PRISONS AND PROBATION
OMBUDSMAN
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Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Bullingdon who died at the John Radcliffe Hospital in August 2012

Our Vision

'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'

This is the report of the investigation into the death of a man at HMP Bullingdon. The man died from venlafaxine and tramadol toxicity at the John Radcliffe Hospital, Oxford, on 21 August 2012 after collapsing at the prison three hours earlier. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators. A review of the man's medical care in prison was undertaken by the clinical reviewer. HMP Bullingdon cooperated fully with the investigation.

The man was remanded to Bullingdon in November 2011. He suffered from chronic fatigue syndrome, chronic pain, migraine, depression and fitting. He had previously self-harmed by overdose and cutting his wrists. The man took a range of prescribed medication for his pain relief and mental health. He often said he needed more pain killers and that the level of pain he experienced sometimes made him want to harm himself. In August 2012, he burnt the letters DNR (do not resuscitate) onto his chest. He was monitored and supported appropriately through suicide and self-harm procedures. Shortly before his collapse on 21 August, he told another prisoner he had taken an overdose.

The man apparently experienced significant pain and his treatment was not straight forward. However, I am concerned that, despite his history of overdose and risk of self-harm, he was allowed to keep large supplies of medication in his cell without a proper assessment of the risk. This included venlafaxine, which is known to be highly toxic in overdose. It is of particular concern that, after the man's self-harm in August, there was still no risk assessment or review of the medication he was allowed to have in his cell. It is also disappointing that, as in another recent investigation at Bullingdon, I once again find it necessary to criticise the use of restraints on a seriously ill prisoner.

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 **May 2013**

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SUMMARY

1. The man was arrested in November 2011 for serious offences against family members. He was remanded into custody at HMP Bullingdon on 30 November. This was his first time in prison.

2. At a routine reception health screen, it was noted that the man suffered from depression, chronic fatigue and fits (seizures) for which he received medication. (Because of a staff oversight it was seven days after he arrived before he received his medication.) The man said he had previously self-harmed by cutting his wrists. After he was sent to prison, a psychologist who had been treating him in the community alerted the prison that he might harm himself and he was monitored as being at risk of suicide and self-harm. He appeared to settle quickly into the prison regime and suicide and self-harm monitoring ended on 12 December.

3. From January 2012, the man repeatedly complained that his medication dosage was too low to counteract his pain. Healthcare staff saw him frequently to review his medication and check on his wellbeing, but he continued to say that the level of medication he was getting was insufficient to deal with his pain. On 3 August, he self-harmed by burning the letters ‘DNR’ (Do Not Resuscitate) on his chest. He said that this was because, if he collapsed in prison, he did not want to be resuscitated but healthcare staff would not give him a DNR form. Suicide and self-harm prevention procedures were opened and he was monitored and offered support.

4. On 21 August, the man collected his afternoon medication as normal but shortly afterwards, he collapsed and had a fit on the wing landing. He stopped breathing but was resuscitated by prison and healthcare staff. Before he collapsed, he had told another prisoner that he had taken an overdose of drugs. An ambulance was called and he had another fit before he was taken to hospital. His condition deteriorated quickly in hospital and he died shortly after 5.30pm.

5. It appears that the man had taken an overdose of medication before he died, but we do not know whether this was with the intention of taking his own life. He had a number of health issues and a history of self-harm and taking overdoses. He was dissatisfied with his medication regime and said he was frequently in pain, which sometimes made him want to self-harm. The investigation found that, although he had been identified as at risk of suicide and self-harm, there had been no review of whether he should have been allowed to keep his medication in his cell. Recommendations are made about this issue, about prescribing practice, suicide and self-harm procedures and the use of restraints.

THE INVESTIGATION PROCESS

6. The investigator visited Bullingdon on 24 August 2012. He met relevant staff and visited the wing and cell where the man lived. He obtained copies of the man's prison and healthcare records. The investigator issued notices to staff and prisoners informing them of the investigation and inviting them to contact him. Subsequently, he interviewed prison and healthcare staff, and four prisoners.

7. A review of the man's clinical care at Bullingdon was undertaken by a clinical reviewer.

8. The investigator carried out interviews in September and October 2012. He gave the Governor initial verbal and written feedback after the interviews.

