Investigation into the circumstances surrounding the death of a prisoner on 30 June 2005 at HMP Ranby

Report by the Prisons and Probation Ombudsman for England and Wales

January 2006

This is the report of an investigation into the circumstances surrounding the death of a prisoner, on 30 June 2005 at HMP Ranby. The prisoner, who was 34, was found dead in bed in his cell when prisoners were unlocked for breakfast.

My colleagues and I would like to extend our condolences to his family and friends for their sad loss.

The post mortem toxicology report confirmed that the cause of death was an overdose of co-codamol. Although he had been prescribed co-codamol and solpadol to treat back pain, traces of other medications, not prescribed for him, were also present in his blood. The post mortem findings have raised serious concerns regarding the prescribing of codeine-based medications in Ranby and the management of medication prescribed for prisoners to hold in their own possession. The prisoner had a long standing history of drug misuse.

One of my investigating officers, conducted the investigation, I am grateful to the Bassetlaw Primary Care Trust who carried out the clinical review and for the opinion of an independent expert, who reported on the prescribing of codeine-based medication. I would also like to thank Ranby prison who ensured that all relevant information was available to my investigator.

I have found no suggestion that the prisoner intended to kill himself; the suggestion is very strongly that he engaged in the reckless abuse of whatever drugs he could chance upon.

Stephen Shaw CBE
Prisons and Probation Ombudsman **January 2006**

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Summary

The prisoner was 34 years old when he died on the 30 June 2005, while in custody at Ranby. He was serving a six year sentence for robbery, dangerous driving and driving while disqualified.

Prison staff were alerted to attend to the prisoner by a fellow prisoner, who at approximately 8.10am summoned staff assistance to his cell. A prison officer arrived at the cell and immediately called for help from other staff. She then radioed to the control room calling for urgent medical assistance.

Health care officers attended, but they were unable to save the prisoner as it appeared he had been dead for some time. His body was in an advanced state of rigor mortis and therefore they did not attempt cardio pulmonary resuscitation (CPR).

The Bassetlaw Primary Care Trust (PCT) carried out a clinical review. The Area Drugs Co-ordinator, Prison Service East Midlands Area, carried out a review of the prescribing procedures for codeine at Ranby. They focus in particular upon the levels of prescription for codeine-based medication at the time of the prisoner's death and management and control of in possession medication generally.

The post mortem toxicology findings confirmed that his death was the result of an overdose of co-codamol,[1] an analgesic medication prescribed to him on 20 June.

This report endorses the recommendations made by the clinical review team from the Bassetlaw Primary Care Trust and the Area Drugs Co-ordinator and makes three further recommendations. It also identifies one area of good practice.

[1] Co-codamol is one of a number of pharmaceutical products which contain codeine phosphate 30mg and paracetamol 500mg. These products are 'prescription only' medicines.

Investigation Methodology

From the beginning, the cause of death was suspected to be drug related. Notices to staff and prisoners were sent to the appointed liaison officer at Ranby, to be displayed around the prison. These announced the investigation and invited staff and prisoners to submit to my investigator any concerns or views they wished to express.

Pending further investigation by the pathologist who undertook the post mortem, my investigator visited Ranby. He was given a tour of the prison visiting all relevant areas of J and K wing, talking to staff involved and meeting with the Governor. My investigator was given access to all the prisoner's records, including his medical records and all other relevant documents. This subsequently included gathering a substantial amount of statistical data which was pertinent to the issues of the prescribing of codeine-based medication and its ramifications.

The Bassetlaw Primary Care Trust carried out a clinical review of the management of the prisoner's health needs while in custody. The Area Drugs Co-ordinator, carried out a review of the prescribing of codeine-based medication at Ranby.

One of my family liaison officers contacted the prisoner's sister, who told my liaison officer that a prisoner at HMP Buckley Hall was considered by the family to be the prisoner's partner and nominated next of kin. My liaison officer and investigator visited HMP Buckley Hall. She said that she did not have any issues she wanted to raise about the prisoner's death. However, she did say that she did not believe that he intended to take his own life, but most likely had overdosed accidentally.

Some changes to what this report says about family liaison were agreed following comments from the Prison Service on an earlier draft.

Background

The prisoner

The prisoner was born in Sheffield on 6 September 1970. He was 34 years old when he died on 30 June 2005 at HMP Ranby while serving a six-year sentence for robbery, dangerous driving and driving while disqualified. He was divorced from his wife of ten years with whom he had two children.

