

**Investigation into the circumstances surrounding the  
death of a man  
at HMP Brixton in July 2010**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**January 2012**

This is the report of an investigation into the circumstances surrounding the death of a man who died in HMP Brixton aged 52 years. He was on remand and had been in the prison for eight days.

The investigation was led by one of my senior investigators. A family liaison officer from this office maintained regular contact with the man's sister throughout the investigation. I would like to thank her for her patience during a protracted investigation and offer her my sincere condolences for her loss.

A clinical review was commissioned from NHS Lambeth, who appointed a clinical reviewer to conduct the review. Prompted by the results of the post mortem and toxicology reports, I requested a further specialist review from NHS Lambeth of the detoxification medication given to the man while at Brixton. I am very grateful to the further clinical reviewer for her very detailed and expert report.

I am also grateful to the liaison officer at HMP Brixton for my investigator and to the Governor and staff for their co-operation with the investigation.

The key issue in this case is the detoxification regime offered to the man at Brixton. He gave apparently contradictory and false information to healthcare staff about his drug use. He was given methadone and diazepam based on this information and the results of his urine screen. However, the urine screen was not a reliable indicator of his drug use because he had received opiate based painkillers and diazepam in the police station the previous day.

I am not unsympathetic to the pressures faced by busy, overcrowded local prisons dealing with increasingly high numbers of prisoners requiring detoxification. Nevertheless, the man did not have his detoxification reviewed by a prison doctor in Brixton and no corroborative evidence of his treatment for substance misuse was sought from medical professionals in the community who knew him. Both of these omissions are contrary to Brixton's own policies on detoxifying prisoners. The second clinical reviewer's report concludes that methadone in combination with diazepam may well have contributed to the man's death. The exact cause of death will not be established until the Coroner's inquest, and may indeed never be known. This case serves as a reminder of the vital importance of making clinical decisions based on accurate information.

I make 16 recommendations as a result of this investigation. I make one recommendation to the Governor to instruct a prison doctor to attend all code one emergencies. The others relate to de-toxification practice and record keeping.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Thea Walton  
Acting Deputy Ombudsman

January 2012

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## SUMMARY

1. The man was 52 years of age, originally from Scotland, who had spent the majority of his life in the South West of England and in London. He had been an alcoholic for some 34 years and also had a past history of using heroin and non-prescription diazepam.
2. Between 29 December 2009 and 21 January 2010, the man's GP records show that he was prescribed methadone. This is the last time his GP records mention methadone.
3. On 14 April 2010, the man registered with a centre which is a charity for the homeless. He said that he was a heavy alcohol consumer but did not abuse any other substances. His keyworker said she did not know of any past or present drug use by him and he was not on methadone between April and July.
4. On 9 July 2010, the man was arrested by police and charged with common assault. He told police that he was heroin and alcohol dependent. He was examined by a Forensic Medical Examiner (FME) early on 10 July who judged him to be withdrawing from opiates. He was given two 30mg dihydrocodeine tablets (an opioid painkiller) and two 5mg diazepam tablets (a benzodiazepine used to treat anxiety and alcohol withdrawal).
5. The man was remanded into custody at HMP Brixton later the same day. It was not his first time in prison. On reception he told a nurse that he was heroin and alcohol dependent and that he had last taken methadone five months previously. He tested positive for opiates and benzodiazepines. He was given first night opiate dependence medication and started on methadone titration the next day. I have seen no direct documentary evidence that he saw a GP during his time in Brixton (although I accept that he did) nor that information about his drug taking was sought from his community GP.
6. At approximately 8.52am on a day in July, the man was found unresponsive on the bed in his cell. An emergency was called and healthcare staff administered cardio pulmonary resuscitation for some 35 minutes. Paramedics relieved them when they arrived and pronounced him dead. There was a long delay before the ambulance was called but I judge that this did not affect the man's chances of survival. In all other respects the emergency response was very good. Brixton's family liaison was of an exemplary standard.
7. A clinical review of the medical care received by the man at Brixton makes several recommendations which I endorse. These relate to referrals to the GP, seeking corroborative evidence from the community and record keeping.
8. Following the results of the post mortem and toxicology reports I requested a specialist review of the detoxification regime given to the man. This review concludes that methadone in combination with diazepam may well have

contributed to his death. It also raises concerns about the fact that he did not see a GP at Brixton to review his detoxification regime and that no corroboration from community sources was sought to establish his alcohol and drug intake. This review also makes several recommendations which I endorse.

9. The man's case highlights issues faced by busy, overcrowded local prisons with a high number of new prisoners requiring detoxification. The exact cause of the man's death is a matter for the Coroner's inquest to decide, but clearly there are lessons to be learned.