9. HM Coroner for Oxfordshire was informed of the investigation. A copy of this report has been sent to him.

10. One of the Ombudsman's family liaison officers (FLO) contacted the man's family shortly after his death. She explained the investigation process. The man's family asked that the investigation should cover the circumstances of how the man died and what medication he had received in prison.

11. We received comments on the draft report from the man's family. His family said that he had a number of chronic illnesses for which he took a variety of medication, but were disappointed in the medical care he received at Bullingdon. His family were particularly concerned that he was given medication to keep in his possession, despite his history of self-harm. They also believed that his previous self-harm history should have led to closer monitoring by healthcare staff. We have considered the man's medical care and the management of his risk in this report.

HMP BULLINGDON

12. HMP Bullingdon operates as an adult male Category C prison with a Category B local function. The prison has six house blocks holding approximately 1100 prisoners.

Her Majesty's Inspectorate of Prisons (HMIP)

13. The last published inspection report by HMCIP was of an unannounced inspection in July 2012. The report noted that the prison was generally safe. There was a good alcohol and drugs strategy, and there was effective action to prevent illegal drugs coming into the prison. Management of prisoners at risk of suicide and self-harm was judged to be reasonable. Health services were in need of improvement and modernisation but dental and mental health services were good. Inspectors considered that the processes supporting the prescribing of in-possession medication needed urgent attention.

Independent Monitoring Board

14. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. In their annual report for the period ending July 2012, the Board at Bullingdon reported that it continued to be generally satisfied with the overall standard of the prison management, treatment of prisoners and facilities provided.

Suicide and self harm monitoring/ Assessment, Care in Custody and Teamwork (ACCT)

15. The Assessment, Care in Custody and Teamwork (ACCT) system is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of supervision and interactions are set according to the perceived risk of harm. As part of the process, a caremap (plan of care, support and intervention) is put in place. There should be regular multi-disciplinary review meetings involving the prisoner.

Previous deaths at HMP Bullingdon

16. There has been one death from natural causes at Bullingdon since the beginning of 2012. This report also made a recommendation about the appropriate use of restraints for hospital escorts.

KEY EVENTS

17. The man was born in 1967. On 28 November 2011, he was convicted of serious sexual offences committed some time previously and remanded into prison custody to await sentencing.

18. Before leaving court, the man suffered a seizure (fit) and was taken to the Royal Berkshire Hospital where he remained for two days before being discharged to prison. No cause was found for the seizure but it was thought likely to have been due to him taking unknown substances.

The man's arrival at HMP Bullingdon

19. The man arrived at Bullingdon on 30 November 2011. Nurse A carried out a routine health screen and recorded the man's basic health observations (weight, pulse, height, blood pressure). He noted that the man suffered from depression relating to Chronic Fatigue Syndrome (CFS) also known as Myalgic Encephalomyelitis (ME). The man reported a history of self-harm and said he had previously made cuts to his wrist while taking prozac (an anti-depressant). He said he did not abuse drugs and did not smoke. The man said his current medication was tramadol (a pain killer), benadryl (an antihistamine), sumatriptan (for migraines) and venaflaxin (an anti-depressant). The nurse recorded that the man had had a seizure at court two days before and that he found it difficult to assess the man because of his vague manner.

20. Nurse A referred the man to the prison doctor and the mental health team. He was moved to the healthcare inpatient unit for monitoring overnight. Because of his offence, the plan was for the man to move in due course to the vulnerable prisoners unit (VPU) unit on E wing.

21. On 31 November, the man's community psychologist contacted the prison to say that the man had said that he would kill himself if he was found guilty at court. The community psychologist confirmed that the man had a history of CFS, depression and stress. Nurse B went to see the man as a result of the information. The man would not discuss whether he had any intention to self-harm but he said that he had told his solicitor that he "could not do a prison term".

22. Nurse B began Assessment Care in Custody and Teamwork (ACCT) procedures, including a detailed ACCT assessment interview. The man continued to refuse to discuss if he had any current intention to harm himself and said he could not recall having a seizure at court. He said he suffered from depression and had attempted suicide two years before by taking an overdose. The nurse noted that the man would remain in the healthcare inpatient unit until he was seen by the prison doctor. The Listener scheme[1] was explained and he was placed on hourly irregular observations.

[1] Listeners are prisoners trained by the Samaritans to offer support to other prisoners.

