Investigation into the circumstances surrounding the death of a man at HMP Brixton on 15 May 2007

Report by the Prisons and Probation Ombudsman for England and Wales

April 2009

This is the report of an investigation into the death of a man who was found dead in his cell at HMP Brixton on 15 May 2007. The man was 24 years old.

I wish to offer my sincere sympathy and condolences to the man's family and friends for their loss. I must also apologise for the delay in issuing this report. This was in part due to the time taken to establish the cause of the man's death, and to obtain the subsequent clinical review conducted by a firm on behalf of Lambeth PCT.

The investigation was conducted by one of my Senior Investigators. I am grateful to the Governor of HMP Brixton and his staff for their help and co-operation during my inquiries. I also thank those prisoners who agreed to take part in the investigation process. Finally, I must thank the clinical reviewer for his report concerning the man's care during his detoxification from alcohol.

This report highlights the dangers associated with withdrawal from alcohol after heavy consumption over a prolonged period. The clinical review team have made a large number of generic recommendations in relation to a series of deaths at Brixton, but none is directly relevant to the circumstances described in this report. I have made two recommendations of my own which have been accepted and implemented by the Governor.

Stephen Shaw CBE
Prisons and Probation Ombudsman **April 2009**

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SUMMARY

The man was arrested for assault and a public order offence on 8 May 2007. After pleading guilty to the charges at a Magistrates Court on 10 May, and spending that night at Hornchurch Police Station due to lack of cell space, he arrived at HMP Brixton on Friday 11 May.

During the reception process, the man told the healthcare nurse that he drank a large amount of alcohol and took a number of controlled drugs each day. The nurse referred him to see the doctor who started the man on a chlordiazepoxide alcohol detoxification regime.

The following day, the man saw the substance misuse nurse and another doctor who prescribed a methadone programme and a benzodiazepine detoxification regime.

The man received his prescribed medication over the weekend, but on Monday 14 May a decision was made by the first nurse and the prison pharmacist to stop the chlordiazepoxide.

The man was transferred to A wing during the afternoon of 14 May. During the following night the man was shivering and his cell mate became concerned. He rang the cell bell to summon the night officer. When the officer arrived at the cell the man told him that he did not want a nurse. The officer returned on other occasions and saw that the man was apparently asleep in his bed.

Just before 8.20am on 15 May, the man's cell was opened along with others on the wing. It was believed that he was still sleeping when he did not answer the officer's call. His cell mate was asked to wake him after a few more minutes so that the man could collect his medication. A short while later, the man's friend came to the cell and discovered that he appeared to be dead.

The alarm was raised and staff responded but found that there was nothing to be done. The man was pronounced dead at 8.40am by a prison doctor.

In December 2007, the post mortem examination report determined that the man died of fatal cardiac arrhythmia due to alcohol withdrawal syndrome. (An arrhythmia is an abnormality of the heart's rhythm that disturbs the electrical impulses which regulate the heart.) Amongst other things, my report recommends that the Governor and Healthcare Manager ensure that regular recording of blood pressure and pulse rates are a standard element of alcohol detoxification regimes.

THE INVESTIGATION PROCESS

1. The investigation was opened at HMP Brixton on 23 May 2007. The Governor and his staff produced the man's core record and a large number of other documents for examination. Notices were displayed around the prison to inform both staff and prisoners of the investigation.

2. My investigator formally interviewed a number of members of staff and prisoners regarding the man's death. The transcripts of those interviews are attached to this report.

3. One of my Family Liaison Officers contacted the man's sister who had been listed as his next of kin. This gave her the opportunity to discuss the purpose of the investigation and to raise any questions she wanted explored and addressed. The man's sister raised several issues about the circumstances of her brother's death. She was concerned about the apparent lack of medical intervention after the man pressed his cell bell during the night of 14/15 May, whether the injuries the man received during his arrest played any part in his death, and the way that she was told about her brother's death and the lack of ongoing contact from the prison subsequently. The man's father instructed a solicitor to act on his behalf in connection with the investigations into his son's death. I hope this report helps the man's family better understand the events leading to his discovery on the morning of 15 May 2007.

4. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the post mortem report. The cause of the man's death was not known until the Home Office Pathologist (who carried out the post mortem) published his report in December 2007.

5. Upon completion, this investigation report will be sent to the Coroner to assist with the inquest into the man's death.

