VPU) had no room he was located in the separation and reintegration Unit (SRU) for his own safety. On his arrival in the SRU, Operational Support Grade (OSG) A noted that the man had no concerns and had been in High Down on a number of occasions.

27. Officer D completed a cell sharing risk assessment (CSRA)[3] and. recorded that the man had been diagnosed with paranoid schizophrenia and said that on a previous sentence he had "nearly strangled a cell mate". The nurse completed the healthcare assessment of the CSRA that there was no increased risk in

[3] The cell sharing risk assessment process is the basis for decision making when a prisoner's location is being decided. It was introduced to improve the ability of staff to risk assess and to track potentially violent or racist prisoners who should not share cells with other prisoners.

relation to his health. However, due to his declaration about harming a cell mate and his history of mental health problems it was recorded that the man was high risk and not suitable to share a cell.

28. On the afternoon of 1 December, an SRU review board (attended by officers and healthcare staff as well as the man) was held to discuss the man's wellbeing. He said that he had received his methadone but not his diazepam. (Nurse B agreed to follow this up and he received it later that same morning). The man said that he was a paranoid schizophrenic and that he had not had his medication for four weeks and that he normally had it every two weeks. He said he did not want mental health support as did not trust them and because he had previously spent time in a secure mental health unit. Senior Officer (SO) A referred the man to the prison's mental health in-reach team (MHIT).

29. At around 2.10pm the same day, the man rang his girlfriend's mother to inform her that had been arrested unexpectedly and had not had the opportunity to tell her daughter. This was the only telephone call he made while he was at High Down.

30. A member of staff from the MHIT went to see the man at around 4.00pm. The man declined to give any information and said that he did not want any contact with the community mental health services. The man was given two paracetamol at around 5.00pm but no reason for their issue was recorded.

31. Around 9.30am on 2 December, Nurse C gave the man his diazepam and recorded no concerns. Nurse D saw the man during her rounds on the SRU later that day. At around midday the man received 20 milligrams of methadone. The man declined his evening meal at around 5.00pm. Officer E double checked whether he was sure he did not want anything. The man said that he did not and wanted to get some sleep. The officer checked on him again at around 6.00pm and recorded that he was okay.

32. The prison then entered patrol state[4] and the day shift staff on the SRU handed over responsibility to OSG A. A roll check[5] was carried out by the OSG at around 7.30pm and he did not note anything untoward. In his statement to the police, the OSG wrote that when he did his cell checks at around 9.00pm he "looked into cell 22 and saw the man tucked up in bed. I did not talk to him and carried on the checks".

33. Around 1.30am on 3 December, OSG A checked on the man and recorded that he was asleep. Prisoner B, who was in the next cell, said the man had a terrible cough and he had only seen him when they passed on the landing to collect food or to go for a shower. The prisoner told the investigator that he woke up around 3.00am on 3 December to use the toilet and then had trouble going back to sleep due to the man's loud snoring. The prisoner said he

[4] After the evening roll call to confirm prisoners are all accounted for, the prison enters what is called patrol state. This is defined as follows: 'Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.'
[5] The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at specified times during the day, and staff must sign that the roll is correct.

banged on the wall and the snoring stopped. OSG A checked on the man at around 6.00am he did not notice anything untoward and noted a "quiet night".

34. Around 8.15am, Officer A started unlocking prisoners on the SRU for breakfast. He arrived at the man's cell at around 8.25am. When the officer opened the observation panel he saw the man lying on his back on his bed with his left arm dangling towards the floor, his eyes were wide open and he was motionless. The officer went into the cell, felt the man's face and checked for a pulse but he could not find one. The officer then asked for assistance from his colleagues, Officers C and Officer F.

35. In his statement, Officer C said that the man showed "no signs of life and appeared to be in the early stages of rigor mortis[6]". Officer C then radioed for help. The time of the request was recorded by Security OSG B as 8.30am and an ambulance was called two minutes later. SO B also came to the cell and checked for a pulse but could not find one.