## THE INVESTIGATION PROCESS

10. The Ombudsman was notified of the man's death on 17 July 2010. The investigation was allocated to a senior investigator on the same day. Notices were issued to staff and prisoners at Brixton telling them that an investigation would be taking place, and inviting those who wished to see the investigator to make themselves known. The investigator did not receive any response to these notices.
11. The investigator visited HMP Brixton on 22 July and met with the Governor, the Deputy Governor and the prison liaison officer. She visited the man's cell on G wing and spoke informally to the officer who had found the man on the day of his death. The investigator read through the man's prison record and collected copies of relevant documents. She spoke by phone to the officer who had entered the man's cell with his colleague.
12. The investigator also spoke to the mental health worker who had worked closely with the man at the centre which is a charity run for the homeless. She also liaised extensively with the detective sergeant from Brixton CID and visited Brixton Police Station to view the police evidence and photographs taken by the scene of crime officers.
13. A clinical review of the man's medical care was commissioned from NHS Lambeth. A clinical reviewer was appointed to undertake the review and the investigator discussed the nature of the investigation with her.
14. The post mortem and toxicology reports were received from the Southwark Coroner on 29 November 2010. After reading these, it was decided to ask NHS Lambeth to commission a further specialist review of the detoxification medication given to the man while he was at Brixton. A further clinical reviewer was appointed and I received her report on 31 March 2011.
15. On 3 December 2010, the investigator spoke to the Governor to update her on the results of the post mortem and toxicology reports. She spoke to the acting Governor on 13 January to tell him that a specialist review had been commissioned from a clinical reviewer and was expected to be completed by the end of March.
16. One of my family liaison officers contacted the man's sister and explained the investigation process. The man's sister asked for as much information as possible about the circumstances of her brother's death. My family liaison officer maintained contact with the man's sister throughout the investigation.

## HMP BRIXTON

17. Built in the Victorian era, Brixton is a local prison serving the magistrates' courts of South London and Inner London and Southwark Crown Courts. It has a certified normal capacity (uncrowded capacity) of 500 but typically houses between 725 and 775 remand and convicted adult males. Many share cells designed for single occupancy. The prison comprises four main residential units. G wing, where this man was located, holds 222 prisoners in 151 cells and is the specialist substance misuse unit. Prisoners undergoing detoxification are held on the top floor (known as 'the fours' landing).
18. NHS Lambeth commissions primary healthcare and substance misuse services for the prison from Care UK. Care UK subcontracts the substance misuse services to South London and Maudesley NHS Foundation Trust (SLaM). Since 2007, Brixton's substance misuse service has adopted the Integrated Drug Treatment System (IDTS). The service is busy and caters for some 150 prisoners at any one time. It is led by a primary healthcare team consisting of one lead nurse, eight nurses and two healthcare assistants. There is also sessional input from General Practitioners (GPs). In common with other London prisons, Brixton is reliant on a number of locum GPs.
19. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Brixton in a full unannounced follow up inspection in December 2010. HMIP's report found that Brixton was chronically overcrowded. About half the population were remand prisoners and two out of every five prisoners surveyed said they had drug dependency issues. The most frequently identified safety issue at Brixton was the availability of illicit drugs. HMIP observed the, "Excellent interaction between IDTS nursing staff and prisoners" and good relationships between discipline staff and those receiving treatment.
20. Every prison has an Independent Monitoring Board (IMB) made up of local people whose job it is to monitor standards to make sure prisoners are being treated fairly and humanely. Each IMB is required to report every year on their findings. In their most recent report, for the period 1 July 2009 to 31 August 2010, the Brixton IMB noted that there had been an increase in the number of prisoners arriving with drug dependency to about 140 a month. In addition the number of prisoners with alcohol dependency had increased by 100% from two years previously. The IMB noted however, that services for prisoners detoxifying had been reviewed and improved and that they were now located on a dedicated landing on G wing.
21. The previous death at Brixton investigated by the Ombudsman was that of an apparently self-inflicted death in March 2008. There are no common themes between that death and the man who is the subject of this report. There have been three deaths at Brixton since the man died – all from natural causes. In one of them the Ombudsman has commissioned a specialist review of the prisoner's detoxification regime in the light of the findings of the post mortem and toxicology. The report has not yet been received or any conclusions made in that case.