23. The man told Dr A later that day that he experienced seizures every few years. He said he had seen a private neurologist about this as well as another neurologist for his ME, chronic pain and headaches. In addition to the medication he had already mentioned, he said he took topiramate (for migraine) and diazepam (for stress and muscle spasm). The man's community GP was contacted and the information about his prescriptions was confirmed.

24. On the evening of 3 December, the man moved to the segregation unit (known as the Separation Support and Care Unit (SSCU) at Bullingdon), as a bed in the healthcare inpatient unit was needed urgently for another prisoner and the VPU was full. An ACCT review was held and noted: *"The man is [on] E wing overflow … to create space. Explained [to him] this is not a punishment".* The man was told it was a temporary move. He expressed no concerns and was reminded of the support available. His ACCT observations remained hourly irregular and his risk of harm was considered "Low".

25. On 4 December, the man complained of having a migraine and told the nurse that he had not received any medication since he had arrived at the prison. The nurse advised him to see the prison doctor the next day. There is no record that he did. On 6 December, he moved back to the healthcare inpatient unit and complained again about not having had any medication and asked to see the doctor.

26. At an ACCT review that day, the man's history of depression was noted. The man said he did not have any current thoughts of self-harm or suicide, but said he felt anxious because he had not had his antidepressant medication. The review agreed that arrangements should be made for him to receive his medication and a referral was made to the mental health team. The ACCT observations remained the same and the man's risk was again rated as low.

27. Later that evening, Nurse C retrieved the medication that the man had given in when he arrived at the prison and asked Dr B to write a new prescription. The doctor noted in the man's records that he had not seen the man, but had been briefed by the nurse that the man took sumatriptan for migraines. The prison was out of stock of sumatriptan, so the doctor prescribed aspirin and noted that a medication review should take place the following day.

28. Dr A reviewed the man's medication on 7 December. She told the investigator she did not know why the man had not been prescribed medication for almost a week, despite the fact that the details of his community prescription had been received on 2 December. The information from the community GP confirmed diagnoses of CFS, migraines and chronic pain. He also suffered from urticaria (rash of the skin). His community medication included tramadol, venlafaxine, topiramate, pregabalin, sumatriptan, diazepam, acrivastine and buprenorphine.

29. Dr A prescribed loratadine (used to treat allergies and urticaria), sumatriptan and tramadol. The man received the loratadine and sumatriptan as in-

possession[2] medication. There is no record that a risk assessment for in-possession medication was completed.

The man's move to Edgecott Unit (VPU)

30. On 10 December, the man moved from the inpatient unit to the Edgecott Unit (E wing). He had previously spent association periods on E wing and it seems he settled quickly.

31. On the afternoon of 12 December, Senior Officer (SO) A chaired an ACCT review attended by Officer A and Nurse D. The man said he had no current thoughts of self-harm or suicide but was worried that he might receive a long sentence in the New Year and he was concerned about his elderly father. The review team reminded the man of the support available and he agreed to tell staff if his mood declined. The man's risk level was still considered to be low and it was agreed that the ACCT should be closed.

32. On 15 December, a community psychiatric Nurse (CPN) and a psychiatrist carried out a mental health review. The man said he had been a patient of the community psychologist (his psychologist) for a number of years and had also been seeing a counsellor. He reported suffering from stress due to family problems. He said that he had had ME for 20 years and took tramadol for this as a pain relief. He said that the pain affected his mental health and that he had previously taken an overdose in an attempt to take his life and was hospitalised as a result. Despite this, the man said that his mood was good at present and that he had no thoughts of self-harm. The psychiatrist noted that he had no immediate concerns about the man but would assess him again after his court hearing.

From January 2012 onwards

33. On 6 January 2012, the man received an 18 year sentence. On his return to Bullingdon he was seen in reception by Nurse E. He was tearful, but declined an offer to move to the inpatient unit temporarily and said he had no thoughts of self-harm.

34. The community psychiatrist assessed the man on 12 January. The man was unhappy at the length of his sentence. He said though that he got on well with the other prisoners on E wing, had applied to go to education and was not depressed. The community psychiatrist had no concerns about the man's mental health and planned a review three to four weeks later.

