PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man in May 2013 at HMP Channings Wood

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 investigation report into the death of a man at HMP Channings Wood in May 2013. He was 41 years old. A post-mortem examination concluded that his death was due to the toxic effects of heroin. I offer my condolences to his family and friends.

A clinical review of the care the man received at the prison was undertaken. HMP Channings Wood cooperated fully with the investigation. The investigation was temporarily suspended pending a pathologist's report.

The man was serving a six year sentence for possession of class A drugs with intent to supply. In preparation for his expected release in October 2013, he was granted periods of temporary release for a work placement and, subsequently, home visits. When he returned to the prison from an overnight family visit on 8 May, he spent the evening with other prisoners who noticed that he seemed to be under the influence of drugs. The next morning, one of the prisoners found him unresponsive in his cell. Prison staff and then ambulance staff attended, but were unable to resuscitate him.

While it is unclear when and where the man took heroin, prisoners returning to Channings Wood from home leave were not routinely seen by reception nurses even if they had a history of drug misuse. This was a possible missed opportunity to identify whether there were any signs that he had taken heroin before he returned to the prison, but overall I am satisfied that Channings Wood could not have predicted or prevented his death.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **April 2014**

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SUMMARY

1. The man was born in April 1972. He had a long history of using and dealing in drugs and many convictions. In January 2011, he was sentenced to six years imprisonment after being convicted of possession of class A drugs with the intention of supplying to others. His earliest release date was 16 October 2013.

2. When he arrived at HMP Exeter after sentencing, the man was dependent on heroin, and began a methadone maintenance programme which he continued when he transferred to Channings Wood on 2 March 2011. By the middle of May he had completed a detoxification programme.

3. During 2012, the man voluntarily undertook drug relapse prevention and harm reduction awareness sessions and seemed motivated to change his life. Towards the end of the year, he moved to Channings Wood's resettlement unit which is used to prepare prisoners for open prison or for return to the community.

4. To prepare him for resettlement into the community, the man had periods of release on temporary licence to work and to visit his family. In January 2013, he started a work placement, five days a week, and received good reports about his progress. In March, he visited his family on day release and then had an overnight visit on 7 and 8 May.

5. Prison staff noticed nothing untoward when the man returned from his home leave at 4.00pm. However, later that afternoon, other prisoners thought that he showed signs of being under the influence of an illicit substance.

6. The next morning, another prisoner went into the man's cell and found unresponsive and in a crouched position on the floor. He called for assistance and staff responded quickly. They attempted to resuscitate him and paramedics arrived ten minutes later and continued to try to resuscitate him. The attempts were unsuccessful and death was pronounced at 8.15am.

7. The post-mortem examination found that the man had died from the toxic effects of heroin. Some heroin was found in his room after his death. We do not know where he acquired the heroin or whether he took it before he returned to the prison or afterwards.

8. The investigation found that prisoners returning from home leave were not assessed by reception nurses and we make a recommendation about this. However, we consider it would have been difficult for staff at Channings Wood to have predicted or prevented the man's death.

THE INVESTIGATION PROCESS

9. Notices were issued to staff and prisoners at HMP Channings Wood, informing them of the investigation and inviting them to contact the investigator if they wished to be involved. No one responded. Another of the Ombudsman's investigators, who was at Channings Wood on 9 May 2013, spoke to the Governor, an operational manager, a chaplain and a number of the man's friends about the circumstances of his death. She also arranged for copies of his prison and health records to be sent to the investigator.

10. On 28 May, the investigator went to Channings Wood, and visited the unit where the man had lived. He interviewed six members of staff and spoke to four prisoners who lived on the same spur and knew him.

11. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.

12. NHS England (Devon, Cornwall and Isles of Scilly Area Team) appointed a clinical reviewer to review the clinical care the man received at Channings Wood.