## KEY EVENTS

22. The man was born just outside Glasgow in January 1958 but had lived in the South West of England and London for a significant part of his adult life. He was only infrequently in contact with his family and his itinerant lifestyle made it hard for them to stay in touch. His sister had not seen him for some nine years. She said that as a young man he worked on oil rigs and also as a chef. He was a good artist and enjoyed drawing and playing the guitar.
23. The man told health workers in the community that he had been dependent on alcohol for some 34 years. His family remember that he started drinking heavily much more recently than this. They were not aware that he ever used heroin. The mental health worker who had close contact with the man in his final months, remembered him as an alcoholic who desperately wanted to stop drinking.
24. The specialist review written by the second clinical reviewer instructed in this case goes into considerable detail about the man's medical treatment in the community between 2009 and July 2010. In summary, he was in receipt of a methadone prescription during the latter months of 2009. Between 29 December 2009 and 21 February 2010, his drug and alcohol addiction problems were managed by staff at a hostel. His GP records for this period show that he was in receipt of a prescription for methadone but this was discontinued after 21 January 2010. This is the last time his GP records mention methadone.
25. On 14 April, the man registered with a centre of the charity which helps homeless people. He reported that he drank heavily but did not abuse any other substance. The next day he was assigned to the complex needs mental health worker. She told the investigator that the man was a regular visitor to the day centre. He attended the alcohol group and said he was anxious to undergo alcohol detoxification. She said she had no knowledge of any past or present drug use by the man and he was not on methadone during the period she knew him between April and July.
26. On 9 July 2010, the man was arrested by police after kicking and punching another man. He was taken to a police station and charged with Actual Bodily Harm (ABH). His custody record shows that he told police that he was heroin and alcohol dependent. The police decided he should be watched every 30 minutes. He was examined by a Forensic Medical Examiner (FME) in the early hours of 10 July who judged him to be withdrawing from opiates. He was given two 30mg dihydrocodeine tablets (an opioid painkiller) and two 5mg diazepam tablets (a benzodiazepine used to treat anxiety and alcohol withdrawal).
27. Later in the morning of 10 July, the man attended a magistrates' court and was remanded into custody and taken to HMP Brixton. His Person Escort Record form (PER – the booklet accompanying a prisoner between police, court and prison that highlights risk factors and records a persons money and

property) recorded that he was an alcoholic and heroin addict (section unsigned).

28. On arrival at Brixton, the man went through the initial reception screening process. A cell sharing risk assessment form (CSRA) was completed by reception staff. It was noted that he required detoxification and that he found it hard to share a cell as he became agitated and angry. The part of the form dealing with healthcare issues was signed by a prison doctor and dated 11 July. At draft stage the prison alerted the investigator to the fact that this doctor was not on duty on 11 July. It is therefore assumed that he did see the man on 10 July but wrote the incorrect date on the CSRA in error.
29. The man was interviewed by a nurse for his initial health screen. As part of the health screen, he gave a sample of urine for a drug screen which gave a positive result for opiates and benzodiazepines but negative for cocaine, cannabinoids, methadone and buprenorphine. The man told the nurse that he had been prescribed methadone five months ago. He also said that he suffered from epileptic fits but was unsure whether these were related to his alcohol or drug dependence. The nurse booked him an appointment with a doctor based both on this information and on concerns that he was dependent on heroin and diazepam. He also noted that the man had a long standing alcohol dependency. He denied ever injecting drugs.
30. A further entry was made in the man's electronic medical record in the afternoon of 10 July at 4.30pm. The entry was made using a particular nurse's log on details. This nurse told the clinical reviewer at interview that she had not made this entry. She said that it might have been made by one of the locum doctors who would not have been given his own log on. The nurse did not know which doctor might have made the entry. In the light of the representations referred to in paragraph 28 it seems likely that the entry was made by the prison doctor following the CSRA. In the entry, it was recorded:

"On 55mg methadone daily, to be assessed regarding his methadone need tomorrow morning, 1<sup>st</sup> night opiate dependence medications given. Needs single cell as he gets easily agitated and aggressive."
31. The man was interviewed a substance misuse nurse the following morning on 11 July. The nurse recorded in the man's electronic medical record that he had a history of heroin misuse since 1985. He recorded that the man told him he was actively dependent on heroin and had last smoked about £40 worth on 9 July. The nurse also recorded that he claimed to be dependent on benzodiazepines, using 30-40mg of non-prescribed street drugs daily. The man told him he had last taken benzodiazepines on 9 July. The nurse assessed him as dependent on heroin and benzodiazepines and wrote that he should be given methadone titration (where a small dose of the drug is given and the amount adjusted according to withdrawal symptoms) for seven days and benzodiazepine detoxification for 11 days.