35. The man saw Dr A on 19 January and reported a number of ailments, including muscle spasms and stiffness in his back. He said his community GP often prescribed him diazepam and this medication had worked well. The doctor told him that she would contact the community GP for confirmation of this and would also contact ME Services in Oxford for risks associated with diazepam. The doctor seems not to have noticed that the man's GP had

[2] In-possession medication is medication retained by prisoners. Prisoners are risk assessed to determine their suitability to hold medication in-possession. Some prescribed medicines are never permitted in-possession.

already confirmed, on 2 December, the medication he had been prescribed in the community. In the meantime, she prescribed baclofen (a muscle relaxant). The loratadine prescription was stopped as the man said it did not work.

36. At a review with his community psychiatrist on 9 February, the man said his mood was low because of shoulder, back and neck pain. He said diazepam was the only medication that would work and that he asked his community GP to write to the prison to confirm that he had received diazepam in the community. The psychiatrist noted that the man's risk of self-harm or suicide was very low and he would be reviewed again in four to six weeks.

37. Dr A reviewed the man on 14 February. By this time, he had started attending education which he said was a useful distraction. The doctor noted that the community GP had confirmed prescriptions of buprenorphine, diazepam, topiramate, pregabalin, venlafaxine and tramadol. The man said that the baclofen previously prescribed by the doctor as a muscle relaxant was not helpful. The doctor prescribed diazepam 5mg (twice a day). As buprenorphine was not available at the prison, the tramadol dose was increased.

38. When the community psychiatrist reviewed the man on 8 March, he noted that his general wellbeing appeared improved. He was still attending education and enjoying it, the diazepam had had a small but positive effect and his mood was good. The psychiatrist noted that there was no evidence of depression and the man had no thoughts of self-harm. The man was content to be discharged from the mental health list and said he would ask to see a prison doctor if problems recurred.

39. On 22 March, information was received to suggest that the man might be selling his prescribed medication to other prisoners. Searches found no evidence to support the allegation.

40. On 12 April, the man was charged with a disciplinary offence when a drawing of his victim was found in his cell. He was found guilty of the charge and given a punishment of seven days cellular confinement in the segregation unit, loss of earnings and loss of gym privileges. While segregated the man was seen daily during healthcare rounds. Dr A noted, on 20 April, that the man was receiving diazepam twice daily and that he needed to be monitored and reviewed later for possible diazepam dependence. (Diazepam is not usually prescribed long term as it can be addictive and can cause side effects.)

41. Dr A reviewed the man's medication on 3 May after the man wrote a letter to the healthcare unit saying that he could no longer cope and wanted an increase in his dose of venlafaxine. The doctor increased the dose. The man also wanted an increase in his dose of diazepam but the doctor was concerned about the possibility of dependency and decided the dosage of this drug should be reduced at a rate of 1mg a week until it stopped

altogether. The man continued to be prescribed sumatriptan, as in-possession medication.

42. Through June and July the man continued to complain about neck and shoulder pain related to his ME and also about migraines. In June, he told the prison doctor that he was fed up with the pain which made him want to self-harm, although he said he would not do so. He asked for his diazepam dose to be doubled to 10mg a day as this had worked for him in the community. The doctor suggested the man should try topical NSAID[3] and ibuprofen gel for one month. A referral was also made for acupuncture for his chronic pain. In addition, referrals were made for a review of the diazepam dose and to the mental healthcare team. The doctor considered the man's risk of self-harm and noted "agreed currently not needing suicide watch – but assess if risk changes".

43. The man was reviewed again by a prison doctor, Dr C on 5 July. He was still experiencing pain and again asked for his diazepam to be increased to 10mg a day. The doctor agreed to this, and noted the man should be reviewed by one of the senior prison doctors (Dr A or Dr D).

44. At review with a mental healthcare nurse on 9 and 11 July, the man again said that he was not getting the right medication for pain. The nurse considered that his low mood was a reaction to pain and the man said he had no thoughts of self-harm.

45. The mental health referral meeting discussed the man when the mental health team advised that they were not equipped to deal with patients needing psychological support for ME. Dr A said that Oxfordshire PCT were not commissioned to provide such a service at Bullingdon so she would refer him to the Department of Psychological Medicine.

46. On the evening of 19 July, the man said he had a migraine and asked for sumatripan tablets at E wing treatment hatch, but there were none. The nurse checked that the man had been given two packets of sumatripan three days earlier and advised the man of alternatives for managing his migraine before a review with a doctor the next day. The man responded angrily saying that his "dead body" would be found in his cell in the morning. The investigator found no evidence that ACCT procedures were considered.

