PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Manchester in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

August 2013

This is a report into the death of a man at HMP Manchester in December 2011. He was 37 years old and was found dead in his cell. The post-mortem report indicated that the primary cause of death was methadone toxicity. I offer my condolences to his family and friends.

A clinical reviewer carried out a review of the man's healthcare at Manchester. The prison cooperated fully with the investigation. I apologise for the late issue of this report.

The man returned to Manchester on 9 December after his licence from a previous sentence was revoked following a further offence. In the community, he had been prescribed Subutex, an opiate replacement, but as he had gone several days without this before arriving at Manchester, he was placed on a methadone maintenance programme, in line with usual treatment practice. He was also prescribed mirtazapine, an anti-depressant, diazepam, a sedative, and pregabalin (an anti-epileptic drug also used for nerve pain).

As the man indicated he might harm himself as he withdrew from drugs, he was placed on suicide and self-harm monitoring. On the night of the incident in December, he was observed four times, on one occasion by two staff after one of them was concerned that he had not moved for some time. The second member of staff said that he saw him move, which allayed their fears. Another check was completed at 6.00am and no concerns were raised. However, at the next check at 7.15am, the officer was concerned at his posture in the bed. Healthcare staff attended but it was apparent that he had been dead for some time.

The clinical reviewer found that the man's medication had been appropriately prescribed, but had some concerns about the use of pregabilin. I have previously advised caution in the use of other sedatives in combination with methadone, but it appears that he might have taken additional methadone to that which he was prescribed. I understand that the officers who checked him in the early hours were satisfied that he had had moved, but I am concerned that a more active effort was not made to gain a response and that record keeping was deficient. I consider there is a need for all staff who work with drug users in prison to be trained to spot the common symptoms of methadone toxicity and drug-induced unconsciousness and how to respond. Nevertheless, I accept that his death could not reasonably have been foreseen or prevented.

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 **August 2013**

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SUMMARY

1. The man had served several prison sentences, during which he had received methadone or Subutex drug treatment. On 9 December 2011, he was arrested while he was on licence in the community for another offence. His licence was revoked and on, 12 December, he was remanded to HMP Manchester. When he arrived, he told a nurse that he had prescriptions for mirtazapine, propanolol, pregabalin, diazepam and Subutex. His community pharmacist told the prison that he had not taken Subutex for three days, so the prescription was not continued. He said that he took diazepam when arrested so that the police would not find it in his possession and he had gone to hospital for a suspected overdose.

2. The man said he felt suicidal as he was withdrawing from drugs. A self-harm monitoring (ACCT) document was opened. A doctor prescribed diazepam and zopiclone for two days to help with the withdrawal symptoms. After he saw a mental health nurse he was admitted to the healthcare unit.

3. The next day, the man began methadone treatment. He preferred Subutex and was initially opposed to the plan but then accepted it. The dose of methadone was increased from 10ml to 40ml over the next few days. He attended a mental health review with a nurse, and a detailed ACCT assessment and review were carried out. He repeatedly said he had no thoughts or plans of harming himself.

4. On 15 December, the man was prescribed mirtazapine and pregabalin. The next day, his treatment plan was reviewed. He said the methadone was making him feel sick and so he had not been taking the full dose. On 18 December, a doctor agreed to consider slowly reducing his dose of methadone to help him move to back to Subutex when he was released.

5. The ACCT was reviewed the next day. The man said he had no thoughts of harming himself and was happy to move to G wing. The ACCT remained open, but he was assessed as a low risk. The next review was scheduled for 27 December. Over the next few days, a number of entries were made into his ACCT document. He attended a wing induction class and said he hoped his partner and children would visit him soon. On 22 December, he asked to see a chaplain as he had been told that one of his children was in hospital. He saw a chaplain the next day and also spoke to his partner.

6. On the night of the incident, the man was observed in his cell four times. Around 3.20am, an officer became concerned that he had not moved for several hours, but another officer checked and thought he saw his hand move. At 7.20am, an officer was unable to rouse him. Nurses did not attempt to resuscitate him as they found signs of rigor mortis.

7. The investigation has looked particularly at the man's drug treatments, the management of his ACCT, the monitoring on the night of the incident, and the emergency response. We make three recommendations: about prescribing

sedative medication with methadone, awareness of drug-induced unconsciousness and the proper completion of ACCT documents.

THE INVESTIGATION PROCESS

8. An investigation was conducted. Notices about the investigation were posted at HMP Manchester giving staff and prisoners the opportunity to contact the investigator with any relevant information. Nobody came forward in response.

9. The investigator spoke to representatives of the prison's senior management. He obtained records relating to the man's time in custody. He conducted interviews with six members of staff at HMP Manchester on 28 and 29 June 2012 and returned to Manchester in December 2012 to conduct a further interview and to review some CCTV footage.

10. Despite a number of attempts we were unable to contact the man's mother to see if there were any issues she wished to have considered during the investigation. We will attempt to contact her again to see if she wished to receive a copy of this report.

11. The local NHS Primary Care Trust (PCT) commissioned a clinical reviewer to conduct a review of the man's clinical care while in custody. He consulted the man's medical records and ACCT document to inform his review.

12. A post-mortem examination and toxicology analysis indicated that the man died as a result of the toxic effects of methadone, with its toxicity enhanced by therapeutic levels of diazepam and mirtazapine. HM Coroner for Manchester (City) District will receive a copy of this report.

13. We regret the delay in issuing the draft report, which is one of a backlog of cases which we are striving to clear.

14. Following the publication of the draft version of this report, and a meeting between the man's family and the investigator, the solicitors representing the family wrote to us. They thought that we had not given an accurate or complete account of the CCTV footage in this report. On 31 May 2013, an Assistant Ombudsman viewed the CCTV footage with the family's solicitors. As a result, we have made some amendments to the report as a result of watching the footage. The family also asked us to add the following:

    "The man was a loving family man who was devoted to his children. He was trying to put his life together but the illness and death of his younger brother hit him very hard because they were very close."