32. It does not appear from the record that there was any consultation with a doctor. However, an appointment was booked for the man to see one within a week and he was also referred for an arthritis consultation.
33. The man's electronic medical record shows that his pulse and blood pressure was monitored twice daily on 12 July, and once on 13 and 14 July. This monitoring is a standard requirement for patients during the first 72 hours of detoxification.
34. The only entry on the man's P NOMIS (the Prison Service's electronic record) during his time in Brixton was dated 15 July. It was a 'red entry' (denoting a warning given by staff) recording that he had been warned about using his cell bell at night to ask for tobacco. The cell bell records show that he did not use his cell bell at all after this date.
35. On 16 July, the man attended a magistrates' court and was again remanded into custody. Because of this court appearance, he missed his scheduled appointment with a prison GP. In a statement to the detective sergeant at Brixton CID, a fellow prisoner at Brixton said that he was working on C wing on the same day. He was employed as a Listener (a prisoner trained and supported by the Samaritans to offer a confidential listening service to other prisoners) and had been asked to go to G wing to speak to another prisoner. The man was in the holding cell having returned from court and he and his fellow prisoner were escorted over to G wing together by an officer.
36. As they passed through the G wing gate, the fellow prisoner said he noticed the man lean against the wall and bend to his knees. The fellow prisoner said it looked like he "needed a breather". He said he asked the man if he was OK and he replied that he just needed a little rest. The escorting officer then also asked the man if he was OK and he said that he was. As they walked into the main area of G wing, the fellow prisoner said he and the man were alone. He introduced himself as a Listener and asked the man if he would like to sit down for a chat. The man said he didn't want to sit down so they just chatted where they stood. The man told his fellow prisoner that he had a "terrible headache" and explained that he had previously had a brain operation. The fellow prisoner asked him if he wanted to see a doctor and he said he didn't but just wanted to get back to his cell. The fellow prisoner said the man was not at all interested in seeing a doctor.
37. The escorting officer said in his statement that he remembered the man walking slowly and that he was "a little unsteady on his feet". As they were walking, the man told him that he had a headache. The officer asked him if he had seen a nurse or doctor and he replied that he hadn't but that he would be OK. He also asked the man if he wanted any painkillers and he said that he did not and was "fine". He told him that he had staples in his head from a previous operation and suffered headaches as a result. The officer reminded him that he could ask night staff for painkillers if he wanted them later and the man said he would "sleep it off". As they walked onto G wing he leant against a wall as if he was tired from the walk. The officer said he asked him if he

was OK and the man said he just wanted to get to his cell so he could go to sleep.

### **The events on the day of the man's death**

38. An officer came on duty on G wing at about 7.30am. In her statement to the detective sergeant she said that she was tasked with the job of 'movement officer'. This meant that her first responsibility was to check all the prisoners on open ACCTs (Assessment Care in Custody and Teamwork is the Prison Service's system for monitoring prisoners thought to be at risk of suicide or self-harm). She did this and then began her second task, which was to count all the prisoners on the four landings of G wing to make sure that the number of prisoners tallied with the count performed by night staff at the end of their shift. (This is a visual check and she was not required to get a response from any of the prisoners.) The officer said she began her count on landing four where the man's cell was. She estimated that she began her roll check between 7.45am and 8.00am. She remembered seeing the man in his cell. She said he was lying on his back apparently asleep. Nothing about his position gave her cause to suspect anything was wrong.
39. At 8.50am, an officer unlocked the man's cell as part of the routine morning unlock of prisoners on medication. In his statement to the detective sergeant, the officer said that he stood in the man's cell doorway and said, "It's time for your morning medication". He received no response and, presuming the man was still asleep, he shouted his name loudly. After again receiving no response, the officer took a step into the cell and noticed that the man was lying on an unmade bed wearing only his trousers and that he did not appear to be breathing. He then shouted to his colleague who was unlocking other prisoners on the landing.
40. The officer who had first found the man said that, as soon as he knew that his colleague was on her way, he went into the man's cell and noticed that he was grey/blue in colour and that his lips were blue. The officer said he also noticed a small amount of white residue around the man's mouth and that his mouth was open. He told my investigator that he could see no sign of disturbance in the man's cell and that he was lying on his bed as if asleep.
41. The officer's colleague entered the cell and the officer who had first found him checked the man's neck for a pulse. He said he could not find one and the man's neck felt cold. The second officer to enter the cell said, in her statement to the detective sergeant, that she too noticed the white residue around the man's mouth. She said he appeared lifeless. She said both her and her colleague were repeatedly calling the man's name loudly. She then left the cell and began to lock those prisoners already out back into their cells. At the same time, the officer who had first found the man used his radio to call the control room. He said he called a 'code one', which is the local code which alerts staff that there is a person not breathing and not showing any signs of life. The control room put out a call to the emergency response nurse. The officer said he then shouted for assistance from other staff.