He was taken into custody on 14 October 2004 and initially held at HMP Doncaster. He was convicted and sentenced on 16 December 2004 and on 8 February 2005 he was transferred to Ranby. His partner, who was his co-defendant, was also imprisoned and at the time of his death she was in Buckley Hall.

While at Ranby, he was treated for various medical problems including sciatica, lower back pain and a bleeding peptic ulcer.

He was a self confessed drug user, regularly taking crack cocaine and heroin, often by intravenous injection. It is probable that he was still actively involved in taking

drugs while in custody, given the anecdotal evidence from his partner. At Doncaster, he had a positive drug test result and due to his involvement in illicit substances was subject to closed (non-contact) visits. He remained on closed visits until his transfer to Ranby.

Ranby Prison

Ranby is a category C male adult training prison, near Retford in Nottinghamshire. It was converted in the early 1970s from its original use as an army camp. While some old billets remain, purpose built accommodation has since been added. It has an operational capacity (maximum crowded capacity) of 1,038, a certified normal accommodation of 912 and a typical daily population of 950 prisoners.

At the end of March 2005, Ranby was given a Prison Service performance rating of level three - "meeting the majority of targets, experiencing no significant problems in doing so, delivering a reasonable and decent regime".

Ranby was last inspected by Her Majesty's Inspectorate of Prisons on 29 – 31 March 2005 when it was subject to an unannounced visit. In her subsequent report, the Chief Inspector, commented that Ranby had made considerable progress since the last full inspection in 2002. However, it is of relevance to my investigation that she added:-

> "Overall, there were better systems for ensuring the safety of prisoners. The major area of continued concern was healthcare, particularly the pharmacy. Healthcare lacked effective clinical leadership, and some pharmacy systems, which we had described as unsafe and possibly illegal at the time of the last inspection, were still in place."

Events leading up to the prisoner's death

The prisoner was on remand at HMP Doncaster from 14 October 2004 until 16 December 2004. He was then convicted and sentenced to six years imprisonment and returned to Doncaster. During his time at Doncaster, he was assessed in relation to his drug habit and offered a detoxification programme. However, he refused the medication offered with the exception of symptomatic relief for gastro-intestinal discomfort. He was transferred to Ranby on 8 February 2005.

He had been receiving co-codamol on a weekly basis since 14 April 2005 for chronic lower back pain and arthritic toes.

On 20 June, he was prescribed a 14 day course of co-codamol in possession. He saw the doctor on 29 June, and said he had taken the medication all at once. The doctor doubted this was the case, and believed he might have sold the drugs. He instead prescribed solpadol[2] on a weekly basis. He asked the healthcare officer to issue this daily. He indicated this on the top of the prescription record, but not in the medical record.

[2] Solpadol are effervescent tablets containing phosphate and paracetamol 500mg. Solpadol and co-codamol are pharmacologically identical but only solpadol tablets are effervescent.

The doctor said the prisoner was put on sleep watch, as he was asking for sleeping tablets and the doctor wanted to see if they were needed.

Later that day, an Officer issued him with a week's supply of solpadol despite the annotation on the prescription chart by the doctor.

Events of 30 June 2005

On the morning of 30 June, an officer was unlocking the cell doors on the third landing on J and K wings. At approximately 8.10am, she was alerted to cell K329 by a prisoner who said that the prisoner was frothing at the mouth. She opened the cell door and could see him lying on his back in his bed and that he was indeed frothing at the mouth. The officer called to another officer, who was out on the landing, who in turn alerted the senior officer.

At 8.11am, the first officer called a code red on her prison radio. A code red is a term used over the radio at Ranby to alert healthcare staff that there is a medical emergency taking place and that their help is required. The senior officer and the second officer arrived at the cell and checked for a response from the prisoner, while the first officer escorted the other prisoner back to his cell and arranged for him to be comforted by a friend. She then returned to the ground floor where she met healthcare officers as they arrived on the wing. They went straight to the cell.

The healthcare officers found that the prisoner had no pulse and was not breathing. His body was cold and his pupils were fixed and dilated. Rigor mortis was in an advanced state. In his incident report, one of the healthcare officers said that he thought the prisoner had been dead for some hours and advised that a doctor should be called to certify the death.