13. One of the Ombudsman's family liaison officers contacted the man's sisters to inform them of the investigation and to offer the opportunity to raise matters for the investigation to consider. One sister asked following questions:

- As he was a known drug user and dealer why was he not searched and drug tested when he returned to the prison from the community?
- When was the last roll check on his wing?
- When his cell was searched after his death, drugs were found, but no items associated with drug use such as spoons, needles or a lighter. Had anybody else had been in the cell?
- There were a number of cigarette stubs in an ashtray but why was no lighter found?
- Who did he last speak to?
- Was there any CCTV footage?
- Why did it take over two hours to be told of his death? (She said the police visited at 10.30am, but by then a prisoner at Channings Wood had already telephoned a member of the family.)
- Why did a further two weeks elapse before she met representatives from the prison?

14. The man's family received a copy of the draft report. One of his sisters pointed out two typographical errors, which have been corrected. She also said that the family remained very unhappy about the way they were contacted by the prison about her brother's death. She said her daughter had telephoned the prison on 9 May and was told that someone would phone back, but this did not happen. The prison then arranged to visit the family on Saturday 11 May. On the day, the prison initially phoned to say they were running late and later to say they would not be able to make it at all. Prison staff eventually visited on Tuesday 14 May.

15. Another of the man's sisters identified the same two typographical errors. She also wrote asking a number of questions, which we have considered and addressed outside of this report in separate correspondence to her.

16. The consultant pathologist who conducted the post-mortem examination hoped to be able to indicate when the man had injected himself with heroin and in particular whether he did so before returning to prison. Our investigation was suspended in the meantime. The pathologist was not ultimately able to determine when the heroin was taken.

HMP CHANNINGS WOOD

14. HMP Channings Wood is a category C training prison near Newton Abbott in Devon. It holds over 700 convicted adult prisoners.

15. Health services at Channings Wood were commissioned by NHS Devon and provided by the Devon Partnership Trust until 31 March 2013. Since 1 April 2013, services have been provided by Dorset NHS University Trust. There is no inpatient unit at the prison and clinics are run similarly to a community GP practice. Nurses are on duty everyday and Devon Doctors provide an out of hours GP service.

16. There had been seven deaths at Channings Wood in the 12 months before the man died. The others were all from natural causes.

HM Inspectorate of Prisons

17. The Inspectorate's last published report on Channings Wood was of an announced full inspection in September 2012. Inspectors found that Channings Wood was a safe and respectful prison and that useful work was being done to support the resettlement of offenders. However, the Chief Inspector noted that "Far too many prisoners thought it was easy to obtain illegal drugs". Inspectors also found evidence that diversion of prescribed medication was a problem.

Independent Monitoring Board

18. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure prisoners are treated fairly and decently. The last report published by the Board at Channings Wood was for the period 1 September 2011 to 31 August 2012. The Board reported that diligent staff at Channings Wood continued to report successes in combating the availability of illicit drugs, but further work was required.

KEY EVENTS

19. The man was born in April 1972. He had many previous convictions, mostly linked to possessing and dealing in drugs. In January 2011, he was sentenced to six years imprisonment for possession of class A drugs with the intention of supplying to others. His earliest release date was 16 October 2013.

20. The man started his sentence at HMP Exeter on 28 January. During his initial healthcare reception screen he was described as "thin, pale, in poor health". He reported a history of heroin misuse and said he was suffering withdrawal symptoms for which he was prescribed methadone (an opiate prescribed as a substitute for heroin).

21. On 2 March 2011, when the man transferred to HMP Channings Wood, he was receiving 30 millilitres (mls) of methadone daily as a maintenance dose.

22. A doctor reviewed the man on 27 April and noted:

> "Fully expects a methadone reduction to zero. Not done a methadone detox before … [but] Is keen to reduce quickly. Opts for 5mls reduction every 3 days …"

23. The man then began a methadone detoxification plan which he completed on 12 May 2011 and was no longer prescribed methadone. He seemed to have settled well at Channings Wood.

24. In March 2012, the man applied for relapse prevention and harm reduction training. He had previously said that most of his friends were drug users and he explained that his goals in applying for training were:

> "To … gain an understanding of coping strategies for when I'm released. To refresh [my] memory of the dangers of drug misuse …"

25. The man attended a number of relapse prevention and harm reduction sessions over the following months. An officer noted:

> "… He stated he enjoyed the groups and hopes to put into practice what he has learned … Tolerance levels and harm reduction discussed …"

26. An officer told the investigator that the man had spent many years in and out of prison but he appeared motivated to change and lead a crime-free life, no longer dependent on drugs. The education sessions included advice on the dangers of sharing needles and how the body's tolerance levels to drugs reduces while in prison. Participants were warned to be careful about the dangers of overdose if they started using drugs again after they left prison. He said that the man understood the dangers.