36. Nurse E and Healthcare Assistant (HCA) B arrived within minutes. The nurse tried to rouse the man but was unable to do so and could not find a pulse. The man was not breathing and when the nurse felt his chest it was cold to touch. She tried to straighten his right leg which was bent but was unable to do so as rigor mortis appeared to have set in.

37. Although Nurse E believed the man was dead he informed SO C and HCA B that they needed to carry out cardiopulmonary resuscitation (CPR)[7] as they could not make the decision as to end of life. They attached a defibrillator[8] and an oxygen mask to the man but the defibrillator could not detect a shockable rhythm. They continued CPR until paramedics arrived and advised them to discontinue. The paramedics pronounced the man dead at 8.44am.

Events after the man's death

38. After the man's death, the prison put in place its death in custody contingency plan. The police visited the prison (as they are required to do for all deaths in custody) interviewed staff and found no suspicious circumstances.

39. Officers told the other prisoners on the SRU later that morning that the man had died and asked whether they required any support or wanted to speak to a Listener (prisoners who are selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress). Prisoners on self-harm and suicide monitoring arrangements were reviewed.

40. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the

[6] Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.
[7] Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.
[8] A defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock.

prisoner. The deputy governor held a debrief that day. No issues were identified and the staff were offered support from the prison's care team.

41. High Down appointed SO D as the prison's family liaison officer. Around 1.00pm on 3 December, the SO and Residential Governor visited the man's family to inform them of his death. In line with national guidance, High Down also offered financial assistance with the costs of the man's funeral, which took place on 20 December 2011.

Post-mortem report

42. A Home Office pathologist and consultant forensic pathologist conducted the post-mortem examination. He concluded:

> "It would appear that the ultimate cause of death is cardio respiratory collapse due to the addictive effects of methadone and diazepam. However, it is also reasonable to suggest that the myocardial fibrosis, a likely sequel to cocaine use, is relevant in its potential to cause a cardiac dysrhythmia and it is the combination of these factors that has led to the death."

43. The Home Office pathologist noted that the man had claimed during a previous time in custody that he had lung cancer but he would not let healthcare staff confirm this by conducting tests. The pathologist found no evidence of lung cancer.

ISSUES

Clinical care

44. As noted, a review of the man's medical care was carried out by the clinical reviewer. From the medical records, it was clear that the man was seen regularly by healthcare staff.

45. The clinical reviewer notes that the man was seen by a doctor while he was in police custody, before he arrived at High Down. The doctor recorded "He [the man] is drug dependent, and needs medication". The doctor prescribed medication while the man was in police custody, but these records did not follow the man into prison. The man told healthcare staff during the reception process of his drug and alcohol addictions. Subsequent tests confirmed his drug intake.

46. Nevertheless, it is important that key information obtained while in police custody is passed to the prison by the Person Escort Form (PER). Records of any medical treatment given while the prisoner is still in police custody should be provided to ensure effective continuity of care.

    The Governor should agree arrangements with the police to ensure that records of medical treatment from periods in police custody are passed to the prison using the Person Escort Form to inform further treatment decisions.

47. The clinical reviewer comments that the man's reception screening was conducted in a "well ordered and precise fashion". The team were well coordinated and showed good team working. However, healthcare staff did not look at the man's past records during the reception screening. The man had been in High Down before and would have had previous clinical records. Healthcare staff said this was because the reception area is busy and there is not time to research previous records.

48. The clinical reviewer confirmed that there is a summary page on SystmOne (the healthcare computer system) which lists active and past medical problems and should be easily and quickly accessible. Neither of the healthcare staff involved in the reception of the man knew how to access this page. The clinical reviewer states that in this case the lack of historical information did not compromise the man's care but it is clearly a training issue which should be addressed.

    The Head of Healthcare should ensure that all healthcare staff know how to locate the summary page of active and past medical problems on SystmOne.

49. When reviewing the man's computerised records, it was not clear to either the investigator or the clinical reviewer whether his prescribed medication had been administered. Paper records were subsequently provided which showed that

all medication had been administered. The clinical reviewer states that all medication records should be recorded on SystmOne.