6. Lambeth Primary Care Trust was asked to prepare a clinical review of the care that the man received whilst at Brixton. A private company, commissioned by the PCT, prepared the report. My office received a copy in March 2008, but we felt that a further report was needed to clarify the detoxification treatment that the man received. That report was received in June 2008. It was prepared by the section head for offender health (substance misuse) at the Department of Health.

7. As a result of questions raised in the clinical reports, some further investigation and interviewing was required regarding the dispensing of the chlordiazepoxide prescribed for the man.

HMP BRIXTON

8. Brixton first opened in 1819 and in its time has been both a prison for women and a military prison. Brixton's primary role now is as a local prison holding remand and trial prisoners committed from the local magistrates courts, as well as the Inner London and Southwark Crown Courts.

9. Ms Anne Owers, Her Majesty's Chief Inspector of Prisons, writes in the introduction to her May 2008 inspection report on Brixton:

> "This will be a disappointing report for the committed management team and the many hardworking staff at Brixton. There are things that can and must be managed better – in particular, the supply of drugs, which requires effective internal management and support from both police and prison security services. However, it is hard to see how Brixton, given its physical limitations, can be transformed into an effective local prison, offering both decency and rehabilitation to its 800 prisoners. Those responsible for offender management in the London area need to decide what role Brixton can and should play in their strategy – perhaps as a resettlement prison for south London – and then ensure that it is resourced for that role. Without that, Brixton will simply continue to recycle its prisoners and risk demoralising its managers and staff."

10. At the time of the man's death, HMP Brixton was in the process of introducing the Integrated Drug Treatment System (IDTS). IDTS is a new approach to drug treatment that involves drug workers, prison healthcare, and uniformed prison staff working together more closely. IDTS represents the first step in a user's journey towards giving up drugs. This may involve them being prescribed medication such as methadone or subutex (buprenorphine).

11. In the section of her 2008 report relating to substance use, the Chief Inspector, Ms Owers, writes:

> "The integrated drug treatment system (IDTS) had started, but full implementation had been hampered by delays in adaptations to the dedicated drug treatment wing. There was good psychosocial support for drug users, but there was little for prisoners with alcohol problems and no separate alcohol strategy. Drug testing was inadequate, and the availability of illicit drugs potentially undermined the good therapeutic work."
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> "Basic alcohol awareness was provided by CARAT workers, but there was no alcohol-specific strategy. There had been no alcohol needs analysis, and it was not possible to ascertain the demand for such work. At the time of the inspection, 30 of the CARAT team's cases (about 10%) indicated alcohol as their primary or secondary substance of choice."

12. In May 2007, healthcare services were commissioned directly by the prison. The visiting doctors came from a local GP practice and mental health services were provided by the Oxleys NHS Trust. HMP Brixton also directly employed

the healthcare staff. Heathcare services at Brixton are now commissioned by Lambeth PCT and are provided by Care UK Ltd and other providers under contract to the company.

13. Each prison has an Independent Monitoring Board (IMB). IMB members are independent and unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained. In the executive summary of the latest IMB report for Brixton (2006-2007), the chairperson writes:

> "The Independent Monitoring Board ('the Board') of HMP Brixton accepts that the past year has been a challenging one for all involved within the prison largely because of the very high turnover of prisoners and the pressures on places. The Board recognised the need for change in order to achieve high standards and it is to the prison's credit that there have been many new initiatives during the reporting year. The Board looks forward to seeing the full impact of these and proposed changes in the coming year."

14. Later in the IMB report, comment is made on the prison's response to a series of six deaths occurring during the reporting year (I have excluded the reference to my own office as this has been the subject of separate correspondence):

> "… the Deputy Governor held a meeting on 29 May 2007 to discuss the recent deaths and to try to identify any common themes or actions that need to be taken. The meeting commissioned the following pieces of work: a review of reception processes; exit survey of prisoners; survey of mid-term prisoners for their views on Reception and how their concerns had been addressed; an assessment of healthcare staff and discipline grades; and a re-launch of the Insiders scheme. This is all highly commendable and should contribute positively to the Safer Custody agenda at HMP Brixton."

15. Since I was given responsibility for investigating all deaths in prison custody in April 2004, there have been nine deaths at Brixton prior to that of the man. In a report issued a year before the man's death, I made a recommendation reminding staff of the correct procedure for the administration of methadone as set out in the relevant guidance. This should include regular monitoring of blood pressure and pulse.