27. In October 2012, the man moved to the prison's resettlement unit, Living Block 6 (LB6). The purpose of LB6 is to prepare prisoners for a transfer to an open prison or for release to the community and prisoners there have the opportunity

of work placements outside the prison. An officer who had worked in LB6 for around three years, told the investigator that he and a colleague had interviewed him to check his suitability for the unit. He said he had interviewed well and seemed motivated to progress and improve his life.

28. On 15 January 2013, after being risk assessed and found suitable for release on temporary licence (ROTL), the man started a work placement with a company in a nearby town, five days a week. Prisoners at Channings Wood with outside work placements are taken to and from work on a prison bus. They go via the prison reception where they change into their work clothing on the way out and change back into prison clothing when they return. Prisoners are strip searched when they come back. They first remove clothing from the waist up; once the upper half of the body has been checked, the prisoner replaces the upper clothing then removes that below the waist. They are also checked with a scanner that detects if they have concealed internally a solid object, such as a mobile telephone.

29. An entry in the man's records on 25 January noted that he was doing exceptionally well and the prison had received very positive reports from his work placement. Another entry on 21 February noted:

> "Work reports remain good. He has exceeded our expectations whilst on the [LB6]. Very good effort, this could be the making of him."

30. In March, the man applied for release on temporary licence to spend a day with his family. (Rebuilding family relationships helps prisoners resettle into the community after their release from prison.) His application was approved and on 6 March, he appears to have had a successful family visit. He subsequently applied for overnight release to stay with one of his sisters and this was approved. His permitted period of absence from prison was from 8.00am on Tuesday 7 May until 4.00pm on Wednesday 8 May.

31. The processes for booking prisoners in and out of reception, conducting strip searches and scanning for mobile telephones are the same for home leave absences as for work placements. Two officers were working in reception on the afternoon of 8 May. Officer A was inputting computer data and Officer B was dealing with prisoners. Officer B told the investigator that the man understood reception processes as he had gone through it so many times going to and from his work placement. Prisoners returning from release on temporary licence or work are not seen by a reception nurse. He said that the man was a naturally quiet man and tended to pass through reception with a minimum of fuss. He said that he had no real recollection of seeing him on 8 May and therefore assumed that there was nothing unusual about him that day.

32. When prisoners return to the prison, reception staff contact their wing to ask for them to be collected. Officer C collected him from reception at around 4.00pm that afternoon. He and Officer B searched him in reception and noticed nothing untoward. Officer C told the investigator that there was nothing about the man to suggest that he was under the influence of any substance. He thought that the only thing remarkable about him was that he was looking unusually smart.

33. The investigator spoke to four prisoners who lived in LB6, three of whom were the man's friends. Prisoner A said that he had seen the man when he returned to LB6 and that he appeared all right at that time. However, when he spoke to him again around an hour later, he was no longer speaking coherently. He said that this was the first time he had seen him apparently under the influence of any substance.

34. Prisoner B did not see the man immediately after his return to LB6 but thought he saw him at around 5.15pm. He said that he was in "a mess" at that point; he was slurring his words, was sleepy and looked like a "crack-head". He said that he had not seen him like that before.

35. Prisoner C told the investigator that he saw the man at the evening roll check (count of prisoners) at around 6.00pm. He said that he was happy as he had seen his son for the first time in around three years, but he seemed to be under the influence of a substance as he was mumbling and incoherent. However, the prisoner said that he was not unsteady on his feet and, unless staff had spoken to the man, they would not have noticed. That was the only time he had seen him in that condition.

36. The officer who completed the evening roll check at 6.15pm noticed nothing untoward. The main gates of the LB6 unit were then locked and staff had no further contact with any of the prisoners until the next morning. A night duty officer is based in a staff office within the LB6 unit but a locked door separates the staff office from the prisoners' rooms.

37. The man played cards until about 9.00pm with four other prisoners in another prisoner's cell and then went back to his own room. The other prisoners thought that he had seemed lethargic and that he was either tired or had been drinking alcohol while outside the prison.