HMP MANCHESTER

15. HMP Manchester is a high secure prison near the city centre. It also operates as a local prison, serving the courts of the Greater Manchester area. It holds up to 1,269 adult male remand, convicted and sentenced prisoners.

16. Healthcare at HMP Manchester is provided by Manchester Mental Health and Social Care Trust (MMHSCT). The prison has 24 hour nursing care and the healthcare centre includes an in-patient unit. Primary care services include access to a range of in-house and visiting specialist clinics.

Integrated Drug Treatment System (IDTS)

17. The Integrated Drug Treatment System (IDTS) aims to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:

    - early custody;
    - improving the integration between clinical and Counselling, Assessment, Referral and Throughcare (CARAT) services; and
    - reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

18. Methadone is used to treat people who enter prison with a dependence on opiates such as heroin. Prisoners requiring a methadone prescription need to provide evidence of opiate use (a urine sample, evidence of withdrawal, or both). If it is unclear what amount was being used in the community, or in the absence of an existing prescription, the dose of methadone is gradually increased until a level safe for methadone maintenance is reached. The prison can check with the pharmacist in the community to verify that the person was on an observed administration schedule and that the most recent dose was within the previous 72 hours.

19. Prisoners are reviewed after 13 weeks and, unless there are specific reasons such as being on remand, on a short sentence or health reasons, they are gradually detoxified by slowly reducing the amount of methadone prescribed.

Her Majesty's Inspectorate of Prisons (HMIP)

20. The latest inspection of Manchester by HMIP took place in September 2011. The report was published in early 2012. In the introduction to the 2011 inspection report the HM Chief Inspector of Prisons indicated that the most serous concern about the prison was the high level of self-inflicted deaths. The Chief Inspector considered that there was room for improvement in the arrangements for prisoners at risk of suicide and self-harm and the prison was not active enough in ensuring lessons were learnt from previous cases. HMIP found that a full integrated drug treatment system (IDTS) service had been introduced, delivered by the Manchester Drugs Service. Prisoners could access a full range of opiate substitution treatments based on individual need

Independent Monitoring Board (IMB)

21. Each prison in England and Wales has an Independent Monitoring Board (IMB), made up of volunteers from the local community who monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The IMB previously recognised the work of the prison staff in maintaining standards despite the ongoing need for efficiency savings. The IMB also commented that prisoners who were prescribed methadone were offered in-depth, comprehensive interviews about drug misuse, physical and mental health, and personal and social functioning.

22. The most recent report IMB report for Manchester covers the period 1 March 2011 to 29 February 2012. Concern was raised about the number of prisoners in the healthcare unit on open ACCTs. The IMB concluded that this sometimes reached an "almost unworkable" level, though they praised the care and dedication of healthcare staff.

23. The IMB noted that, following the HMIP report, a multi-agency suicide prevention task force had been set up. This included health professionals, prison staff, prisoners, Samaritans, voluntary sector specialists and representatives from other relevant organisations including the PPO.

Previous deaths at Manchester

24. Since this office took over responsibility for investigating all deaths in prison custody in 2004, there have been 43 deaths at Manchester before the man's. Two deaths in 2011 were the result of methadone toxicity. After investigating one of these cases, a recommendation was made about the clinical risks of prescribing sedatives in conjunction with methadone. The same issue is covered again in this report. Five prisoners have died at Manchester since the man's death.

KEY EVENTS

25. The man was remanded to HMP Manchester in December 2010 and, after being sentenced to 12 months' imprisonment, was transferred to HMP Shrewsbury. During this sentence he received methadone treatment and diazepam detoxification. He was released on licence from Shrewsbury on 29 June 2011 to live at probation service approved premises.

26. After breaching the conditions of his licence, the man was returned to HMP Manchester on 23 September, 2011. On arrival he reported that he had been prescribed Subutex (a medication used to treat opiate addiction), pregabalin (a medication used for epilepsy and for neuropathic pain), propanolol (a beta blocker used for high blood pressure and anxiety) and mirtazapine (an antidepressant medication), and that he additionally bought benzodiazepines (a psychoactive drug). His prescription medications were confirmed by his doctor in the community, and he was prescribed Subutex and mirtazapine, as well as starting a diazepam reduction programme. The pregabalin prescription was not continued. On 6 October, it was noted that he was attempting to conceal and not take his Subutex. This was discussed with him, and from then on the medication was crushed to aid supervised administration.

27. The man was released on 20 October 2011 and remained on licence. On 9 December, he was arrested for a new offence of burglary. His licence was revoked and, after appearing at a Magistrates' Court on 12 December, he was remanded to HMP Manchester. The person escort record (PER) noted 'drug withdrawal' as a medical issue and alerted escorting staff to the fact that he had previously escaped from police custody. No other risks were detailed.

28. A nurse carried out a routine health screen when the man arrived and noted that he said he had been in a psychiatric hospital a few years earlier and was involved with the community mental health team as he suffered from paranoia. He told the nurse that he had tried to harm himself five years earlier outside prison, but he did not have any thoughts of suicide or self-harm at the time. He also said he had prescriptions for mirtazapine, propanolol, pregabalin, diazepam and Subutex. In addition to his prescribed medication, he used heroin and cocaine.

