PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man in October 2011 at HMP Wayland

Report by the Prisons and Probation Ombudsman for England and Wales

March 2013

This is the report of the investigation into the death of a man in October 2011 at HMP Wayland. He was found unresponsive in his cell around 8.15am by a prisoner. The alarm was raised, and wing and healthcare staff carried out cardiac pulmonary resuscitation (CPR). A paramedic arrived at 8.35am and, despite the attempts to save his life, his death was confirmed at 8.42am by ambulance staff. He was 46 years old. I extend my condolences to his family and friends.

Her Majesty's Coroner for Norfolk carried out a post mortem examination on the man. The report found that his death was due to natural causes caused by pneumonia. A review of his medical care whilst at Wayland was commissioned by NHS Norfolk and Waveney. A clinical reviewer undertook the review on behalf of the local PCT.

An investigator was appointed to carry out the investigation on my behalf. I am grateful for the assistance of the Governor and his staff at Wayland.

The care provided to the man was generally sound, and staff reacted professionally to his sudden collapse. However, the lack of the use of an appropriate emergency code by staff meant that the responding nurse failed to bring the correct equipment. I am reassured that the Governor quickly recognised this oversight, and has already new issued guidance to all staff.

Of more continuing concern was the general inadequacy of the integrated drug treatment service (IDTS) function at Wayland. The man was a user of this service and, although his death was unconnected, the investigation uncovered concerns that require rectification. The clinical reviewer shares these concerns, and I would expect the Governor to respond to the issues raised in this report to ensure that other prisoners on IDTS receive an appropriate level of care.

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 **March 2013**

CONTENTS

SUMMARY

1. The man was sentenced to 30 months imprisonment on 7 June 2011 and sent to HMP Bedford. It was noted by healthcare staff at Bedford that he had been prescribed methadone in the community to manage his substance misuse. (Methadone is a prescribed substitute for heroin.) A full medical assessment of his health was undertaken where it was noted that he had asthma, and pain in his legs caused by a car accident in 2001. He was also dependent on benzodiazepines (additive medication for depression and anxiety).

2. On 17 June, the man was transferred to HMP Wayland and located on the Integrated Drug Treatment Service (IDTS) wing to participate in a drug therapy programme to address his substance misuse. He was a regular visitor to the healthcare unit to discuss the pain in his legs and ankles. He was prescribed pain relief, and medication to control his asthma. He reduced his dosage of methadone through the IDTS programme and continued with diazepam (a benzodiazepine). However, it was noted that he would try to negotiate with healthcare staff for pregabalin when his methadone dosage was reduced. (Pregabalin is usually prescribed for epilepsy and it is known for its effect of brain activity.)

3. A nurse prescribed anti-biotic medication for the man on 21 September, following an examination of his chest which indicated that he might have a chest infection or Chronic Obstructive Pulmonary Disease (COPD), a progressive lung disease. A week later, a nurse spoke to him and he told her that he was feeling much better. He said he had no shortness of breath and was reducing his level of smoking.

4. A night duty officer answered the man's cell alarm bell on 4 October at 3.00am. He told the officer that his knees hurt and that he could not sleep. The officer advised him that he should speak to the day staff in the morning to see if healthcare staff could visit him. A few minutes later, the officer observed him getting back into his bed.

5. At around 8.10am, a friend of the man's looked through his cell observation panel and called to him. He was lying face down on his bed and was not responsive to his friend's call. The friend then shouted to officers for assistance. Four officers and a senior officer (SO) immediately responded and entered the cell. Two officers moved him to the floor and began CPR. The SO fetched a defibrillator (a machine that sends electrical impulses to the heart). The machine indicated that no shock was possible, as there was no electrical activity in his heart.

6. A nurse arrived at the cell and assisted the officers with CPR. At 8.23am, a first response paramedic arrived and carried out a medical assessment of the man. The paramedic was joined by two Ambulance Service colleagues at 8.30am, and they took over his medical care. His death was confirmed by the paramedic at 8.42am. His family was informed of his

death by a member of the chaplaincy from HMP The Mount, a prison near to their home.

THE INVESTIGATION PROCESS

7. The investigation into the man's death was opened on 7 October when the investigator visited Wayland. She was met by the prison's liaison officer for the investigation and the Governor of Wayland. She reviewed the man's prison file and asked for copies of documents relevant to the investigation to be forwarded to her. Later, she visited D wing and spoke informally to two prisoners.