KEY FINDINGS

16. On Tuesday 8 May 2007, police were called to a disturbance in a town in Essex. After a violent struggle, they arrested the man. The man was taken to the local police station and charged with a public order offence and assaulting a police officer. He appeared at a Magistrates Court on 10 May, and was sentenced to four months imprisonment after pleading guilty to the charges.

17. The man was held overnight at Hornchurch Police Station due to a lack of prison cell spaces. The following day (Friday 11 May), he was taken to HMP Brixton and went through the usual reception process. He was seen by the second nurse who completed the First Reception Health Screen form. The man told the nurse that he had last been in prison earlier in the year at Leicester. The man had bruises on his face and arms which he said he had sustained at the police station. He said that he was allergic to penicillin and had been diagnosed with epilepsy but was not taking any treatment for the condition. When asked about substance abuse, the man told the nurse that he drank two to two and a half bottles of vodka. Although the frequency is not clear from the form, he answered "none" when asked how much he had drunk in the week before coming into custody.

18. When asked about any drug use, the man said that he used heroin, benzodiazepines, amphetamine and crack cocaine daily, and had last used methadone over the previous weekend. The man denied any mental health problems then or in the past. The second nurse referred the man to see a doctor in relation to his substance misuse. Whilst still in reception, the man saw the prison doctor who started him on an alcohol detoxification regime consisting of daily vitamin B and thiamine and a reducing dose of chlordiazepoxide (librium). He received his first 25mg dose before moving onto a wing.

19. As part of the reception process, the man saw the first officer who carried out a Cell Sharing Risk Assessment (CSRA). During the course of the interview for that process, the man told the officer that he had previously been convicted of racially abusing a police officer. For that reason the officer assessed the risk that the man might assault a cell mate as being high. Later, a governor agreed with the assessment. He decided that the man could share a cell, but only with another white prisoner. The man was put into a cell on G wing sharing with a man he knew, first cell mate.

20. The man telephoned his sister that evening. The conversation consisted mainly of the man asking to be sent some money and talking to his sister about his arrest and his injuries. The man did not mention drugs or any withdrawal symptoms he was having.

21. The next day the man was seen by the third nurse, a substance misuse nurse. He told the nurse that he used £50 of heroin, £100 of crack cocaine, and eight to ten 'blues' (valium), and drank one and a half bottles of vodka and ten cans of *Stella* lager daily. When interviewed by my investigator, the third nurse said that the man's daily list of drugs and alcohol was believable but she always

checks by taking a urine sample for testing. In the man's case he tested positive only for opiates and benzodiazepines, although he had been in custody since the evening of 8 May. The nurse noted that the man also complained of withdrawal symptoms, hot and cold flushes, aching bones, gastro-intestinal symptoms and insomnia.

22. The third nurse put the man onto a benzodiazepine detoxification regime starting at 15mg twice a day and a methadone maintenance regime starting at 20mls. The man was to be reviewed by the substance misuse doctor the following Monday (14 May).

23. The man received two out of the three 25mg of chlordiazepoxide on 12 May, missing the noon dose. On 13 May, he received the morning and midday doses but did not get the evening dose. He did receive two doses of diazepam and 30mls of methadone. In order to be given his medication, the man was required to attend the medication hatch on the wing at set times during the day.

24. The second officer wrote the following entry in the wing history sheet about the man and his cell mate on the night of 13 May:

> "Prisoners (the man) and (his first cell mate) have been demanding to see a doctor and to have medication – This is the third night in a row that they have done this – I have checked with H6 (on call nurse) on all occasions and they have had all they are entitled to. Remind them both in the morning to put apps in to see doctor as now the man is claiming to be allergic to his meds and his first cell mate is throwing up all the time."

25. In her interview with my investigator, the second officer was asked if she was concerned about either man's health. She replied:

> "Obviously I am not medically trained but that was on the third night and they didn't appear any different on that day than they had done the two previous days so from my point of view they weren't any worse health-wise. They were the same and I didn't have keys to open the door so I couldn't see any evidence of there being any vomit in the cell or anyone looking like they were so ill that they couldn't do anything else. They were both sort of standing up wandering around the cell and because we were watching the man's first cell mate … you would go up there when they weren't looking at you looking and they would just be sitting there smoking or watching the tv or chatting or doing what they do."