50. In his review, the clinical reviewer states:

> "I would recommend that all drug records are recorded on SystmOne. If a dose had been missed then such an error could have triggered a seizure in someone already prone to such events. I have also seen written copies of the methadone and diazepam medicine charts which confirm they were issued. I have no evidence that the man's care was compromised."

51. It is important that all matters relating to a prisoner's treatment are appropriately recorded and easily accessible. SystmOne is a comprehensive package that allows a prisoner's entire treatment history at the prison to be recorded and ensures effective continuity of care.

The Head of Healthcare should ensure that all medication records are recorded on SystmOne as part of the comprehensive clinical record of a prisoner's care.

52. The clinical reviewer notes the post-mortem report states that the man's death as "cardiopulmonary failure secondary to myocardial fibrosis and methadone and diazepam co-toxicity". He says that it is known that heart damage can be associated with cocaine abuse and this increases the chances of sudden death. The man was a known cocaine user and was supported in his withdrawal from opiates. Methadone was prescribed for the man's heroin addiction to stabilise his condition and the clinical reviewer states that the process of assessment and prescribing methadone followed the set guidelines. The man's withdrawal from alcohol was supported with a prescription of diazepam. The clinical reviewer states that this also followed the set guidelines. He notes that the man had similar withdrawal programmes in the past without any problems. He confirms that both drugs (methadone and diazepam) were prescribed within the therapeutic range. He states:

> "The clinical imperative was to stabilise his withdrawal which itself is a risk if diazepam is not used. The levels of the drugs are within the therapeutic range. The lifestyle of the man almost certainly contributed to his death by the myocardial fibrosis."

53. Prison Service Instruction (PSI) 45 2010 requires prisoners who are detoxifying from alcohol or drugs, to have clinical interactions twice a day for a minimum period of five days, and for "stimulant" users this is a requirement for the first 72 hours. During his stay in the SRU at High Down, the man was regularly visited by staff from the substance misuse team on at least two occasions each day and his clinical observations were recorded each time as required.

Use of the segregation unit

54. When the man arrived at High Down he asked to be treated as a vulnerable prisoner but there was no room on the vulnerable prisoner unit (VPU) (as all 74 places had been allocated) he was given a cell in the segregation unit (the separation and reintegration unit.)

55. We recognise that as a prison serving the local courts, High Down has a high throughput of prisoners and reception staff will not know their offences/concerns about their own safety until their arrival at the prison. However, the SRU should not be used as an overflow facility for someone who is not a problem prisoner and not subject to segregation procedures. In his review, the clinical reviewer recommended that High Down should ensure that adequate space is available in the vulnerable prisoners unit for prisoners at all times especially those on a drug withdrawal scheme

56. When the investigator visited the prison to open the investigation he raised the issue of using the SRU as an overflow facility for vulnerable prisoners with staff and the Governor. On 18 December, an additional 18 spaces were made available for vulnerable prisoners. On 14 February 2012, following a review of accommodation, High Down converted further space and now has 122 spaces for vulnerable prisoners.

57. However, we are concerned that the man's vulnerable prisoner status meant that he was not offered admission to the stabilisation unit and the support that this would have provided. We do not believe that the segregation unit is an appropriate place for someone who is withdrawing from drugs and alcohol, the latter of which is particularly dangerous. PSO 3550 on clinical services for substance misusers requires treatment for alcohol withdrawal to take place 'where possible in health care centre by trained and experienced staff'. PSI 45/2010 states that all drug and alcohol dependent prisoners arriving at a prison must always be offered immediate admission to a stabilisation unit. Such units have 24 hour nursing cover and offer support and expertise in the management of substance misuse. While the man had the required twice daily clinical observations in the segregation unit, we are concerned that he did not have the higher level of input, support and observations available to other prisoners on the stabilisation unit which PSI 45/2010 requires. Nor did he go to the healthcare centre as an alternative. There does not appear to have been any risk assessment to indicate that the man would have been at increased risk of harm from other prisoners on the stabilisation unit. However, if there was such a risk, we consider that he should have gone to the healthcare centre where there is 24 hour nursing cover.