47. The pharmacy technician noted in the man's medical record that the man had previously said he had lost the sumatripan tablets. She was concerned that the man was using the medication as a preventative drug rather than as treatment for a migraine attack. A doctor's appointment was suggested to review whether the medication was appropriate for him. Despite this concern, about how he was using the sumatripan, there is nothing to suggest that a risk assessment to review his suitability to have the medication in-possession was considered.

[3] Topical NSAID is a non-steroidal anti-inflammatory medication that is applied directly to the skin.

August 2012 onwards

48. On 3 August, the man told Nurse F and Officer E that he had used a joss stick to burn the letters DNR (Do Not Resuscitate) onto his chest. An ACCT was opened. His mood was low and he said he did it because he wanted to show how upset he was at his medication management. His main issue was that he believed he was not receiving the correct dosage of medication for his pain, compared to what he had received in the community. He said he had no thoughts of self-harm or suicide at present. He was placed on hourly observations and conversations and reminded of support mechanisms. A referral was made to the mental health team.

49. At the first ACCT review, the man reiterated his dissatisfaction with his medication regime and said that he was in so much pain he considered death a better option. His ACCT risk level was noted as medium and he was placed on hourly irregular observations and conversations with staff. An appointment with Dr A was arranged.

50. Around the same day, 3 August, the man wrote a letter to his community psychologist to say that he felt unsupported by the prison and he could not take much more. He said that he had asked healthcare staff for a DNR form but, as no-one had helped him, he had taken the extreme action of burning the letters DNR onto his chest. (The prison was not aware that this letter had been sent to the community psychologist. The community psychologist was on leave at the time and did not respond to the man until 3 September, after the man's death. He enclosed a copy of the man's letter with his response. The prison then intercepted the letter and became aware of its contents.)

51. At an ACCT review on 9 August, the man said that he had thoughts of self-harm because of the pain he was in. It was noted that he was due to have a review of his medication the next day. The ACCT was kept open.

52. On 10 August, the man told Dr A that he had neck muscle tension, felt stressed and asked for his level of diazepam to be increased from 5mg twice a day. He also wanted his topiramate doubled from 200mg to 400mg (although it was not noted on his medical record when this drug was initially prescribed). The man's dose of topiramate was already at the maximum licensed for migraine and so was not increased. Dr A prescribed pregabalin (100mg) and the man's prescription of diazepam was to remain at 5mg (twice a day) for two weeks and then be reduced gradually until it was stopped altogether. The man was also referred for physiotherapy and to the prison psychologist. Diazepam and pregabalin were prescribed to be administered under supervision, while topiramate was prescribed as in-possession.

53. At an ACCT review on 14 August, the man again said that he had thoughts of self-harm. He was also very lethargic. He was encouraged to continue with education, to work and to take up a hobby. His ACCT observations

continued at the same level of hourly irregular observations and conversations with staff.

54. On 15 and 16 August, the man submitted written complaints about not receiving his afternoon medication on each of these days. On 16 August, he had arranged an alternative time in the afternoon to collect his medication because he had a visit. However, when he went to collect the medication after his visit the medication had not been put aside for him.

Events in August 2012

55. On the morning of the man's death, he collected his medication as normal. He was given pregabalin, tramadol and diazepam, supervised by Nurse G. He was also given venlafaxine, as daily in-possession medication, to be taken in the morning and then later in the day.

56. The man then went to work before returning to the wing at 11.30am for lunch. Before lunch, the man told Officer C that he wanted a cell move as he was not getting on with his cellmate. He declined the officer's offer to mediate and the officer told him to pack his belongings over the lunch period and he would find him a new cell. The cell identified was one occupied by a friend of the man's and the man was happy with the proposal. The officer unlocked the man's cell around 1.45pm and the man moved his belongings to the new cell and cleaned it and mopped the floor.

57. At about 2.50pm Nurse G administered the man's afternoon medication of tramadol, pregabalin and diazepam which he took under supervision. The nurse said that the man was his usual quiet self and walked slowly away. After he had taken his medication, the man sat on one of the landing chairs and spoke to another prisoner. The prisoner told the investigator that he often chatted with the man, who had previously shown him the letters DNR, burnt on his chest and told him that if he ever collapsed in prison he did not want to be resuscitated.