26. The fourth officer who was on the day shift on G wing on 14 May wrote the following entry in the man's history sheet:

> "The man has been a complete drain on staff over the weekend. He has many issues he expects staff to resolve rather than help himself. Also the man has been warned about his use of cell bell."

27. During an interview with my investigator the officer explained what was meant by the above entry:

> "The man, over the course of the weekend had many queries, he wanted and requested items over and over again, for example I had given him a tube of toothpaste on the Saturday but on Sunday he wants another one, he also had issues around his clothing where I had given him a complete kit change top to bottom socks etc, and yet on Sunday he required another pair. Because of the busyness of the wing that sort of behaviour from prisoners is a drain on staff if you are dealing with the same prisoner for the same things over and over again … there were just constant enquiries, well not enquiries so much, constant needs, constant requests for information. I can give an example … if he asked me about a visit on Saturday morning he would ask me again the same question Saturday afternoon and then Sunday morning and again. Just because the wing is so busy and so many prisoners need your one to one attention, answering the same question five times is a drain on staff."

28. The fifth officer also said that the man appeared to be coping with his detoxification regime. She was unaware if he was collecting his medication, but presumed that he was. The man and his first cell mate had been told that they would be moving to A wing on 14 May, although it was unlikely that they would remain together, at least initially.

29. Later that morning the man saw the substance misuse doctor. The doctor noted, "still feels rough, keep on 40mls for seven days and review. The man was also given first dose of hep b vaccination." The man did not complain to the doctor about any of the issues he had raised with night staff over the weekend.

30. The man saw the fourth nurse on the wing and approached her. She later entered on the computerised medical record that he complained of enuresis (bedwetting). The fourth nurse said that the man was active and appeared to be in a good frame of mind when she spoke to him. He did not say anything about the drugs he was on or any other problems. The nurse asked a colleague, the first nurse, to collect a urine sample from the man. The first nurse later noted that the man had been given a specimen bottle but was unable to provide a sample at that time.

31. The first nurse gave the man his two doses of diazepam that day and recorded that "nil" symptoms were assessed. The man also received his 40mls of methadone in the afternoon of 14 May, but he did not get any chlordiazepoxide at all that day.

32. The alcohol detoxification regime sheet has a line through the chlordiazepoxide and "stopped ref. to" the first nurse written above it. My investigator interviewed the first nurse and spoke with the pharmacist. The first nurse said that he saw the prescriptions for chlordiazepoxide and diazepam and realised that the man had been prescribed two doses of benzodiazepine medication when only one was needed. He also pointed out that both drugs and the prescribed methadone have a side effect of depressing the respiratory system. The

pharmacist had agreed with the decision and praised the nurse for noticing the duplication.

33. In the afternoon the man was moved to A wing and into cell 20 on the two's landing. There is no evidence that another Cell Sharing Risk Assessment was completed. The man's new cell mate was a black man born in Ghana. The man was directed to his cell by the sixth officer. He described the man as glassy eyed, coherent, but not quite 'with it'. The officer also remembered that the man kept calling 'sarge'. The man's second cell mate said that the man told him he had been given his medication just before he came to the cell.

34. The man and his second cell mate went to collect their tea meal and returned to their cell to eat it. The man did not eat all of his food and offered some to his cell mate. The man's second cell mate was then taken out of the cell for a legal visit.

35. At some time during the evening association period, the man spoke to the seventh officer who was in the wing office on the three's landing. He asked him if it was possible to be put into a cell with his first cell mate again. The officer told him that it was not possible at that time but that that he would see what could be done the following day.

36. When the man's second cell mate returned to the cell, he saw that the man was lying on the top bunk, fully clothed and shivering. The man asked him how long he had been asleep and his cell mate told him that he had been away for about two hours.

37. The man went back to sleep for a while but when he awoke the man's second cell mate saw that he was still shivering. He pressed the cell bell at 10.15pm to call for an officer and the eighth officer responded. The officer was told by the man's second cell mate that the man was not well and the eighth officer saw for himself that the man was shivering. He told the man that he would get a nurse but the man told him that he did not want one. The eighth officer said that he would return later to check on him. He returned to the cell about an hour later. When he opened the door observation flap, the man's second cell mate came to the door and told him that the man was asleep. The eighth officer checked the cell about two hours later and saw that both occupants were apparently asleep in their beds.