29. A nurse from the prison's substance misuse team then saw the man and confirmed with his pharmacist in the community that he was prescribed 16mg of Subutex daily, and had last picked this up on Friday 9 December. The pharmacist had observed him taking his Friday dose, and he had taken away his Subutex for the following two days to self-administer, as normal. He told the nurse that he had been given Subutex as prescribed in police custody and at court. When the nurse attempted to confirm this, he then admitted this was not the case. His weekend doses of Subutex were found with his property.

30. The man told the nurse that he had used heroin and crack cocaine on 8 December. He said that although he was on a prescribed diazepam reduction programme, he took an additional 2-4mg daily, and that when he was arrested

the police took him to hospital as he suspected that he might have accidentally overdosed on diazepam. He said he felt suicidal due to withdrawal from drugs, and could not cope another night without his medication as he did not feel physically well. He also said he was having a 'rough time' and felt depressed. The nurse opened an ACCT document and referred him to the prison's mental health team. She also referred him to see a doctor that evening, and the substance misuse doctor the next day.

31. The nurse completed an ACCT 'concern and keep safe' form. She indicated that her concerns were around 'suicide attempt or intent to kill self', 'very low mood' and 'problems related to drug/alcohol withdrawal'. She wrote that the man felt suicidal due to physical drug use withdrawal, felt depressed, and was withdrawing from opiates and benzodiazepines. She wrote much the same information on the page indicating triggers and warning signs.

32. The nurse used a standardised test for assessing drug withdrawal. The man also provided a urine sample which tested positive for opiates, benzodiazepine and cocaine. A doctor saw him and wrote in his clinical record that he presented a high risk of suicide and self-harm. He appeared low in mood with poor concentration, but was clear in thought. He said he would not harm himself. Because of his high score on the benzodiazepine withdrawal scale, a doctor prescribed 10mg of diazepam for that night and the next day, and zopiclone for two nights to help him sleep. He scheduled a review for the next day. He was admitted to a safer cell in the prison's healthcare unit. (Safer cells are designed to reduce the number of possible ligature points.)

33. A routine cell sharing risk assessment was completed. A nurse wrote on the form that the man said he had serious problems, was finding it difficult to deal with them and felt like he might assault a cellmate. He was assessed as high risk in terms of cell sharing, and was allocated a single cell until such time as the risk was reduced.

34. A registered mental health nurse, who works in the healthcare inpatient unit, saw the man that evening and noted that he made good eye contact and that it was easy to establish a rapport with him. He denied any thoughts of self-harm or suicide and said he just needed to "get his head down". She made him aware of the support services that were available to him, such as Listeners (prisoners trained by the Samaritans to offer confidential peer support) and a telephone to contact the Samaritans directly. She noted that she would monitor him and assess his mental state.

35. A Senior Officer (SO) completed the ACCT immediate action plan form. This records actions taken to keep the person safe during the first 24 hours, before a more detailed assessment is undertaken. The SO noted that the man was in a safer cell, was being observed under ACCT (recorded on the front page of the document as three quality entries during the day and four recorded observations during the night), had made a telephone call to his partner, was aware of support mechanisms, and had been prescribed 10mg of diazepam.

36. The next day, a doctor saw the man and noted that, although he had been prescribed Subutex in the community, his last dose was four days earlier. He was therefore considered out of treatment in terms of continuation of medication. He was offered methadone in line with the Integrated Drugs Treatment Strategy (IDTS) policy and NICE guidelines (starting with a 10ml daily dose and increasing by 10ml daily to 40ml), but he became "mildly verbally aggressive" and said he would harm himself if he could not have Subutex. (The standard IDTS treatment plan for those out of treatment is to prescribe methadone.) He said he would rather die than take methadone. He later apologised, said he was frustrated, and agreed to begin methadone treatment. Because of his high score for benzodiazepine withdrawal, a diazepam detoxification was also started. A nurse wrote in his clinical record that he had commenced diazepam detoxification and methadone titration, and continued to live in the healthcare unit. He would be monitored for five days, with a joint care plan completed after this time.

37. A nurse saw the man on 13 December, for a mental health review and noted that he appeared bright in mood and denied any thoughts of harming himself. He said he wanted to move to an ordinary residential unit. He also talked about his family as a support system and said he would never harm himself. When asked about his overdose of diazepam on 9 December, he said this was not a suicide attempt, and that he took the tablets because he did not want the police to find them. The nurse concluded that although he had been admitted to the healthcare unit because of concerns about self-harm, he denied any such thoughts. His speech was normal in rate, tone and volume, and there was no evidence of thought disorder. Nevertheless, the nurse referred him to see a psychiatrist.

38. Another nurse completed an ACCT assessment interview with the man that day. He again explained that he felt low as he was withdrawing from drugs, and that his overdose of diazepam when arrested was not a suicide attempt. He said that he had cut his wrists five years earlier after his brother died. He said he had no thoughts or plans of self-harm and that he wanted to move to a residential wing. He talked about his partner, children and mother as supportive factors. She wrote that he was to see the psychiatrist for an assessment, and would be encouraged to join in with wing activities.

39. An ACCT review took place at 2.25pm, shortly after the nurse finished the assessment interview. She summarised on the review form the points noted during the assessment, and concluded that the man was a low risk in terms of self-harm. She noted that a routine referral had been made to the psychiatrist, and that a further review would take place on 19 December.

40. The nurse also completed the caremap, part of the ACCT document that aims to identify issues and goals, as well as the action required to achieve them. She listed withdrawal symptoms as the first issue, with an associated goal for the man to withdraw without issues. This would be achieved using the detoxification programme. Another issue identified was low mood, the goal being for his mood to stabilise. In terms of the action required, she noted that a referral had been made for mental health assessment, and that he would be

encouraged to participate in wing activities. He would also be able to voice any concerns that he had using the prison's chaplaincy service, Listeners, and the Samaritans (by telephone).