58. The prisoner said that there seemed to be something wrong with the man that day. He said he looked tired, his face was pale and he had beads of sweat on his head. When he asked the man if he was okay, he nodded his head but then said "I've OD'd" (taken an overdose). The man told the prisoner not to tell anyone.

59. After being told to return to their cells, the prisoner said the man walked a short distance before becoming unsteady on his feet and collapsed. The prisoner called out and staff responded immediately. The man began to fit and Officer C shouted for a nurse and radioed a level one emergency (an emergency call for assistance from staff, including healthcare staff). This was timed at 2.52pm in the incident log. An ambulance was called at 2.55pm.

60. Officer D and Nurse G arrived within seconds. The man had stopped fitting and he was on his back on the floor. His face was grey, he was not breathing and staff could find no pulse. The nurse and the officer started

cardiopulmonary resuscitation (CPR). More nurses arrived with emergency equipment. CPR continued and the man began to breathe independently and his pulse resumed. The man was given oxygen through a face mask.

61. The prisoner told Officer C that the man had told him he had taken an overdose and this information was passed to the nurses. The man was asked if he was in pain and whether he had taken an overdose, but he shook his head to both questions. An ECG[4] check showed he had a very rapid heart rate. A prison doctor, Dr E, administered naloxone (to counter the effects of possible methadone overdose) through a canula [5]

62. At 3.18pm, the man suffered a violent fit which lasted about 40 seconds. Ambulance technicians had arrived by this time. The man was put in the recovery position and supported by nurses. After this seizure he appeared less alert than previously. He opened his eyes when spoken to, but no longer made grunting noises as he had done after the first fit.

63. The man was taken to hospital accompanied by prison nurses and two officers. He was handcuffed to one of the officers by an escort chain (a chain 1.8 metres long with handcuffs at each end attached to an officer and the prisoner). At this time the man was falling in and out of consciousness. The ambulance left the prison 3.35pm and 10 minutes later he suffered a further seizure. The escort chain was removed (and not used again) in case an electric shock might need to be delivered. However a pulse was soon found.

64. At hospital, he was taken to the resuscitation unit where his condition deteriorated quickly. He had another violent seizure at 5.05pm and, despite treatment, his death was pronounced at 5.36pm.

After the man's death

65. Officer E and Officer F were the prison's family liaison officers and visited the man's father around 7.00pm that evening and informed him of his son's death and explained the formalities for the death of someone in custody. They left contact numbers for the prison and Coroner and in line with Prison Service guidance, explained that financial assistance would be offered towards the funeral costs.

66. Debrief meetings were held for officers and nurses who knew the man and who were involved in the emergency response, and the support of the prison care team was offered. Prisoners on Edgecott Unit were informed and offered support. Officer G spoke to all prisoners on open ACCTs in case they had been adversely affected by the man's death. Listeners were spoken to and briefed about that some prisoners might need additional support. A memorial service for the man was held the next week in the prison chapel.

Medication found in the man's cell

[4] ECG (electrocardiogram) is a test that measures the electrical activity of the heart.
[5] A canula is a tube that can be inserted into the body, often for the delivery or removal of fluid.

67. A routine search of the man's cell was carried out after his death. Among a number of antiseptic creams and pain relieving gels, prison staff found the following medication. All of it prescribed to him and allowed to be kept in-possession:

- Topiramate 200mg (6 tablets) – used to control convulsions (fits) in some forms of epilepsy, is also used to prevent migraine headaches
- Omeprazole 10mg (6 tablets) – used to treat gastroesophageal reflux disease and other conditions caused by excess stomach acid.
- Paracetamol 500mg (20 tablets) – pain relief
- Benadryl – an antihistamine used to treat sneezing, runny nose, itching and other allergies.
- Sumatriptan 50mg (3 tablets) for migraine
- Ibuprofen 200mg (21 tablets) – for pain relief and inflammation caused by arthritis, muscular pains.
- Senna 7.5mg (56 tablets) – used to treat constipation.

Post-mortem report

68. The post-mortem report notes that there was no evidence that the man had any natural disease which caused or contributed to his death. Based on toxicological findings (shown below), his cause of death was found to be venlafaxine and tramadol toxicity.