38. Officer C arrived for work at about 7.40am on 9 May. He went to LB6 to relieve the night duty operational support officer (OSG). As he arrived, Prisoner B banged on the door of LB6 to say there was a problem with the man. The prisoner had gone into his unlocked room seconds before and found him unresponsive on the floor.

39. Officer C and the OSG went to the man's room and found him in a crouching position on the floor. The officer put his hand on his shoulder and shook him but got no response. However, he thought that he felt warm. He radioed a code blue emergency (which indicates a prisoner who is unconscious or has severe breathing problems). The code blue call was logged at 7.45am and the control room requested an emergency ambulance at the same time. A number of prison staff and nurses responded. They checked him for a pulse and found none and moved him to the landing where there was more room. The staff started cardiopulmonary resuscitation (CPR) and checked him with a defibrillator[1], which advised not to shock and to continue CPR. Ambulance

[1] An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about management of the patient including whether or not an electrical shock should be given to re-establish an effective heart rhythm

paramedics arrived at 7.55am and took over the CPR attempts. However, they were unable to insert a breathing tube into his windpipe, apparently because of rigor mortis[2] of the jaw. They continued the resuscitation efforts until 8.15am, when they pronounced him dead. After his death, the police found a package of heroin in his cell.

40. The police suggested that there might be difficulties if prison staff visited the man's family home to inform them of his death and it seemed likely that there would be a police investigation because of the possibility that his death was drug-related. Therefore, the police visited the family home around two hours later to break the news. The Head of Security and the duty governor that day visited the family on 14 May, with one of the prison family liaison officers. They explained the processes after a death in custody and offered assistance with funeral expenses in line with national Prison Service guidelines. One of the man's sisters later visited the prison. A prison chaplain conducted the funeral service.

41. Staff involved in the emergency response were offered support from the prison's care team. Checks were made on prisoners subject to monitoring under the suicide and self-harm prevention measures in case they had been affected by the man's death.

Post-mortem findings

42. A consultant pathologist conducted a post-mortem examination. He noted that the man had multiple needle puncture marks on his arms, although he acknowledged that some of them might have been associated with the resuscitation attempts. He also noted that blood and urine samples confirmed the presence of heroin at a level within the lower part of the range that can be associated with fatalities after intravenous heroin injection. He explained that analysis of morphine ratios (where the body metabolises heroin into morphine) suggested that he had died some time after his heroin use. He further explained that death can be delayed when there is a prolonged period of unconsciousness due to the respiratory depressant effects of the heroin; his crouching position might have further compromised his breathing and that a prolonged period of unconsciousness presents a significant risk of sudden death due to the effects of hypoxia (low blood oxygen levels). He noted that vomit was detected in the airways, in keeping with aspiration (breathing vomit into the lungs). He concluded that:

> "Overall, I am of the opinion that he died as a result of the toxic effects of heroin. His death was somewhat delayed and followed a prolonged period of unconsciousness. It is not possible to determine … precisely when the heroin was administered."

[2] Rigor mortis is stiffening of the muscles after death.

ISSUES

Clinical care

43. The clinical reviewer reviewed the man's clinical care at Channing Wood. She noted that he had detoxified twice before in prison and should therefore have been considered at high risk of relapse. She noted that there were no apparent protocols for assessing prisoners returning from day release for possession or ingestion of drugs. However, in terms of his clinical care, she considered that he was given appropriate levels of support and advice during detoxification, equivalent to that expected in the community.

The man's return from temporary release on 8 May 2013

44. By 8 May, the man had been working in the community for four months. He worked five days each week in a town near Channings Wood, on day release. Reports from his employer were very positive. He was allowed temporary release for a day visit to his family on 6 March and then a two-day family visit on 7 and 8 May.

45. When the man returned to Channings Wood on 8 May, he went through the same reception process as he had experienced many times when he returned from work and from his previous family visit. This entailed establishing his identity at the prison gate and in reception and then being strip searched. Prison staff did not notice anything to suggest that he might be under the influence of drugs. The law does not allow prison officers to conduct more intimate and invasive searches, but a prisoner can be asked to squat during a search if there is reasonable suspicion that he has illicit articles concealed. There was no intelligence about him and he was not asked to squat during the strip search.