41. On 14 December, a psychiatrist wrote in his clinical record that the man had asked to be prescribed mirtazapine and propanolol as he had been prescribed it in the community. She told him that she needed confirmation from his doctor in the community before she could issue a prescription. She noted that he reported good sleep and appetite, that his mood was fine, and that he denied any thoughts of harming himself. There were no depressive or psychotic symptoms, or evidence of mental illness. She planned to review him in one week.

42. The same day, a doctor recorded that the man's doctor in the community confirmed that he had been prescribed Subutex, mirtazapine and pregabalin.

43. On 15 December, the psychiatrist prescribed mirtazapine and a doctor prescribed pregabalin for the man. (Prescription charts indicate that he received 200mg of pregabalin in the morning, 300mg of pregabalin and 30mg of mirtazapine at night, every day from 15 December until 23 December.) A nurse wrote in the clinical record that day that he was settled and felt happy now that his medication was correct. The nurse also wrote that he was compliant with wing procedures, had not expressed any thoughts of suicide or self-harm, but remained on an ACCT.

44. The next morning, a healthcare assistant wrote in the clinical record that the man joined in association and exercise, and had not voiced any thoughts of self-harm. A nurse held the five-day review of the man's treatment plan. He said that methadone made him feel sick so he was not taking it all. The nurse made an appointment for him to discuss this with the doctor on 19 December.

45. On 17 December, a nurse recorded that the man remained compliant with the wing regime and had not voiced any thoughts of self-harm. A healthcare assistant made a similar note on the morning of 18 December. Appropriate entries were made in the ACCT document.

46. The man saw a doctor on the morning of 18 December, to discuss his drug treatment plan. (This was one day earlier than had originally been arranged.) He continued to feel aggrieved that he was being prescribed methadone rather than Subutex. The doctor explained that his prescription was in accordance with the IDTS policy and that nothing could be done except to prepare him for release on a dose that would enable him to convert back to Subutex in the community with the least possible delay. They agreed that he would continue to take 40mg daily for a few days and then consider slowly reducing the level to 30mg daily by the date he thought he would be released, 28 December. (Although his licence expired on 28 December, he had been convicted of a separate offence and had a court hearing scheduled for 9 January 2012. It is therefore likely that he would have remained in custody until at least this date.) The doctor agreed to reschedule his diazepam doses

to twice daily and slow down the rate of reduction to 2mg every three days. He also asked to transfer to a residential unit from the healthcare wing.

47. A nurse wrote in the clinical record on the morning of 19 December, that the man's ACCT would be reviewed that day. She noted that he had not expressed any thoughts of self-harm. Shortly afterwards, the psychiatrist saw him and described him as bright in mood with good eye contact and rapport. He denied any thoughts of self-harm and again mentioned his children as supportive factors. She noted that he appeared settled and stable, and was fit for normal location.

48. The man's ACCT was reviewed that afternoon. Two nurses, a SO and an officer attended, as well as the man. His level of risk was assessed as low. He said he was feeling okay and said he did not have any thoughts of harming himself. He said he had no unresolved issues and was happy to move to a residential wing. He also said he would speak to members of staff on his wing if he encountered any problems. A nurse from the mental health team would continue to work with him after he had moved from the healthcare unit. The ACCT remained open, but he was discharged from the inpatient wing and moved to a safer cell on G wing. The cell happened to be covered by closed circuit television (CCTV) but this did not form part of his management plan and the CCTV footage was not monitored closely. The next ACCT review was scheduled for 27 December.

49. On 20 December, it was noted in the man's ACCT document that he had attended the wing induction class and seemed alert and attentive throughout. He said he hoped his partner and children would visit him soon. The next day, he spoke to an officer and said that, although he was a little depressed because he would not see his family over Christmas, he would be fine. The officer noted that he was interacting well with other prisoners and seemed settled on the unit.

50. On 22 December, a note was made in his ACCT ongoing record that the man asked to contact the chaplaincy because he had been told that one of his children was in hospital. The person making the note contacted the chaplaincy and arranged for someone to see him. The next day he told an officer that he felt fine and mentioned no ongoing concerns. A chaplain wrote in the ACCT record that he had seen the man and that he had spoken to his partner. He told the chaplain that he was experiencing problems sleeping and was advised to speak to the doctor. There was no reference to his children.

51. After the publication of the draft version of this report, an Assistant Ombudsman viewed the CCTV footage from the man's cell from 11.32 on the day of the incident. (The investigator had previously viewed CCTV footage from approximately 5.30pm, in order to establish whether ACCT checks had been completed as recorded.) At 2.05pm, it appears that he is retching into the sink. Although it is not completely clear, then he appears to put an item, possibly a cup, on the table in front of the television. At 2.10pm, another prisoner entered the cell. He gave him the item from the table, and the prisoner appears to swallow from the item. Over the next two hours, he spent

most of the time in his cell. Several other prisoners visited him during this time.

52. The man left his cell at 4.05pm. Officer A told the investigator that, around 4.00pm on the day of the incident, the man asked if he could have a chat with him the next day. He asked him if it was anything urgent, but he said it was not. He said he asked him if he had any problems, and that they could talk if he did, but he said that was not the case. He returned to his cell at 4.07pm with another prisoner. The Muslim chaplain visited him at 4.17pm, and this visit was noted on his ACCT form. He then appears to clean his cell for 20 minutes.

53. The man left this cell at 4.45pm, returning seven minutes later with a dinner tray. After eating, he appears to throw something down the toilet at 5.04pm.