69. The toxicology report included the following account:

> *"A very high concentration of venlafaxine was detected in the blood sample taken from the man. The venlafaxine concentration detected was greater than the highest calibration standard at 40 milligrams per litre of blood. Such a concentration falls well within the range of values where death has been attributed to venlafaxine overdose alone … The results show the man had taken more venlafaxine than would be prescribed.*
>
> *It should be noted that venlafaxine is a drug which is particularly susceptible to post-mortem redistribution … however this alone could not account for the very high concentration detected."*
>
> *"A high concentration of tramadol was detected in the blood sample taken from the man. The concentration falls at the lower end of the range of values where death has been attributed to tramadol overdose alone and shows he had taken more tramadol than would be prescribed …"*

ISSUES

70. The clinical review was conducted by the clinical reviewer who made four recommendations about the man's medical care. While the report draws no formal conclusion about the adequacy of the man's care, it highlights a concern that the man was prescribed a combination of medications without full, appropriate risk assessments.

Clinical care

Administration of medication

71. The man arrived at Bullingdon on 30 November 2011. He had been prescribed a combination of drugs which was confirmed two days after his arrival by his community GP. Despite this, he did not receive any medication until 7 December, a week later. The man was concerned that he had been prescribed diazepam in the community to treat his pain, but this was not prescribed until February 2012. When a new prisoner arrives at prison it is important that there is a continuity of care and that key healthcare information is obtained and the necessary action or referral is made. In the man's case, his previous medical history was obtained quickly but there was some delay prescribing his medication.

72. Once his medication was prescribed, the man attended the medication hatch daily to collect medication. He twice submitted written complaints about not receiving his medication. On these occasions he had made prior alternative arrangements with healthcare staff to collect his medication at a different time due to attendance at education or visits, but he was still unable to do so. The clinical reviewer notes that these delays could have raised the risk of him having a seizure.

The Head of Healthcare should ensure that there are no unavoidable delays in ensuring appropriate continuity of care in the provision of medication for new arrivals.

Monitoring of medication

73. The man did not have a diagnosed heart condition. However the clinical reviewer notes that the combination of medication that he was prescribed would put him at high risk of developing a cardiac dysrythmia[6]. In particular, his tramadol and venlafaxine were increased making the risk of a dysrythmia greater, particularly if any additional (illicit) medication was taken. The clinical reviewer notes that medical guidance no longer requires regular ECG[7] monitoring of a patient on venlafaxine. However it should be considered in a situation where the patient, as with the man is also taking other medications which can affect the heart. There is no evidence that this was considered.

[6] Cardiac dysrythmia (irregular heartbeat or abnormal heart rhythm) symptoms include palpitations, dizziness, fainting, shortness of breath and chest discomfort
[7] ECG (electrocardiogram) is a test that measures the electrical activity of the heart.

The Head of Healthcare should ensure that all medical practitioners are fully alert to the risks when prescribing complex combinations of drugs and are able to obtain appropriate pharmacy advice.

In-possession medication

74. The man was allowed to keep supplies of medication in his cell, although he had a history of self-harm and overdose. This increased the risk and opportunity for a self-administered overdose. There was no documented evidence that decisions about which medication the man should be allowed in his possession were based on a formal risk assessment. It is a particular concern that there is no clear record when venlafaxine was prescribed and why, a drug known to be dangerous in overdose, was given to the man as daily in-possession rather than under supervision. As the results of the toxicology report indicate that he had taken more venlafaxine than would have been prescribed, it is possible that he had stock-piled some of this medication or alternatively had illicitly obtained additional supplies from other prisoners. He also had a high amount of tramodol in his blood, above the level he was prescribed which also suggests he had either previously secreted some of this medication or obtained it from other prisoners.

75. The man had a large amount of medication found in his cell after his death which he had been allowed to keep in his possession. Including venlafaxine, all these medications are susceptible to cause overdose if stock piled and taken in more than the recommended doses. They can also have side effects such as nausea, vomiting, anxiety, seizures (fits) and cardiac arrhythmia.

76. As the man had a history of overdose, and was considered at risk of suicide and self harm it is a concern that he should have had such ready access to potentially dangerous medication without a recorded risk assessment either at the time the medication was prescribed or as part of an ACCT review. PSI 64/2011 requires ACCT case reviews to “consider and agree whether any items which the prisoner might use to self-harm should be removed from them.” This was not considered at any of his ACCT reviews. The clinical reviewer considers that there should be a presumption that no one on an ACCT has in-possession medication unless a doctor makes an explicit documented exception to this, on the basis of a clear written risk assessment.