46. We do not know whether the man brought the heroin into the prison or acquired it in the prison after his return. The pathologist was unable to establish when he took heroin. He could have taken it before he returned to Channings Wood or some time in prison that evening. No evidence of equipment to administer the heroin, such as a needle, was found in his room. This might suggest that he took the heroin before he returned, but he could also have injected the heroin elsewhere in the unit. We therefore cannot know whether closer questioning during the reception process would have identified any problem.

47. Prison Service Order (PSO) 3050 *Continuity of healthcare for prisoners* states:

> "Events that require a prisoner to leave the prison and pass back through prison reception can have a significant impact on the health of a prisoner. Examples of such events are as follows:
>
> - Court appearance;
> - Sentencing at court;
> - Return from home visit;

For those prisoners passing through reception, prisons must have protocols in place for screening them for any potential healthcare, or suicide/self-harm issues."

48. Prisoners returning from temporary release are not seen by a reception nurse at Channings Wood. We understand why this might not be considered necessary for prisoners returning from routine work placements. However, when the man returned to the prison on 8 May, he was coming back from two days' home release. Although he appeared to have made good progress in tackling his drug problems this was a particularly testing time. He had a long history of drug abuse in the community and it might have been reasonable to consider that he had had spent some of his time with associates who had a similar history of drug abuse. While we cannot know whether this would have made a difference to the outcome in his case (who could have obtained and taken the heroin after his return) we consider that where possible a nurse should see all prisoners returning from a period of home leave in line with the guidance in PSO 3050. Resettlement overnight release can be a stressful experience for prisoners and this might help to identify anyone coming back to the prison with substance use problems or other issues that healthcare staff could help with. We make the following recommendations:

The Governor and the Head of Healthcare should ensure that when prisoners return from overnight resettlement leave, they receive a reception health screen, in line with PSO 3050. When such prisoners are suspected of being under the influence of drugs they should be tested.

The evening of the incident

49. The man went back to LB6 with the other prisoners who had returned to the prison and spent time with them during the afternoon and into the evening. Their evidence suggests that he did not show signs of being under the influence of an illicit substance when he first returned to the unit but did so around 60 to 90 minutes later. Several of the prisoners said that his speech became incoherent, although he was not unsteady on his feet.

50. Nothing untoward was noted during the final evening roll check of prisoners in LB6 at 6.00pm. The man spent part of the evening playing cards with other prisoners who thought he seemed lethargic but they assumed he was either tired or had had some alcohol while outside the prison. None of the prisoners reported any concerns to staff about him and we are satisfied that there was nothing to suggest to the staff that he might be at risk because he had taken drugs.

Drug equipment

51. The man's sister asked why none of the items associated with drug preparation and use, such as a hypodermic needle, a spoon and a lighter, were found in her brother's room after his death and asked if other prisoners had been there.

52. Evidence suggests that deaths caused through smoking heroin are rare so it seems likely that the man injected the substance. That is implied too by the pathologist who also noted that his body had multiple needle puncture marks. As we have noted, we do not know whether he took the drugs before or after he returned to the prison. No drug-taking equipment was found in his cell and we do not know what happened to his cigarette lighter. However, prisoners living on LB6 are able to go into each others' rooms and it is possible that he took the heroin in another prisoner's room or elsewhere on the houseblock. No other prisoners said they went to his room that evening, but this cannot be verified. Nor can we establish whether he went to anyone else's room later, because LB6 is not covered by CCTV.

Emergency call bells

53. The rooms in LB6 do not contain emergency bells for prisoners to request help from staff. The clinical reviewer indicates that, although the man was probably beyond resuscitation when he was found, the absence of a call bell meant there could have been a delay in seeking medical help. However, there is no indication that this led to delay in his case and help was obtained quickly. As prisoners are not locked in their rooms in LB6 and there is an alarm bell on the landing which prisoners can use in an emergency, we are satisfied that there is no overriding need for individual bells in rooms.