38. At approximately 8.20am on 15 May, the sixth officer began to unlock the cells on A2 landing for 'free flow', a system whereby certain gates around the prison are opened and staff stand by those gates and other areas. Prisoners are then allowed to walk to wherever they need to be, such as healthcare, gym or the medication hatch. The officer opened the man's cell, saw both men were in their beds and called out to the man that he had a doctor's appointment. The sixth officer shook the bottom of the man's mattress. The man's second cell mate woke at that point and explained that the man had had a bad night. The officer told the man's second cell mate to let the man sleep for another 15 minutes.

39. The seventh officer went to the man's cell to tell him that he needed to collect his medication from the hatch on the landing below. He found the man still apparently asleep and his cell mate in the process of getting dressed. The man's second cell mate laughed and said that the man was still asleep. The officer told the cell mate to inform the man that he needed to get down to medication, and that he would return shortly to check.

40. A short while later the man's first cell mate went to the man's cell to see him. The man's second cell mate was in the cell talking to another prisoner. The man's first cell mate clapped his hands and told the man to get up. He pulled back the bedclothes and saw that the man was blue in colour. The man's first cell mate left the cell and called out to the seventh officer who immediately returned. The officer later told my investigator that his initial impression was that the man was dead. The sixth officer arrived at the cell and the seventh officer told him to remain at the door while he went to alert healthcare staff. He ran to the medication hatch, but saw that the man's first cell mate was already there telling the nurse that the man was dead in his cell. The seventh officer informed the first Senior Officer (SO) of the situation and the SO then put out a 'code one' message over the radio timed at 8.22am. (Brixton, like many other prisons, uses a number code system for alerting staff to medical emergencies, with 'code one' indicating the most serious and urgent.)

41. The sixth officer waited by the cell door to keep away the prisoners who had begun to gather around. After looking at the man, the sixth officer also believed that the man had been dead for some time.

42. The first Principal Officer (PO) was on A1 landing when he was approached by a prisoner who told him that there was a dead body on the two's. The first PO followed the prisoner to the man's cell. The prisoner told him that he was First Aid trained and they both entered the cell. The prisoner checked the man for a pulse but could not detect one. Again the PO's first thought was that the man was dead. The two men left the cell and the first PO went in search of the man's cell mate.

43. Healthcare staff responded to the 'code one' call. A nurse entered the cell and checked the man for a pulse, any response to stimuli or signs of breathing. She could not find any. A Senior Healthcare Nurse also attended the cell and confirmed the lack of vital signs. In her interview with my investigator, she said that in her opinion the man had been dead for some time as his skin was blue and he was quite stiff.

44. One of the doctors at the prison, attended the man's cell and pronounced him dead at 8.40am.

45. Two white and two pink tablets, which were later determined to be indigestion remedy and ibuprofen respectively, were found in the man's cell.

46. The first Principal Officer found the man's second cell mate being comforted by other prisoners in a cell opposite. The first Principal Officer took him and three other prisoners to another cell where the man's second cell mate was spoken

to by healthcare staff. Later, they were taken to a holding room on A one landing where they were given tea.

47. A second Principal Officer, a family liaison officer for the prison and the Deputy Governor set out to break the news to the man's family. They arrived at his sister's address but no one was at home. The second Principal Officer then telephoned the man's sister and explained that he needed to speak with her. The man's sister was unwilling to return home without being told why it was so important but the Principal Officer was not happy to pass on such news on the telephone. Eventually, a compromise was reached with the Principal Officer agreeing to meet the man's sister and her father in a local supermarket car park.

48. Later that day the staff involved in the discovery of the man were brought together for a 'hot de-brief'. (The purposes of a hot debrief are to acknowledge what happened and the role of the staff involved, to normalise the situation and to ensure that the immediate staff needs have been met.)

49. A post mortem examination was conducted by a Home Office Pathologist. His report was not completed until December 2007. The pathologist concluded that the man died of a fatal cardiac arrhythmia due to alcohol withdrawal syndrome. (An arrhythmia is an abnormality of the heart's rhythm that disturbs the electrical impulses which regulate the heart. The heart may beat too slowly, too quickly or in an irregular way. The symptoms a person may experience include palpitations, loss of consciousness, dizziness and breathlessness. In extreme cases, certain types of arrhythmia can cause sudden cardiac death.)