The other healthcare officer gave a similar account in his report, but he also noticed that the prisoner had a small amount of white foam on his lips, and that there were six empty single dose solpadol sachets on the prisoner's bedside cabinet.

Events following the discovery of the prisoner's body

At 8.25am, all the staff left the cell and the cell door was locked and sealed with an officer remaining outside the cell door as log keeper. His responsibility was to keep a record of anyone entering the cell and to keep the area sterile and secure.

A sergeant and a police constable from Retford police arrived and entered the cell at approximately 9.40am and left a few minutes later. At 9.50am, the doctor and healthcare principal officer arrived and the doctor confirmed that the prisoner was dead. A police inspector and a sergeant arrived and entered the cell at 10.08am leaving a few minutes later. At 12.04pm, the scenes of crime officer and police doctor arrived at the cell to check for forensic details, leaving at 12.26pm. The funeral directors arrived at 3.20pm and removed the prisoner's body from the prison.

Prison Service Order 2710 sets out what action must be taken following a death in custody. Chapter 5 sections 3 and 4 both state that an immediate post incident

debrief or (hot de-brief) should be carried out before the staff involved go off duty. On this occasion this was not carried out. However, support for the staff has since been offered by the Head of Programmes/Psychology, and this was continuing during my investigation.

Within the local contingency plans it states that all persons involved should complete an incident report. Individual incident reports were not completed until my investigator alerted the Governor to the omission.

A post mortem examination was carried out at the University of Leicester on 30 June. Although initially unable to establish the cause of death, the pathologist suspected it was drug related and asked for a toxicology report. It was received on 21 September and led the pathologist to conclude that the cause of death was an overdose of co-codamol.

Contacting the prisoner's family

Following the death of the prisoner, the decision was taken by the Governor that because the prison's family liaison officer was not on duty, the prisoner's sister, would be contacted and informed by South Yorkshire Police. She informed the prison that a serving prisoner at Buckley Hall, was the prisoner's partner, and considered by his family to be his nominated next of kin.

Prison staff at Buckley Hall, informed his partner of his sad death, and prompt arrangements were made for her to attend his funeral. She was given access to the prison chaplaincy team when she felt she needed to speak to them.

Clinical Review

Bassetlaw Primary Care Trust completed a clinical review into the care of the prisoner at Ranby. During the course of the review, they interviewed the prison doctor and healthcare officers who were involved. They also reviewed all the available medical documentation.

Their report concludes that there was a poor standard of clinical record keeping. The patient's excess taking of co-codamol, the changing of his medication and the dosage had not been recorded. The report stated that this was unacceptable and suggested that the medical records could be computerised to allow all notes to be read and completed to an acceptable standard.

The reviewers criticised the manner in which medication was dispensed and the forms used to record the information. They concluded that for some reason the instruction to dispense solpadol daily was not carried out. The dispensing forms do not include a section indicating that a drug should be issued daily. They concluded the form required amendment and the prescribing system should be computerised.

The term sleep watch used at Ranby is not a medical observation and appears an inappropriate way of gauging whether sleeping tablets should be prescribed or not. However, the reviewers stated that this issue did not appear to have had an impact in this case.

Independent of the clinical review, the area drugs co-ordinator for the Prison Service in the East Midlands, examined the prescribing of codeine- based medication at Ranby. Following a routine monitoring visit in May, the area Manager's staff officer had brought to her attention that there was a high level of prescribing of codeine-based preparations. 15% of Ranby's population were being prescribed a codeine-based preparation which was a cause for concern. Staff suspected that prisoners were trying to mask their heroin use by obtaining a prescription for codeine-based medication. It is not always possible for mandatory drug testing (MDT) or voluntary drug testing (VDT) to differentiate between heroin and codeine. Codeine could also be traded to other prisoners.

The area drugs co-ordinator made a number of detailed recommendations to improve the management of medication at Ranby.

Findings and Conclusions

The clinical reviewers found that the prisoner appeared to have received medical care of the standard they expected. However, they concluded that the quality of the continuous medical record was poor.

The post mortem report concluded that the cause of death was an overdose of co-codamol. The analysis of the post mortem blood samples showed not only the presence of a codeine level above the quoted lethal range but also the presence of other therapeutic medications not prescribed to the prisoner. These were amitriptyline, a tricyclic antidepressant, and carbamazepine, an anti-epileptic agent, both of which were present below the therapeutic range. Mirtazepine, another antidepressant drug, was present at a level within the therapeutic range. In addition, traces of ibruprofen, mefanamic acid and diclofenac which the prisoner had been prescribed at some time previously were detected as well as olanzepine, tramadol and metoclopromide which he had never been prescribed. The picture which emerges from these findings is one of someone who would take medication indiscriminately.