77. At the time of the man's death there was no specific policy/guidance in place at Bullingdon for medication in-possession. A review was conducted after his death and guidance was issued to all staff reminded them that when an ACCT is opened, they should report the details to the healthcare team to enable a review of any medications that the prisoner might have in possession. In addition, the guidance notes that consideration should be given for additional reviews of medication as part of the ACCT review process. We welcome this guidance for those subject to ACCT procedures, but there is also a need to ensure that the risk associated with in-possession medication is appropriately assessed for all prisoners.

The Governor and Head of Healthcare should ensure that prisoners on medication with a high potential for harm are routinely risk assessed for any medication that is to be held in-possession.

Suicide and self-harm monitoring (ACCT)

78. The man was a troubled and unhappy man because of his imprisonment and his medical condition. These factors influenced his mood and his propensity to consider self-harm. A review of the records suggests he remained at significant risk of self-harm throughout his stay and constantly complained about pain and the effect this had on his mood. When this was recognised, he was monitored and supported under ACCT procedures with multidisciplinary input at reviews. The ACCT Caremap for the man identified his main issues as medication, employment and communication. All were reasonably addressed throughout his stay. He maintained attendance at education classes and interacted with his other prisoners, officers and healthcare staff.

Emergency response

79. The management of the man's collapse was rapid, professional, and well documented. The actions of all the staff who attended, particularly the two nurses, were commendable and ensured that he received appropriate and swift emergency care.

Restraints and security

80. The Prison Service has a duty to protect the public when escorting prisoners to outside hospital, and a responsibility to balance this with treating prisoners with humanity, maintaining their dignity. The level of restraints used should be necessary in all the circumstances. The risk assessment should consider the risk of escape and the risk to the public, also taking into account factors such as the prisoner's health and mobility.

81. Before being transferred to hospital, prison staff decided that the man would be accompanied by two officers, restrained or attached to one of the officers by an escort chain (approximate length of chain 1.8 metres). Medical opinion was sought in respect of whether there was any objections to the use of restraints, and no objections were raised.

82. Minutes before being taken to hospital, the man had had life saving resuscitation and had experienced two violent fits. He was described as barely conscious and extremely weak. Yet despite this, restraints were applied. In these circumstances, it is hard to see how any use of restraints was justified. It also seems likely that the presence of two officers would have been more than an adequate security precaution.

The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and that these factors are

fully taken into account in deciding the level of escort and whether restraints are needed.

Recommendations

1. The Head of Healthcare should ensure that there are no unavoidable delays in ensuring appropriate continuity of care in the provision of medication for new arrivals.

   The National Offender Management Service accepted this recommendation, writing:

   Advice relating to this has been given to new providers and the establishment is working with our new healthcare provider, Virgin Healthcare, to ensure that unavoidable delays in ensuring appropriate continuity of care are avoided.

2. The Head of Healthcare should ensure that all medical practitioners are fully alert to the risks when prescribing complex combinations of drugs and are able to obtain appropriate pharmacy advice.

   The National Offender Management Service accepted this recommendation, writing:

   The establishment has met with the new healthcare provider, Virgin Healthcare who are now working with the new pharmacist and the GP's to ensure that all medical practitioners have access to appropriate advice and understand the risk relating to complex combinations of drugs.

3. The Governor and Head of Healthcare should ensure that prisoners on medication with a high potential for harm are routinely risk assessed for any medication that is to be held in-possession.

   The National Offender Management Service accepted this recommendation, writing:

   An information sharing agreement exists between the establishment's healthcare provider and the establishment to ensure that information (including information that may link to risk of harm to self) is shared to ensure that when prescribing in possession medication all known risks are taken into consideration. The information sharing agreement will be reviewed with Bullingdon's new healthcare provider (who started on 1st April 2013).

   In addition to the above a notice to staff will be published to remind staff to ensure that they inform healthcare where a prisoner has a raised potential for harm (including going on an ACCT) so that healthcare can review any in possession medication.

4. The Governor should ensure that a prisoner's health and mobility and actual risk at the time are fully considered and that these factors are fully taken into account in deciding the level of escort and whether restraints are needed.

The National Offender Management Service accepted this recommendation, writing:

The Governor has informed all duty managers that when completing individual risk assessments the individual's health and mobility should be taken into account when deciding the level of escort.