54. From 5.07pm, the man appears to spend much of the next hour retching, either in the sink/toilet area or while sitting on his bed. At 5.54pm, he spent about a minute by the window of the cell. At 6.09pm, he moved towards the cell door and appears to be looking through the gap between the door and the frame (he is not talking to anyone through the hatch). At 6.18pm, he moved to the chair and appears to collapse on the desk, not moving again until 7.20pm. After changing the channel on the television, he moved to the bed.

55. Officer B was working overnight on G wing, from the night of the incident until the following morning. She started her shift at 7.30pm and did not recall any members of staff who were finishing their shifts mentioning any concerns about the man. She was aware that he had an open ACCT document and that he needed to be checked four times at night.

56. At 7.34pm, the door of the cell opened. It is not clear who this was, although the ACCT record suggests that an officer entered the cell and spoke to the man (this officer was not spoken to by the PPO). The officer left the cell at 7.35pm.

57. Officer B completed the first check on the man at 8.00pm. She wrote in the ACCT document that he was lying on his back, appeared to be asleep, and that movement was observed. During interview, she could not recall the exact nature of the movement. She had no concerns about him after conducting the 8.00pm check. (The CCTV record suggests that this check actually took place at 7.46pm.)

58. According to the CCTV footage, the man moved very little after this check. By 10.22pm, he was lying on his right hand side, with his right arm straight out and his left arm over that, at an angle. This is the position he was found in the following morning. After reviewing the footage, the Assistant Ombudsman did not detect any movement after 10.33pm.

59. The next check was at 12.05am (according to the CCTV, this was actually 11.55pm). Officer B wrote in the ACCT document that the man was lying on his right side and appeared to be asleep. She did not record whether she saw

him move, but his position had changed since the previous check and she was not concerned about his wellbeing at this point.

60. Officer B wrote in the ACCT document at 3.20am (3.10am on CCTV) that the man was lying on his right side, appeared asleep, and that movement of his hand was seen. She explained at interview that when she completed her check, she was concerned because he did not appear to have moved since the last time she had observed him. She asked a colleague working on K wing to attend G wing and check on him. She said that when the officer attended and looked through the observation panel, he said he saw his hand move.

61. The Assistant Ombudsman has subsequently reviewed the footage with the man's family's solicitor. The hatch opens at 3.10am. The light in the cell is switched on at 3.11am, and switched off again at 3.13am. The hatch opened again at 3.16am, and closed again at 3.20am. During this time, he did not appear to have moved. However, the CCTV camera is at the back of the cell, looking at the door, and the television was still on. It is possible that, looking through the hatch, with the light of the wing behind the viewer and the television flickering, the officers thought that they saw movement.

62. The fourth check of the man was conducted at 6.00am. Officer B wrote in the ACCT document that he was lying on his left side and appeared to be asleep. However, she told the investigator during interview that she was mistaken, and that he was in fact lying on his right side. She said his arms were outside the covers and she was not concerned about him.

63. Officer A began work at 6.30am the next day, and estimated that he arrived on G wing at around 6.50am. He received a handover about the overnight period from Officer B. She was not able to recall exactly what she said to Officer A, but said that she mentioned the man. She reiterated to the investigator that she had not been concerned about him at that time, and that her previous concerns had been resolved. Officer A told the investigator that, because of what Officer B had told him, he went to the cell after completing a routine check of all prisoners for the roll count, and checking the other prisoners who were subject to ACCT monitoring. He reached the cell around 7.15am, looked through the observation panel and saw that the man was lying in bed. He said that he appeared slumped, with his head and arms hanging from the side of the bed. He saw liquid on the floor of the cell and noticed that the television was on.

64. As he was concerned about the man, Officer A went to the adjacent K wing to ask Officer C for a second opinion. When the officers returned to G wing and she looked through the observation panel, a radio message confirmed that the roll check of prisoners was correct and that the patrol state had ended which meant that cells could be unlocked routinely. Both officers then went into the cell. Officer A said the man was lying on his right side. (The ACCT ongoing record at 6.00am indicated he was lying on his left side. The CCTV footage clearly shows that he was lying on his right hand side.) He told the investigator that he was not able to rouse him, and that he felt very cold and

stiff. Officer C relayed a Priority 1 radio message at 7.25am. A Priority 1 message indicates a life threatening situation.

65. Three nurses were in the prison's healthcare unit when the radio message was received. Nurse A asked the other two nurses to collect emergency medical equipment and then attend the wing, while he went directly to the wing. After arriving on the wing, but before reaching the cell, he asked a member of staff to call an ambulance. When he arrived at the cell, he found that the man's cell door was unlocked and open, with two officers inside trying to gain a verbal response from him. He also described him as lying on his right side.

66. Nurse A was unable to elicit a vocal response from the man. He checked for a carotid pulse but could not find one, and noticed that he felt "exceptionally cold". He also observed that his limbs felt very stiff, which he attributed to rigor mortis. When the covers were removed he noticed lividity marks (which are caused by the pooling of blood after the heart stops beating). As a result of these signs, he concluded that he had died some time earlier and decided not to attempt resuscitation. He told the investigator that he thought it was futile and would be undignified for him.

67. After completing his assessment, Nurse A went to a nearby wing office as the prison's control room had asked for information about the man's condition. He explained that, although he believed that he was dead, an ambulance would still be required. While he was speaking to the control room, the other two nurses arrived at the cell. Nurse B, unaware of her colleague's decision, initially asked for the man to be placed on the floor of the cell so that she could assess him. However, she told the investigator that, when officers tried to move him, it quickly became clear that he was very stiff and rigor mortis had set in. She reached the same conclusion as Nurse A, that resuscitation would be futile. The other nurse also agreed with this decision. He was placed back on the bed.

68. An ambulance was called at 7.30am. It arrived at the prison at 7.35am, and paramedics entered G wing at 7.40am. At 7.42am, after assessing the man, paramedics pronounced that he had died. The paramedics noted that he displayed obvious signs of rigor mortis.