42. The officer who had first found the man said he went back into his cell and got out the protective face mask he carried on his belt. As he put it on the man's face, the emergency response nurse came into the cell. He said in his statement to the detective sergeant that he received a call to go to a "code one on G4 landing" at about 8.55am. He said he went as quickly as possible to the man's cell and took his first aid kit with him. He could find no signs of life.
43. A nurse said in his statement that he was standing at the G wing medical hatch with the emergency response nurse at about 8.55am when he heard the call on the radio for the emergency response nurse to attend a code one on G4 landing. He said that the emergency response nurse went up to the fourth landing immediately and he paused only to lock the medical hatch before following him. When he entered the man's cell, the nurse said he saw the emergency response nurse moving the man's arms. From the restricted movement in the man's limbs, the nurse said he recognised rigor mortis was present. The nurse said he and the emergency response nurse decided to begin cardio-pulmonary resuscitation (CPR). They were immediately joined in the cell by a third and fourth nurse. The nurse and the emergency response nurse alternated giving the man chest compressions while the third nurse gave rescue breaths using an ambu-bag (a bag and mask attached to an oxygen cylinder).
44. A defibrillator (a portable electronic device that automatically reads cardiac output and advises what to do) was attached to the man and advised that CPR continue. (This is because the machine could not detect a heart rhythm that would respond to an electric shock.) The nurses continued CPR for some 35 minutes until paramedics from the London Ambulance Service arrived in the cell and instructed them to stop. The paramedics then pronounced the man dead. The records obtained from the London Ambulance Service show that the ambulance was called at 9.25am and the first responder arrived at the prison four minutes and 13 seconds later at 9.29am.

### **Hot debrief**

45. The Governor held a hot debrief (a meeting held at the first opportunity after a serious incident to identify those involved and make sure they are OK) in the late morning of the man's death. It was attended by all of the staff who responded to finding him that morning. Staff spoke about their actions. The prison Chaplain attended in his capacity as member of the prison's Care and Welfare Team. The Governor noted that there had been a delay in the ambulance being called after the code one emergency was called over the radio.

### **Family liaison**

46. The prison Chaplain was appointed as family liaison officer. The man had given his mother as his next of kin, with an address for her in Glasgow. The prison Chaplain contacted the local police force there and asked them to visit

the address and inform the man's mother of her son's death but they found that sadly his mother had died in April 2010. The police did however manage to trace the man's sister and passed her details to the prison Chaplain.

47. The prison Chaplain contacted the man's sister by telephone on 21 July and had a long conversation with her. He told her that the prison would cover her brother's funeral expenses and he also sent her three copies of her brother's photograph the same day. The man's sister asked the prison Chaplain for details of the conversation her brother had with a fellow prisoner on the day he died. The prison Chaplain called her again on 26 July to relay these details.
48. On 29 July, the prison Chaplain spoke to the man's sister again to ask for details about his early life in preparation for his funeral service. The man's sister emailed him a poem to be read at the service. The prison Chaplain was contacted by four members of staff from the centre of the charity for the homeless who had known the man well and wanted to attend his funeral. He passed their details to the man's sister so she could contact them.
49. The man's funeral took place on 3 August. His sister was not able to attend but the prison Chaplain recorded the service on his video camera. When there were difficulties transferring it to a format that the man's sister was able to use, he sent her his camera and the tape to enable her to watch it. The man's sister later contacted him to say that she had found watching the recording helpful.
50. The prison Chaplain made repeated, but unsuccessful, attempts on the man's sister's behalf to retrieve her brother's property from the South London Coroner and Brixton CID. The Ombudsman's family liaison officer also made repeated attempts to retrieve the man's property. Despite the family liaison officer arranging for the Coroner's officer to sign a release form to allow the police to send the property to the man's sister, this issue had not been resolved at the time of writing.

### **Post Mortem report and toxicology**

51. A consultant forensic pathologist completed a Post Mortem examination of the man's body at a public mortuary on 18 July. On the same day, samples were sent to the Forensic Science Service where they were analysed by an expert in forensic toxicology. The consultant forensic pathologist's report and the expert in forensic toxicology's statement were sent to the South London Coroner on 2 November.
52. The toxicology report submitted by the expert in forensic toxicology showed that methadone and diazepam had been found in the man's blood sample. The levels of diazepam were consistent with therapeutic use and he did not think that diazepam contributed to his death. The man's urine sample contained a low concentration of GHB (gamma hydroxybutyrate – a substance which occurs naturally in the body but may also be taken illicitly). The expert in forensic toxicology concluded that this finding was of no

significance in the man's death. The possible presence of a trace amount of dihydrocodeine was also indicated in his urine but was not conclusively confirmed. Again, the expert in forensic toxicology concluded that this had no bearing on the man's death. His urine sample also gave a strong positive response to the screening for methadone. No alcohol was found in any of his samples.