50. Alcohol withdrawal syndrome is a cluster of symptoms observed in persons who stop drinking alcohol following continuous and heavy consumption. Milder forms of the syndrome include tremulousness, seizures, and hallucinations, typically occurring between six and 48 hours after the last drink. A more serious syndrome, delirium tremens (DTs), involves profound confusion, hallucinations, and severe autonomic nervous system overactivity, typically beginning between 48 and 96 hours after the last drink

51. In a report in June 2007, a forensic scientist stated that the man had a level of chlordiazepoxide in his system below that to be expected from his prescribed dose, which would accord with his not taking the drug on 14 May and only having taken it for two days. The forensic scientist wrote that he could not rule out some post mortem breakdown of the drug. His conclusion was, "It is possible that the man's alcohol withdrawal symptoms were not adequately controlled when he died, however, I cannot say whether this was a causal factor in his death."

ISSUES

Family concerns

52. The man's sister was concerned about the apparent lack of medical intervention during the night of 14/15 May. As detailed earlier, the night duty officer (the eighth officer) responded to the cell bell and offered to fetch the nurse to see the man. The man told the officer that he was alright and did not want the nurse. The officer returned later, as he said he would, and the man's second cell mate told him that the man was asleep. On a later check the officer saw that both men were apparently asleep. I believe the officer's actions to be reasonable under the circumstances.

53. Various injuries were noted on the man when he arrived at the local police station and his family have asked whether those injuries played any part in his death. A thorough post mortem examination was carried out by a Home Office pathologist on 16 May 2007. In his report the pathologist writes, "Multiple injuries were found at post mortem examination, although these were of minor severity, and most were non-recent. Some of the injuries could have been sustained during the man's arrest, although these did not, in my opinion, contribute to his death."

54. The final matter raised by the family was how the news of the man's death was passed to them. They feel that more could have been done to ensure the news was broken in more appropriate surroundings. I obviously have great sympathy for the bereaved family. It is deeply upsetting to lose someone so young, so unexpectedly, when they are in prison. However, my judgement is that, while the eventual location was manifestly not ideal, the prison staff did their best to accommodate the family's wishes and needs at that time.

Clinical Review

55. Lambeth Primary Care Trust agreed to carry out a review of the man's clinical care and treatment while at Brixton. After a considerable delay, Lambeth PCT commissioned a private company (that conducts work for the Department of Health as well as other organisations.) to carry out the review on its behalf. The review following the man's death was one of five reviews into deaths at Brixton commissioned in the same way, and at the same time, from the company. No specific recommendations were made in the man's review, but a number of generic recommendations were made based on the findings from all five reviews. I have judged it sufficient simply to append the clinical review to this report.

56. After receipt of the clinical review, Lambeth PCT asked the section head for offender health (substance misuse) at the Department of Health, to comment specifically on the detoxification arrangements relating to the man. His report is also appended to this report but I reproduce part of his conclusion here:

> "The first night clinical management of the man's substance withdrawal was consistent with Dept Health (2006) guidance with regard to alcohol.

It is unclear whether an opioid prescription would have been indicated at that time, as no withdrawal scale was used. His management on the first night had, in my view, no bearing on the man's death.

"The clinical substance misuse assessment carried out with the man on 12th May was satisfactory in every regard excepting the absence of baseline blood pressure and pulse readings.

"The prescribed management of the man's poly-substance dependence from 12th to 14th May 2007 was broadly consistent with Dept Health prison clinical guidance. The guidance recommends that methadone is prescribed and given in sub-divided doses during the first five days of treatment, but the fact that the methadone was prescribed in full single-day doses appears to have no relevance to the man's death. The benzodiazepine reduction regimen was considerably more brisk than Dept Health guidance, but as reduction had not begun at the time the man died, this too was not a factor.

"There appears to have been a significant break-down in communication that resulted in the man not receiving five of his prescribed doses of chlordiazepoxide (two at 25 milligrams and three at 20 milligrams).

"The very heavy dependent pattern of drinking, the possibility of sedative (valium) dependence, and a history of epilepsy mean that in my opinion regular recording of blood pressure and pulse rates would have been indicated in this case; increases in either blood pressure or pulse are often signs of unmanaged withdrawal."