Events after the man's death

69. A meeting known as a 'hot debrief' took place on the same morning. This involved the members of staff who had been involved discussing what had happened and vocalising their thoughts and feelings. Brief minutes of this meeting were taken.

70. The prison's Safer Custody Department told the investigator that all prisoners subject to ACCT monitoring were reviewed on 24 December. Members of the chaplaincy team attended G wing to support prisoners and staff.

71. Family liaison officers from the prison visited the man's family on the morning of his discovery to inform them of his death. Unfortunately, a prisoner at Manchester who knew him and his family had already telephoned them and told them that he had died. The family liaison officers offered ongoing support to the family and the prison offered to contribute towards the costs of the funeral.

72. A post-mortem examination took place on 24 December. A blood sample was sent for toxicological analysis and this was completed in March 2012. The post-mortem report was completed on 12 April and concluded that the cause of the man's death was the toxic effects of methadone, enhanced by the presence of therapeutic levels of diazepam and mirtazapine.

ISSUES

Drug treatment

73. When the man arrived at HMP Manchester on 12 December, he saw a substance misuse nurse who asked him about his illicit drug use and prescribed treatment. Assessments were completed regarding his level of withdrawal, and he saw a doctor who prescribed medication to help alleviate withdrawal symptoms during his first two nights in custody. The day after his arrival, a treatment plan was formed.

Methadone

74. On 13 December, the man saw a doctor, who prescribed methadone on a titrating dose from 10ml to 40ml. He did not initially want to be prescribed methadone, at least initially, because he preferred Subutex, another opiate substitute, which he had been prescribed in the community. However, because he had not taken his prescribed dose of Subutex for three days before entering custody, that treatment plan was not continued. His methadone titration programme was in accordance with established IDTS procedures.

75. The man had a supervised dose of methadone, which meant that staff watched him take it and he was not allowed to take it away, every day from 13 December to 23 December. At the time of his death, his prescribed dose of methadone was 40ml daily. Accurate records were kept of the prescription and its administration.

76. The clinical reviewer, in his review of the man's clinical care, concluded that the methadone prescription was appropriate. He noted that a daily dose of 40ml was at the lower end of the recognised therapeutic range.

77. A forensic pathologist completed the post-mortem report. In it, she noted that the toxicological blood analysis revealed a "very high" level of methadone, and said:

> "Considerable tolerance can be developed to opiates, methadone included, such that users can survive the central nervous system (CNS) depressant effects of a particular dose which would be fatal in a naïve user. The man had been prescribed methadone on a number of occasions during his detention, including his final detention and accordingly, he would have developed some tolerance to this substance. Although the blood level here is in the range commonly associated with fatalities, it is actually very difficult to state what constitutes a fatal dose in a person habituated to methadone because of the tolerance they have developed. In addition, methadone levels can be artificially elevated due to post-mortem distribution. Nevertheless, even with these caveats, the blood level here was high.

> "Methadone has a long half-life and so doses may be cumulative over a period of hours to days. Whether the level here could have been achieved by his properly taking only the methadone he was prescribed (this seems unlikely), or whether it probably reflects his storing up prescribed methadone (to take a single larger dose than prescribed) or his acquisition of an additional illicit supply is not within my expertise. However, the fact that the diazepam and mirtazapine were detected at therapeutic levels and the methadone was not suggests that he had taken more methadone than was prescribed to him on a daily basis."

78. The post-mortem report does not reach a definite conclusion about whether the man had taken more methadone than was prescribed to him. However, the clinical reviewer mentioned that his prescription was at the lower end of the therapeutic range, and the pathologist thought it unlikely that the level of methadone found in his blood would arise from taking only that which was prescribed. It is possible that he used more methadone than was prescribed to him.

79. Methadone is a controlled substance and prisoners are not allowed to have it in their possession. Methadone treatment is based on supervised administration, where members of staff observe prisoners ingesting their daily dosage. Nevertheless, there are methods of circumventing this system, which allow prisoners to appear to have ingested their methadone when in fact they have not. As a result, methadone is sometimes illicitly traded in prisons.

80. (In response to the publication of the draft report, NOMS asked us to add that "methadone is prescribed and distributed in liquid form. We would also like it noting that whilst staff are supervising methadone treatment they always ensure that the prisoners drink a cup of water prior to administration of methadone and afterwards to minimise the risk of secretion".)

81. The man did not mention to members of staff that his prescribed methadone dose was insufficient. In fact, when he attended a review of his treatment plan on 16 December, he said that he was not taking his full dose because it made him feel sick. When he saw a doctor about this, consideration was given to reducing his methadone prescription so that he would be better prepared to move back to a Subutex prescription in the community.

82. Although we cannot be certain that the man took more methadone than was prescribed to him, it seems likely that he did. His daily dose was in line with IDTS policies for methadone treatment. Administration of the medication was supervised and there were no concerns that he was attempting to store up his medication (although this had been raised as an issue in October 2011, when he was prescribed Subutex). Nevertheless, it is possible that he obtained an illicit supply of methadone or did not properly ingest his own medication and stored it up to take a bigger dose.

Diazepam and mirtazapine

83. When the man arrived at Manchester on 12 December, he was found to be withdrawing from benzodiazepines. He said that he was on a prescribed diazepam reduction programme but took an additional 2-4mg daily. Because of his high score for benzodiazepine withdrawal, a doctor prescribed 10mg of diazepam daily for two nights in order to help him to manage his withdrawal symptoms. On 13 December, a doctor prescribed a diazepam detoxification programme, which involved a reducing course of diazepam.

84. A psychiatrist prescribed mirtazapine for the man after confirmation from his doctor that he was in receipt of such a prescription in the community.