53. With regard to the levels of methadone found in the man's samples, the expert in forensic toxicology concluded:

"... although the methadone level found in [the man's] blood at the time of death would be considered toxic, and potentially fatal, to a naïve or occasional user of the drug it would also be considered sustainable by a regular and tolerant user of the drug. The concentration of methadone found appears higher than might be expected following the use of 40 milligrams of the drug per day but experience has shown that (presumably due to post mortem distribution) post mortem blood levels of the drug can be significantly elevated above expected values. However, I can not rule out the possibility that [the man] had taken methadone additional to his prescribed dose. Neither can I rule out the use of methadone as a contributory factor in the cause of his death."

54. In his post mortem report, the consultant forensic pathologist said he had found no evidence of natural disease to cause or contribute to the man's death. He acknowledged the expert in forensic toxicology's report and concluded that,

"The opinion of an expert in the use of detoxification regimes may be valuable in assessing the treatment and events leading to the death of [the man]."

## ISSUES

### The general clinical care afforded to the man

55. A clinical review was completed into the man's medical care at Brixton. What follows is a summary of her main observations.
56. The clinical reviewer noted that the man was appropriately screened in reception and referred to the substance misuse team at Brixton. He was assessed by a member of that team and started on a methadone titration and benzodiazepine detoxification.
57. However, the clinical reviewer found no documentation showing the man had been seen by a GP at Brixton. A nurse told her that she thought the GP used her log on details to record the entry on the man's medical record at 4.31pm on 10 July. I note that the duty doctor signed the medical section of the man's cell sharing risk assessment on 11 July, apparently in error. We assume that the man was seen by him on 10 July, but it is not clear from the records.
58. There was no documentary evidence that a GP had made any prescription for the man, despite there being evidence of signed prescription charts. The clinical reviewer spoke to a GP at Brixton who told her that it was a regular occurrence for him to sign prescription charts without seeing the patient. This was due to the GP clinic being very busy. He added that substance misuse patients are assessed by substance misuse nurses who recommend appropriate prescriptions. The man was due to see a GP on 16 July, but missed his appointment because he was in court. He was also referred to a GP because of his arthritis but it does not appear he saw a doctor in this context either.
59. The clinical reviewer noted that Brixton's Opiate Protocol provides that contact should be made with a prisoner's community GP to establish what medication may have been prescribed to them. The man signed a medical information sharing agreement as part of the reception process on 10 July. There is no evidence that anyone at Brixton made contact with the man's GP to independently verify the information he gave them about his drug and alcohol abuse.
60. A substance misuse transfer form completed for the man's court appearance on 16 July showed he was given 40mls of methadone and 10mg of diazepam that morning. However, the clinical reviewer comments that there is no mention of his drug or alcohol abuse in the medical section of the PER that accompanied him to court.
61. The clinical reviewer makes several recommendations, mostly relating to the accurate recording of information. I endorse these and draw them to the attention of the Head of Healthcare at Brixton. The recommendations are listed in full in the recommendations section of this report.

## The findings of the second clinical reviewer's specialist review

62. Following the investigator's conversation with the man's keyworker and the results of the post mortem and toxicology reports, the Ombudsman commissioned a specialist review of the detoxification regime prescribed and administered to him. The review was undertaken by a qualified consultant in Forensic and Addiction Psychiatry. She has lead clinical responsibility for the care of prisoners with substance misuse problems at HMP Wandsworth. She also works in the Shaftesbury Clinic Medium Secure Forensic Unit, where she set up a substance misuse support service. Her report is extremely detailed.
63. The second clinical reviewer's overall opinion is that, in the context of a busy inner London local prison, the quality of the clinical history taking and assessments were "generally good and certainly acceptable for prison healthcare practice". She did however note some shortcomings.
64. Firstly and most notably, the second clinical reviewer notes that there were no clearly documented medical contacts on the man's electronic medical record. There were no entries made on the clinical system in respect of prescribing for him. This is contrary to Brixton's Medicines Policy and Procedures Protocol. She concludes that this is an area of significant concern.
65. The second clinical reviewer also highlights the failure to assess the man's alcohol history in further depth and to use the SAD-Q screening tool (Severity of Alcohol Dependence Questionnaire - a short, self-administered, 20-item questionnaire designed by the World Health Organisation to measure severity of dependence on alcohol). In her opinion, there was enough information from the man's account of his drinking and history of fits to warrant a further screen and investigation. She tempers this opinion by observing that he was not showing any clear evidence of withdrawing from alcohol in Brixton.
66. With regard to the medication prescribed for, and the treatment offered to, the man, the second clinical reviewer notes that the man's initial urine screen satisfied the criteria for diagnosing him as dependent on opiates and benzodiazepines. She says:

"I am on clinical grounds in support of the fact that both these medications were started, it was appropriate. The doses of methadone prescribed and diazepam are well within clinical guidelines, however as combined medication I am of the opinion that greater caution should have been employed in terms of the rapidity with which the methadone was titrated up given the fact he was also on a large dose of diazepam ... Crucially his opiate tolerance had not at this stage been established."
67. The man gave inconsistent accounts of his opiate use. On the one hand he said he had not been in receipt of methadone for five months and on the other he said that he had been given 55ml of methadone by his GP. Like the first clinical reviewer, the second clinical reviewer notes that there are no records to show that attempts were made to obtain corroborative evidence from the

community. The Brixton Opiate Protocol advises that, “ the following day, if the prisoner was prescribed methadone by a community provider this dose should be confirmed”.

68. The second clinical reviewer goes on to say that, although the incremental increases in methadone given to the man are within local and national policy guidelines, for the reasons above and in combination with a high dose of diazepam and no reliable history of use in the community, she would have titrated his methadone up more slowly.
69. Commenting on the first clinical reviewer’s account of her conversation with the prison GP, the second clinical reviewer said that she was concerned that substance misuse patients are assessed by substance misuse nurses who recommend appropriate prescriptions. She said she was unclear about the skills and training of substance misuse nurses at Brixton but “ this aspect of the substance misuse service at Brixton needs to be evaluated in further depth to fully appreciate the significance”.
70. Considering the factors that possibly contributed to the man’s death, the second clinical reviewer concludes:

“In summary on giving very careful consideration to all the evidence, it is my opinion that methadone in combination with diazepam may well have contributed towards [the man’s] death. I found no evidence of any clinical practices that were grossly at odds with my understanding and appreciation of working within the field of prison addictions services.”
71. The second clinical reviewer goes on to say that she found three failings which she thinks were of relevance to the man’s death. The first of these was the failure to contact the man’s GP to obtain independent verification of his methadone use in the community. Secondly, she cites the doses of methadone given to him in combination with diazepam in the absence of corroborative evidence about his opiate tolerance. These drugs combined have a risk of central nervous system depression and respiratory compromise. Thirdly, she cites the fact that he missed his five day scheduled follow up appointment with the GP on 16 July because he was in court. He therefore missed the opportunity for a medical review at a crucial time in his methadone maintenance programme.
72. The second clinical reviewer makes a number of recommendations that I endorse. These are listed in full in the recommendations section of this report.

### **The prison’s response to the man’s death**

73. The first clinical reviewer concludes that the response from the Brixton healthcare team to the man being found unresponsive in his cell on the day of his death was “excellent”. When the emergency response nurse arrived at

the man's cell, he did not find a pulse or signs that he was breathing. Nurses began cardio pulmonary resuscitation (CPR) at 8.55am and oxygen was given. A defibrillator (a portable electronic device that automatically reads cardiac output and advises what to do) was attached to the man and advised that CPR continue. Resuscitation continued until 9.35am, when the ambulance arrived and paramedics declared the man to be dead. All the nurses who attended him had received up to date basic life support training.

74. The local policy at Brixton is that once a code one emergency is received by the control room the officer on duty calls an ambulance. The control room log shows that the code one was received in the control room at 8.55am on the morning of the man's death. The log also shows an entry at 8.55am recording that an ambulance had been called. This time is crossed through and the time "9.15am" has been written in above it. The electronic record received from the London Ambulance Service shows that the 999 call from Brixton was not in fact made until 9.25am.
75. When the investigator opened the investigation on 22 July, this issue was raised by the then Governor. She told the investigator that the officer in the control room, a very experienced officer, had forgotten to call the ambulance and had admitted his mistake at the hot debrief held later on the morning the man died. The Governor said she had reiterated to staff that an ambulance should automatically be called in receipt of a code one emergency call. A review of procedures had taken place and she was satisfied that the fault was not with the instructions given to staff or the contingency plans in place. She said that the officer in question had been upset that he had forgotten to make the call and could not explain why he had not done it.
76. I consider that the delay in calling the ambulance did not impact on the man's chances of survival. There were clearly signs of rigor mortis when staff found him that morning. The most regrettable consequence of not calling the ambulance immediately is that healthcare staff continued resuscitation for some 35 minutes before being relieved by the paramedics who could pronounce that the man had died. This must necessarily have been both distressing and hard work for them. In the circumstances it would have been helpful if a prison doctor had been present at the resuscitation and had pronounced death.