Chlordiazepoxide

57. The man was prescribed chlordiazepoxide (librium) by the doctor when he first arrived at Brixton to help relieve the symptoms of his detoxification from alcohol. The following day another doctor prescribed methadone and a benzodiazepine detoxification regime using diazepam (valium). On Monday 14 May, the first nurse looked at the three charts and was concerned that two different benzodiazepines had been prescribed. An additional concern was the possible effect of all three drugs on the man's respiratory system. The first nurse brought the matter to the attention of the prison pharmacist who agreed and stopped the chlordiazepoxide.

58. Both the pharmacist and the nurse realised that the decision had to be confirmed by a doctor. Unfortunately, the first nurse believed that the pharmacist would inform the doctor and the pharmacist believed that the nurse would do it. Both members of staff think it likely that a doctor was spoken to about the decision but there is no record thereof, and no specific recollection of such a conversation.

59. My investigator asked the clinical reviewer to comment on the decision of the nurse and the pharmacist to stop the chlordiazepoxide:

"From the documents we reviewed at our meeting it is clear that there had been a clinical decision to discontinue the man's chlordiazepoxide prescription, to avoid a risk of over-sedation. This is understandable, as the therapeutic 'window' between effective pharmacological management of coexisting opiate, alcohol and tranquilliser withdrawal, and poisoning (ie overdose) is relatively narrow.

"My recommendation made in my report dated 23rd June 2008 remains unchanged: that the regular recording of blood pressure and pulse rates should be a standard element of alcohol detoxification, as these are reliable indicators of severity of alcohol withdrawal. Unfortunately, without these data I am unable to be certain that the man had experienced very marked alcohol withdrawal and had died as a consequence of this."

60. Once the chlordiazepoxide was stopped, the man should have been reassessed to confirm whether the decision was correct or not.

The Governor and the Healthcare Manager should ensure that the regular recording of blood pressure and pulse rates is a standard element of alcohol detoxification regimes.

Staff response

61. Staff responded swiftly once concern about the man was raised. One issue I must address, however, is the absence of any resuscitation attempt. Brixton's death in custody contingency plan makes it clear that the task of the first staff on the scene is to attempt to maintain life and to raise the alarm. After raising the alarm with a 'code 1' message, the next listed action is to "ensure that you render first aid as appropriate". In most circumstances I would expect the staff to carry out Cardio Pulmonary Resuscitation (CPR) until relieved or advised to stop by medical staff. However, in this case each person who saw the man lying on his bunk was of the opinion that he had died some time previously. This was based on his colour, temperature and lack of breathing or pulse. Under the circumstances, I do not believe it would have been respectful either to the staff concerned or to the man's memory had CPR been attempted.

Cell Sharing Risk Assessment

62. When the man arrived at Brixton on 11 May, a CSRA was properly completed. As a result a decision was made that he should only share a cell with another white prisoner. On 14 May, the man was put into a cell on A wing with a black Ghanaian man. Luckily, that oversight did not cause any problems on this occasion. Nevertheless, the fact remains that no re-assessment was undertaken before the man was allocated a cell.

The Governor should remind staff of the importance of the Cell Sharing Risk Assessment procedure and instigate any training required.

RECOMMENDATIONS

1. The Governor and the Healthcare Manager should ensure that that the regular recording of blood pressure and pulse rates is a standard element of alcohol detoxification regimes.

   This recommendation has been accepted and completed. The Governor responded,

   > *"1. All patients identified at reception as having a drug and/or alcohol problem should have baseline observations completed.*
   > *2. There are clear reception protocols in place and staff are inducted and sign to confirm they have read and understood the SOP*
   > *3. Patients undergoing alcohol detoxification should have daily monitoring of BP and pulse*
   > *4. Clear protocols are in place for all nursing staff and assisted alcohol withdrawal*
   > *5. All staff receive training in alcohol awareness*
   > *6. There is a lead nurse for alcohol*
   > *7. Monitoring of alcohol treatment is ongoing via the IDTS Implementation Meeting and Clinical Governance Meeting".*

2. The Governor should remind staff of the importance of the Cell Sharing Risk Assessment procedure and instigate any training required.

   This recommendation has been accepted and completed. The Governor responded,

   > *"Staff Information Notice issued reminding staff of Cell Sharing Risk Assessment procedures".*