Contact with the man's family

54. Prison Service Instruction (PSI) 64/2011, gives advice about contacting families after a death in custody, and includes guidance on seeking police advice on who should break the news. We are satisfied that it was reasonable for Channings Wood to follow the advice that a police officer should break the news. The family were informed at around 10.30am, a little over two hours after his death was pronounced. Discussions with the police inevitably took a little time and it is unfortunate that in the meantime another prisoner had informed his family of his death. Despite this, we are satisfied that the prison acted reasonably in their efforts to inform his family. Prison staff visited five days later. It is unclear whether there was any contact in the meantime, as there was a change of family liaison officer and no liaison notes were made before 14 May, which we draw to the attention of the Governor. However, we consider that overall the family liaison arrangements were satisfactory in the circumstances.

RECOMMENDATION

The Governor and the Head of Healthcare should ensure that when prisoners return from overnight resettlement leave, they receive a reception health screen, in line with PSO 3050. When such prisoners are suspected of being under the influence of drugs they should be tested.

Action Plan: The Man - HMP Channings Wood May 2013

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and the Head of Healthcare should ensure that when prisoners return from overnight resettlement leave, they receive a reception health screen, in line with PSO 3050. When such prisoners are suspected of being under the influence of drugs they should be tested.		Process was re-established in May 2013 to ensure that all resettlement leave prisoners were seen on return from leave. Discussions have taken place between Healthcare and enhanced wings from which prisoner go on home leave (usually LB6). Process is in place for seeing those prior to and on return from leave. However, this process needs to be amended to include and reflect the need for drug testing where appropriate and to determine if this would be undertaken by healthcare or prison staff. Also, clear guidelines needed for prison staff on how to safely manage a prisoner who tests positive and is clearly under the influence. Recent guidance from Dorset issued on managing instances on intoxication and should be followed accordingly.	**Completed** **(see Annex A)** **End April 2014** **(see Annex B)**	

ANNEX A

PROCESS FOR SEEING THOSE FOR ROTL

(Release On Temporary Licence)

It is a prison requirement that anyone going for ROTL is seen by a nurse prior to going and on their return to the prison.

As most of those on overnight/home leave work outside of the prison during the core day, they are unable to be seen in the regular nurse clinic appointments in the morning.

We will follow the procedure below:

- Admin staff will identify any prisoners due for ROTL from c-nomis diary
- Admin staff will write in the healthcare observation book the day before a prisoner is going on leave so we are aware he needs to be seen
- On return from outside work, LB6 staff will bring the prisoner to Healthcare to be seen (approx 1530-1600). If this is not possible, then they will be seen on ED by the nurse.
- Nursing staff will complete the top part of the form and sign, together with the prisoner. Nurses should ask when the prisoner is due back and write this date on the ROTL form and also in the observation book.
- The prisoner will then be seen in the same way when they return from leave.
- Any concerns re the health and wellbeing of anyone returning from home leave will be managed via the same channels as for anyone else of concern (ie duty GP/out of hours GP for advice).

ANNEX B

Dorset HealthCare University NHS Foundation Trust

GUIDANCE FOR STAFF MANAGING PATIENTS SUSPECTED OF INTOXICATION WITH ILLICIT SUBSTANCES

Advice for Healthcare staff:

This guidance should be followed along with

POLICY FOR THE MANAGEMENT OF SELF-POISONING IN THE DEVON AND DORSET PRISON CLUSTER, which can be found on the Dorset intranet (Printed copy in Healthcare)

When attending acute episodes that are suspected of being due to intoxicants (altered consciousness/perceptions/behaviour or collapse) always complete assessment before assuming the cause.

If it is ***safe*** to do so:

During working hours Mon-Fri

1. Perform a set of clinical observations on the patient (Blood pressure, pulse, respiration rate, temperature and GCS.)
2. Observe any physical symptoms (movement, shaking etc)
3. Record level of agitation/restlessness/aggression
4. Record levels of orientation.
5. Record if patient refuses examination or if you are unable to examine with reasons.
6. Gather information from patient and observers about behaviour and symptoms immediately prior to presentation, consider all possible causes
7. Ask about all prescribed medication and any non-prescribed medication or substance used by patient in past 24 hrs.
8. Immediately inform the *doctor on duty locally*. If no doctor is in the prison, see the GP rota for doctors on duty elsewhere in Devon cluster.
9. If you need to leave the patient, ensure a member of discipline staff can observe them at all times until guidance from a GP is obtained.
10. **If you believe the patient is sufficiently unwell, a 999 ambulance must be called. Do not wait to speak to a doctor.**