85. The clinical reviewer noted in his clinical review that diazepam was prescribed in line with national guidance, and that the prison followed good practice by obtaining the man's community medical records and continuing his prescription of mirtazapine.

86. In the post-mortem report, the pathologist stated that:

> "Methadone's depressant effects can be enhanced by other central nervous system depressants such as alcohol, diazepam and mirtazapine. The man was prescribed diazepam and mirtazapine, and these medications were detected at therapeutic levels, consistent with his having taken these medications in the prescribed manner."

87. She went on to recognise the toxicologist's conclusion that the toxic effect of the methadone could have been increased by the diazepam and mirtazapine. As a result, she concluded that his death was caused by the toxic effects of methadone and that its toxicity was enhanced by the presence of therapeutic levels of diazepam and mirtazapine.

Pregabalin

88. The man was prescribed pregabalin by a doctor on 15 December, after his doctor in the community confirmed that he was in receipt of a prescription for this medication. The clinical reviewer concluded in his review that it was reasonable to prescribe pregabalin after confirming that he was in receipt of it, but suggested that a reduced dosage might have been considered in light of the six-day gap in treatment. He further discussed the use of this medication, stating:

> "Substance misuse doctors and prison GPs have been aware for several years of the widespread abuse and addiction associated with pregabalin. This anti-epileptic drug is used for neuropathic (nerve damage) pain. It increases the effects of opiate drugs, has diazepam-type effects and causes euphoria in some patients. Many patients have learned to describe 'shooting pains' or 'electric shocks' in order to obtain prescriptions for pregabalin."

89. The clinical reviewer went on to say:

> "Pregabalin is widely recognised as a drug with very significant abuse potential. For safety reasons, its use should be avoided wherever possible in patients with a history of substance misuse. This recommendation is supported by existing consensus publications on prescribing and also in national guidelines for pain management in prisons, currently in development.
>
> "Extreme caution should be exercised in prescribing pregabalin along with other sedating drugs. In particular, the synergistic (additive) effect with opiates and benzodiazepines may be dangerous.
>
> "The post-mortem and toxicology results do not include any reference to pregabalin. Consideration should be given to including this drug in the investigation of potentially drug-related deaths."

90. As the clinical reviewer stated, pregabalin was not part of the toxicological blood analysis and therefore did not form part of the post-mortem report. However, he is also very clear about its potential for abuse and the caution that should be exercised in prescribing pregabalin alongside other sedating drugs. The man was prescribed methadone, diazepam and mirtazapine, and the depressant effects of these medications have already been discussed. It is, of course, not possible to conclude that the use of pregabalin played any part in his death. Nevertheless, healthcare staff should be aware of its significant abuse potential and its sedative effect. Decisions about prescribing pregabalin should be properly documented, particularly in the case of substance misuse patients and those prescribed other depressant medication.

91. After a death at Manchester in March 2011 (reported on in March 2012), we investigated the prescribing of other depressant medication, and in particular mirtazapine, in conjunction with methadone. During that investigation, a doctor at the prison explained that it was her expectation that no other sedative medication should be prescribed in the first five days of a methadone programme. (In their response to this draft report, NOMS asked us to point out that the doctor clarified her explanation after the publication of the draft report in the previous investigation. She said that "she would have waited until the client was stable on his methadone before prescribing sedatives … all clients had individual needs and that the mirtazapine prescribed was a very low dose".) In this case, the man was prescribed diazepam and mirtazapine, both of which can enhance the CNS depressant effects of methadone. After the previous death, we made a recommendation that was rejected by Manchester on the basis that all doctors are expected to adhere to the standards of practice set out in GMC guidance and good medical practice. We recognise that expectation but believe that highlighting clinical risks can do no harm. We make a similar recommendation here, encompassing the use of pregabalin in conjunction with methadone about which the clinical reviewer also had concerns.

The Head of Healthcare should ensure that prison and visiting clinicians are aware of the clinical risks associated with prescribing sedatives, and pregabalin, in combination with methadone, and that a considered judgement is made and properly recorded in each case.

92. In general terms, the clinical reviewer concluded that:

> "The man received satisfactory, equivalent and appropriate healthcare from Manchester's healthcare department. I do not believe that his death could have been prevented by any changes in the care he received."

Assessment, Care in Custody and Teamwork (ACCT)

93. When the man arrived at Manchester on 12 December, an ACCT document was opened when he said he felt suicidal due to drug withdrawal. In line with established ACCT procedures, an immediate action plan was formed, and a full ACCT assessment took place the next day. A review took place after the assessment, and a further review took place on 19 December, before he was discharged from the inpatient unit. A referral was also made for him to see a psychiatrist, and he had a number of reviews with a mental health nurse.

94. The ACCT document was generally well maintained. The man repeatedly denied that he had any thoughts of harming himself. At the time of his death he was assessed as low risk, though still subject to the ACCT.

95. Over the course of the incident, four entries were made in the ongoing record of the man's ACCT document. This was consistent with the number of observations that should have taken place overnight, according to the ACCT document.

Observation on the night of the incident

96. Officer B explained to the investigator that she checked on the man as required. She made entries in the ACCT document at 8.00pm, 12.05am, 3.20am and 6.00am. She observed movement at 8.00pm and noted that he was lying on his back. She wrote that he was lying on his right side when she conducted the 12.05am check.

97. When she was interviewed, Officer B gave a full account of the options available to her if she became concerned about any prisoner on the wing during the night. These ranged from asking another member of staff for help, entering a cell in an emergency or using approved radio call signs to summon immediate medical assistance if required. When she checked the man at around 3.20am, she became concerned that he seemed to be in the same position as at the earlier check. She then asked her colleague from K wing, Officer C, to check on him, and he told her that he saw his hand move. She said her concerns about his wellbeing were therefore allayed.