Examination of statistics, performance data and security reports from Ranby showed that, in the quarter ending in June 2005, the rate of positive mandatory drug tests (MDT) was running at 12.75 %. This was more than double the annual performance target of 6 %. Subsequent action taken by the management of the prison caused the prescribing of codeine- based medication by the doctors to be significantly curtailed. In July and August, the rate of positive MDT was 5.88 % and 4 % respectively. The prison report on the results for August 2005 concluded that:-

> "The decision to reduce the amount of codeine-based medication issued from health care has had a great impact on the amount of positive opiate results."

There was evidence in the performance reports examined by my investigator that there was a trade in prescribed medication with associated bullying, intimidation and theft. The potential for these behaviours to occur is escalated when in-possession medication procedures are unmanaged. In the prisoner's case, the latest instruction was to issue his medication daily but this was not followed. The Chief Inspector of

Prisons reported earlier this year that the health care service at Ranby, particularly the pharmacy, gave her great cause for concern. Recommendations about pharmacy services made in 2002 had not been fully acted upon.

South Yorkshire police delivered the news of the prisoner's death to his sister in the first instance. I do not generally consider it appropriate to use the police to inform family members of the death of a loved one. The Prison Service's newly revised guidance, Liaison with Bereaved Families Following a Death in Custody (Prison Service Order 2710), explores the issues to be considered when taking the decision on how news of a death in custody is to be delivered. The Prison Service Order (PSO) recommends that the news is broken to a family as soon as possible after the death, face to face, by a dedicated family liaison officer along with the chaplain, Governor or most senior individual available. The use of police officers to break the sad news is not encouraged as they may not be trained in breaking the news of a death and may have no knowledge of how prisons work. This can leave the family with lots of unanswered questions and with an impression that the Prison Service is not taking the death seriously. The new policy did not come into force until 4 January 2006, and so was not in operation at the time of the prisoner's death. I hope that management at Ranby will consider the new policy and develop local guidance in line with the approach it recommends.

Recommendations

I support the recommendations of the clinical reviewers from the Bassetlaw Primary Care Trust (PCT), which can be summarised as:

1. To improve the standards of medical records and record keeping.

2. To amend and improve the dispensing forms and computerise the prescribing system.

3. Although it did not appear to have an impact on the prisoner's case, the use of the procedure known as 'sleep watch' appeared to be an inappropriate way of gauging whether sleeping pills should be prescribed.

4. There should be procedures to minimise the sharing of prescription medications.

In company with the clinical reviewers, I support the detailed recommendations of the area drugs co-ordinator, which were in summary:

1. For the Governor, Director of Bassetlaw PCT, Healthcare Manager and representative from Prison Health Development team to address the issue of prescribing codeine-based medications.

2. For the healthcare manager to secure the co-operation of the doctors and provide ongoing support to them in implementing changes in prescribing.

3. For healthcare to provide a regular report at monthly Drug Strategy meetings on numbers of prisoners being prescribed opiate-based medications.

4. To reduce trade in prescribed medications.

5. To consider the option of stopping all in-possession opiate-based medication.

6. To require prisoners to sign a medication compact and carry out audits to ensure compliance, i.e. they have the correct amount of medication in possession.

I recommend that the PCT in partnership with the Governor and head of healthcare should consider the early implementation of these recommendations.

I recommend that the local contingency plan for handling a death in custody be reviewed to ensure that the requirement for incident reports be made more prominent, thereby raising the likelihood of timely compliance.

I further recommend that the post incident de-brief procedure in the local contingency plan be placed within the section labelled Support for Staff and Prisoners on the front page of the document. This should ensure that incident

commanders are aware that this is an important part of the support system designed to care for those involved in a death in custody.

Finally, I recommend that the prison reviews its arrangements for breaking the news of a death in custody to bereaved relatives, to ensure that this is normally done face to face by prison staff.

Good Practice

The use of the term Code Red to summon help to serious medical emergencies is good practice, as everyone carrying a radio and those within hearing distance of a radio will know what help is needed.