The Governor should give consideration to amending local guidance to staff to provide that, if one is on duty in the prison, a doctor is called to all code one emergencies as a matter of routine.

77. A delay in calling an ambulance has not been a feature in any of the three deaths subsequent to that of this man. In the light of this and the assurances received from the Governor by the investigator that the delay in this case was an individual and uncharacteristic error, I make no recommendation.

## **Family liaison**

78. The family liaison provided by the prison Chaplain was exemplary. He went to some length to ensure that the man's funeral service was personalised and meaningful. I have not come across another example of a funeral service being recorded for the benefit of family who are unable to attend. I do not consider that it is appropriate for me to make a wider recommendation that this practice is adopted throughout the Prison Service but I do consider that the sensitive and thoughtful way the prison Chaplain behaved towards the man's sister is an example of good practice.

## CONCLUSION

79. The man gave apparently contradictory and false information to healthcare staff in reception at Brixton. He claimed to have been using heroin in the community. I have seen no evidence that this was true. He also claimed to have last had methadone five months previously but also that he was in receipt of a prescription from his GP for 55mls of methadone daily. He was given methadone and diazepam based on this information and the results of his urine screen. Unfortunately the results of his urine screen simply reflected the medication given to him by the police during the early hours of the same day.
80. I am not unsympathetic to the pressures faced by busy, overcrowded local prisons dealing with increasingly high numbers of prisoners requiring detoxification. I realise that it is an enormous and demanding task and that trying to obtain information from the community may not be straightforward. Nevertheless the provision in Brixton's own Opiate Protocol that, "the following day, if the prisoner was prescribed methadone by a community provider this dose should be confirmed", is there for a reason. The risks of prescribing methadone in combination with diazepam increase the need to obtain as full a picture as possible of the prisoner's drug use outside prison.
81. The second clinical reviewer's report concludes that methadone in combination with diazepam may well have contributed to the man's death. The exact cause of death will not be established until the Coroner's inquest, and may indeed never be known.

## RECOMMENDATIONS

The following recommendation is a local recommendation directed to the Governor of Brixton.

1. **The Governor should give consideration to amending local guidance to staff to provide that, if one is on duty in the prison, a doctor is called to all code one emergencies as a matter of routine.**

The following recommendations are local recommendations and are directed to the Head of Healthcare at Brixton in conjunction with the PCT.

### From the clinical review

2. There should be a clear system for referring new prisoners to the GP when they present in reception. In this particular case the man presented in reception with a previous hand wound that potentially required follow up and a history from him of arthritis that would suggest he would require a general GP consultation with a view to a management plan. Due to there not being any previous medical history obtained, there is no evidence to suggest that this history was substantiated; however I would consider it good practice for the man to have received a consultation to explore this further.
3. Non-confidential relevant medical information (such as whether a prisoner has drug or alcohol misuse issues and is undergoing detoxification or what medication a prisoner is taking and how it might affect them) should be recorded on the Prisoner Escort Record to make escort and court staff aware of the prisoner's medical condition and any needs they might have.
4. Confirmatory health information should be sought from a prisoner's GP or community clinic within the first two days of admission, for clarification of prescribing and treatment. It was noted on SystemOne that the man consented to information sharing and he signed an Agreement to Information Sharing Form. However there is no evidence documented that the Information Sharing Form was faxed to his GP or any other community care provider during the time he was in prison.
5. All prisoners with substance misuse issues must be seen by a GP within the first 24hrs, and in any case before a prescription for controlled drugs is written.
6. GPs must document every consultation that they have with a prisoner which must include any prescription that they have written.
7. All members of staff must use their own password when using the SystemOne clinical IT system. We have been assured by the I. M & T manager that systems are now in place to provide all staff including locums with passwords.

8. All drug sensitivities must be documented on the front page of the patients prescription chart.

From the second clinical reviewer's report

9. Importance of accurate recording of all information & adherence where possible to protocols and policies e.g. medications prescribed being also recorded onto SystmOne.
10. Passwords and user access on SystmOne only to be utilised for the individual that this is assigned to. Emergency passwords and IT access for temporary staff via other identity transparent means.
11. The Head of Healthcare should remind staff that baseline observations taken during the first 72 hours of a prisoner's detoxification regime should be done twice a day with a significant gap in between.
12. Importance of screening for alcohol in addition to careful attention to the results of urine analysis.
13. Systems must be put into place to ensure that important clinical follow up appointments do not clash with others e.g. court timings, so opportunities are not missed for a patient to be reviewed.
14. It is crucial that the Substance Misuse Service attempts to contact external agencies at the earliest convenience. A standard system should be developed for this purpose.
15. Adherence to a consistent single record for prescribing and monitoring all health care related to substance misuse i.e. on SystmOne.