98. With hindsight it appears unfortunate that no further action was taken. Officer B took what she considered reasonable action. She was concerned that the

man did not seem to have moved, but she had no reason to think that anything was seriously wrong. Officer C, who attended the wing, reassured her that he saw the man's hand move and she accepted her colleague's observation, which indicated to her that he was alive. However, we are concerned that as well as being subject to ACCT monitoring he was also on a methadone maintenance regime. While we make no particular criticism of Officer B, we consider that in such circumstances officers should be alert to the risk of methadone toxicity and drug-induced unconsciousness and ensure they gain a positive response from a prisoner whenever there are concerns about their wellbeing.

The Governor should ensure that staff who monitor prisoners on methadone maintenance regimes are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication, and try to gain an active response from them whenever there are concerns about their wellbeing.

99. The CCTV footage from the wing shows Officer B completing cell checks, including the man's cell, at approximately the times recorded in the ACCT document. The footage also shows Officer C attending the wing and looking into his cell for a few minutes at around 3.20am, at the time she said that he came to the wing.

100. Although Officer B took some action, this was not properly recorded in the ACCT document. There was no mention of Officer C attending the wing, and nothing to indicate that it was him, rather than her, who observed movement. Furthermore, the descriptions of the man's position were not always correctly recorded. Officer B wrote that he was lying on his back when she checked him at 12.05am, but the CCTV footage shows that he was lying on his right side. He had been in this position - essentially the same position in which he was found the next morning - since around 10.30pm. She also mistakenly wrote in the ACCT document that, at the time of the 6.00am check, he was lying on his left side. In fact, he was lying on his right side.

101. It is essential that complete and accurate records are maintained in ACCT documents, particularly when some concerns have been identified and are being addressed. Although the CCTV footage confirms that Officer C also checked on him, this should have been recorded. We therefore make the following recommendation:

The Governor should ensure that staff record all significant events in ACCT documents.

Emergency response

102. After starting his shift, Officer A completed his roll count of all prisoners, checked the other prisoners with open ACCTs, then went to the man's cell. This was an appropriate course of action as, although Officer B had told him that she had been concerned during the night, she also said that the situation had been resolved.

103. When the Priority 1 call was made at 7.25am, three nurses responded. Nurse A went immediately to the man's cell, while two other nurses went to get emergency equipment. He arrived at 7.28am. His assessment was that resuscitation would be futile. The other two nurses agreed with this decision. An ambulance was called at 7.30 and, when paramedics arrived at 7.40am, they found clear signs of rigor mortis.

104. The clinical reviewer wrote:

> "It was appropriate for staff not to attempt resuscitation in this case. The man had clearly been dead for some hours; resuscitation would have been futile and undignified."

105. We endorse the view that, in cases where there are obvious signs of death such as rigor mortis, it is appropriate that resuscitation is not attempted.

CONCLUSION

106. The man was recalled to HMP Manchester in December 2011 and also charged with other offences. He had been prescribed Subutex in the community but had not taken it for several days and began a methadone maintenance programme in prison. An ACCT was opened because he said he felt suicidal as a result of withdrawing from drugs.

107. The man was also prescribed mirtazapine and pregabalin, which he had received in the community. On the night of the incident a prison officer checked on him four times. When the officer became concerned that he had not moved for some time, she asked a colleague to check. He said he thought he saw him move so there was no further concern. No active attempt to get a response was made. Shortly before 7.20am the next morning, his cell was unlocked and he could not be roused. Nurses attended but resuscitation was not attempted as it was apparent he had been dead for some time.

108. The man died of methadone toxicity apparently exacerbated by the sedative effects of other drugs he had taken. It is possible that he took additional methadone, other than that he was prescribed. While there is nothing to indicate that his prescribing was not appropriate and in line with current guideline, as in a previous case at Manchester we suggest a more cautious approach to prescribing sedatives with methadone and the clinical reviewer is particularly concerned about the use of pregabilin for those with substance misuse problems. His ACCT document was reasonably maintained although concerns noted in the early hours of the morning were not properly documented and observations were not accurately recorded. Once he was found unresponsive there was an appropriate emergency response.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prison and visiting clinicians are aware of the clinical risks associated with prescribing sedatives, and in particular pregabalin, in combination with methadone, and that a considered judgement is made and properly recorded in each case.

   NOMS accepted the recommendation and commented:

   All doctors are expected to adhere to the standards of practise set out in GMC guidance, good medical practise. This states that in providing care a doctor must

   1.Prescribe drugs or treatment, including repeat prescriptions, only when you have adequate knowledge of the patients health and are satisfied that the drugs or treatment serves the patients need.

   2 Provides effective treatments based on the best available evidence.
   Also system one has an automatic warning system for medication interactions, such as those which may result in increased sedation, which is activated when prescribed.

2. The Governor should ensure that staff who monitor prisoners on methadone maintenance regimes are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication, and try to gain an active response from them whenever there are concerns about their wellbeing.

   NOMS accepted the recommendation and commented:

   We currently have a training package in place that is delivered to front line staff working on the detoxification units. This training covers symptoms of drug induced unconsciousness and methadone toxicity. The Drug Strategy Manager will ensure that the training package is updated to include the need for staff to illicit a response from a prisoner is they have concerns about their wellbeing.

3. The Governor and Head of Safer Custody should ensure that staff record all significant events in ACCT documents.

   NOMS accepted the recommendation and commented:

   An audit has already been completed on recoding of significant events. The Head of Safer Prisons will develop and issue guidance to staff on recording significant events in both the ACCT documents and during case reviews.