    The Governor and Head of Healthcare should ensure that vulnerable prisoners withdrawing from alcohol or drugs receive appropriate treatment and care in a unit with trained and experienced staff.

The emergency response

58. An officer discovered the man unresponsive when unlocking cells at 8.25am in December. Within minutes an officer had radioed for and received assistance, an ambulance had been called, and attempts were being made to resuscitate the man. The paramedics arrived at the prison quickly; they pronounced death at 8.44am. From both the records and the investigator's interviews with staff it appears that, after the man was discovered, all those involved acted quickly and in a professional manner.

59. In his review, the clinical reviewer states: "The record made and statements from the prison officers show a coordinated and appropriate response where no effort was spared to resuscitate the prisoner".

60. However, we are concerned that despite the man showing signs of rigor mortis which was identified by both officers and healthcare staff, the nurses felt obliged to carry out CPR. As the man was found at 8.25am and nurses arrived shortly afterwards, we can estimate that CPR continued for approximately 15 minutes before paramedics arrived and confirmed death at 8.44am. The European Resuscitation Council Guidelines for Resuscitation 2010 (Section 10) states that "Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile …"

61. Prison Service guidance in PSO 2700 annex 13A which applied at the time says that there is no expectation on prison staff to attempt resuscitation when rigor mortis is clearly present. It is also distressing for staff and disrespectful to the deceased. We are concerned that healthcare staff believe they are required to carry out resuscitation procedures in these circumstances.

The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

CONCLUSION

62. The man arrived at High Down on 30 November 2011. He had been arrested the previous day and treated for drug withdrawal but the records from his time in police custody did not accompany him to the prison. Treatment for drug and alcohol withdrawal continued at High Down but, because he was a vulnerable prisoner and there were no places in the vulnerable prisoners unit he was placed in the segregation unit rather than in the dedicated detoxification/stabilisation unit.

63. The clinical reviewer concluded that the care the man received was comparable to what he could have expected in the community, although he indicates some areas of learning for healthcare staff. We are concerned that the man was held in the segregation unit rather than a dedicated detoxification/stabilisation unit or the healthcare centre as Prison Service guidance expects. This would have allowed more appropriate observation levels. We are also concerned that healthcare staff felt obliged to attempt resuscitation even though it was clear that the man had been dead for some time.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. That response is included in italics below the recommendation.

1. The Governor should agree arrangements with the police to ensure that records of medical treatment from periods in police custody are passed to the prison using the Person Escort Form to inform further treatment decisions.

   Not accepted - This is not within the powers of HMP High Down who receive prisoners from all police forces. As it stands, there are instructions that the police must abide with to ensure that the relevant information is entered onto the Person Escort Report (PER) form. We understand that these instructions, and the PER, are under review.

2. The Head of Healthcare should ensure that all healthcare staff know how to locate the summary page of active and past medical problems on SystmOne.

   Accepted - All new staff undergo training on SystmOne provided by the SystmOne Facilitator. There is ongoing training as and when SystemOne is developed. All staff have been informed by a global email where to locate the summary page.

3. The Head of Healthcare should ensure that all medication records are recorded on SystmOne as part of the comprehensive clinical record of a prisoner's care.

   Accepted - SystmOne drug administration functionality was not fit for purpose and TPP have been working on this. However, internally we have looked at the system, particularly around risk areas and are developing a process to ensure it is safe to administer medication via SystmOne. We anticipate that in 2013 we will go live in High Down with drug administration on SystmOne.

4. The Governor and Head of Healthcare should ensure that staff are given guidance about the circumstances in which resuscitation is not appropriate.

   Accepted - Our resuscitation protocol and guidelines have been updated to ensure that staff react appropriately when resuscitation is not indicated i.e. when rigor mortis has set in. High Down's Basic Life Support training now includes this recent update.

5. The Governor and Head of Healthcare should ensure that vulnerable prisoners withdrawing from alcohol or drugs receive appropriate treatment and care in a unit with trained and experienced staff.

   Accepted - All prisoners who enter the prison with substance misuse issues are assessed substance misuse staff (i.e. doctor or nurse).