11. Ensure that you ask the GP about any recommendations for levels of observation.
12. Once guidance sought from GP, inform:
    a. Nurse in charge
    b. SMS service manager or deputy, to arrange consultation with SMS GP or clinical lead nurse.
13. GP to advise any requirements for ongoing observations, opiate reversal (in response to depressed consciousness/respiration), and/or re-location to A&E
14. Seek advice from Toxbase
15. Ensure you take part in any ACCT/Safeguarding proceedings resulting from an incident, and advise the prison on the GP recommendations for keeping the prisoner safe.
16. Check for any related incidents or concerns among other prisoners.
17. Record all your findings on SystmOne.
18. Raise a Ulysses incident report

Out of hours Sat and Sun and after 6pm

1. Perform a set of clinical observations on the patient (Blood pressure, pulse, respiration rate, temperature and GCS)
2. Observe any physical symptoms (movement, shaking etc)
3. Record level of agitation/restlessness/aggression
4. Record levels of orientation.
5. Record if patient refuses examination or if you are unable to examine with reasons.
6. Gather information from patient and observers about behaviour and symptoms immediately prior to presentation, consider all possible causes
7. Ask about all prescribed medication and any non-prescribed medication or substance used by patient in past 24 hrs.

8. Immediately inform the OOH GP via SWAST (Tel:0300 334000)
9. If you need to leave the patient, ensure a member of discipline staff can observe them at all times until guidance from a GP is obtained.
10. **If you believe the patient is sufficiently unwell, a 999 ambulance must be called. Do not wait to speak to a doctor.**
11. Ensure that you ask the GP about any recommendations for levels of observation or re-location to A&E
12. Seek advice from Toxbase
13. Once guidance sought from GP, inform the duty manager (Oscar 1) and the nurse in charge of any plans.
14. Ensure you take part in any ACCT/Safeguarding proceedings resulting from an incident, and advise the prison on the GP recommendations for keeping the prisoner safe.
15. Check for any related incidents or concerns among other prisoners.
16. Record all your findings on SystmOne
17. Raise a Ulysses incident report

You have a duty of care to remain with the patient until all necessary clinical assessments and safeguarding procedures are in place. Staff are not permitted to leave the prison, even if their shift has ended, until all measures have been completed and the duty manager is satisfied.

Consider re-location to A&E if BP<95 systolic or respiration below 10/min.

Advice for discipline staff during working day:

1. Call Healthcare to see the prisoner, via the radio if necessary. ‘Code Blue’ should be used in an emergency.
2. Stay with the prisoner until Healthcare are on scene. Undertake any necessary emergency first aid.
3. Advise Healthcare staff if you feel it is safe/unsafe to examine the prisoner.
4. In the case of an emergency the Healthcare staff attending may require you to assist with record keeping and communicating with Comms/duty manager (Oscar 1).
5. Healthcare will take advice from a GP regarding the management of the prisoner and will relay this to the duty manager (Oscar 1).

6. Undertake any ACCT processes, if required, to keep the prisoner safe.

Out of Hours:

1. Put any necessary procedures in place to observe the patient.
2. Undertake emergency first aid if required, and it is safe to do so.
3. Immediately call the OOH GP on 03000 334000
4. **If you believe the patient is sufficiently unwell, a 999 ambulance must be called. Do not wait to speak to a doctor.**
5. Stay with the prisoner until the GP or paramedics are on scene.
6. Advise Healthcare staff if you feel it is safe/unsafe to examine the prisoner.
7. If a prisoner refuses examination or treatment, please take advice from the attending clinicians regarding any necessary level of observation overnight.
8. Leave a message for Hotel One to contact duty manager (Oscar 1) on arrival for work the following morning for briefing.

These guidelines do not override any Prison Service instructions regarding the management of violent/aggression. If a prisoner is very aggressive, it should not stop you making a call to the OOH service, even if they may be unable to safely enter a cell to see the prisoner.