8. The Ombudsman's terms of reference and notices to staff and prisoners had been sent to the prison in advance of the investigator's visit. The Independent Monitoring Board (IMB) and Prison Officers' Association (POA) did not ask to see her. Her contact details were made available to them should they wish to make contact. (The IMB are volunteers drawn from the community who monitor the day to day life of the prison, its staff and prisoners.)

9. A review of the man's medical care while at Wayland was commissioned by the local PCT. A clinical reviewer carried out that review and I am grateful for her assistance in this investigation.

10. One of the office's family liaison officers contacted the man's brother to inform him of the process of the investigation and to invite him to raise any issues he would like the investigation to consider. He raised the following points which are considered in the issues section of this report.

    - He wanted to know what his brother's steroid medication was for and the dosages he was prescribed.
    - He wanted to know if the combination of methadone and steroid prescriptions could have affected his brother.
    - He wanted to know of any other medication that his brother was prescribed.
    - He wanted to know if his brother had taken any illicit drugs.

11. On 25 October, the investigator, an Assistant Ombudsman and the clinical reviewer interviewed staff and prisoners at Wayland. The investigator and one of the office's senior investigators returned to Wayland to interview further members of healthcare and prison staff on 25 November and 7 December. In response to something raised in the investigation, the Governor confirmed on 7 December that he had circulated an instruction to all prison staff for code blue or red to be used in a medical emergency.

12. On 9 December, the investigator wrote to the Governor to provide feedback on the initial findings of the investigation. At this time, the post mortem examination result was unknown so clinical feedback was limited. However, no immediate concerns were noted.

13. The investigation report was issued in draft for consultation with the man's family, the prison, and healthcare providers. The report has been updated with the prison's response to the recommendation at the last page. The

family and their legal representatives raised a number of concerns about the level of healthcare that he received while in custody. We agree with their concerns about healthcare provision at Wayland, and have responded to their comments in separate correspondence.

HMP WAYLAND

14. HMP Wayland is a category C adult male prison (a medium secure prison offering opportunities in education, work and resettlement) containing 1017 prisoners across 13 wings. The man was located on D wing for IDTS prisoners in a single cell. The regime provides a range of workshops and training facilities, including a farms and gardens area.

15. Healthcare at Wayland is commissioned by the NHS. The providers of those services are the NHS and a private health provider. There is a healthcare manager, nurses and support staff. Many of the staff employed by Serco are agency workers. The service is provided between 8.00am and 8.30pm from Monday to Thursday and from 8.00am to 5.30pm on a Friday, Saturday and Sunday.

16. On his reception into both Bedford and Wayland, the man was placed on the Integrated Drug Treatment System (IDTS). IDTS is a Prison Service scheme which aims to increase the amount and quality of substance misuse treatment available to prisoners, with particular emphasis on the early days in custody. It is intended to improve the links between clinical and non-clinical services and reinforce continuity of care from the community into prison, between prisons, and on release into the community. As part of the IDTS programme, prisoners can be prescribed methadone (a heroin substitute).

17. The expected benefits from IDTS are:

- Reduction in self-inflicted deaths and self-harm among those most at risk
- Reduction in post release deaths
- Fewer incidents of violent aggression
- Better engagement in prison regime
- Reduction in drug taking
- Reduction in injecting behaviour
- Reduction in offending

18. Wayland was last inspected by HM Chief Inspector of Prisons in June 2011. The report noted that the prison: "… in most areas are producing some good outcomes for prisoners". However, the report said of the healthcare services:

> "There were wider problems with the provision of healthcare services in the prison. Strategic management of healthcare was poor and the partnerships arrangements were weak. Staff shortages had a detrimental effect on the care of prisoners and chaotic arrangements for the administration of medication had a negative impact on the regime of the prison as a whole."

19. Similarly the report said of IDTS:

> "Prisoners appeared to have lost confidence in the IDTS and were abusive and threatening at the medication hatch. Vacant IDTS posts needed to be filled as a matter of urgency and an individualised opiate dose reduction regime introduced to replace the current inflexible regime."

20. Since the inspection by HMCIP the healthcare provider, Serco, replaced the head of healthcare in September. The new manager told the investigator that his priorities were to recruit permanent healthcare staff including nurses and doctors. At the time of circulation of this report, a full time doctor and several nursing staff have been appointed, including a lead nurse for IDTS. The administration of medication and IDTS has been revised and new methods implemented to address the criticisms made in the HMCIP report. Actions and planning are now jointly considered between the healthcare unit and prison.

21. An extract from the Independent Monitoring Board's 2009-2010 annual report said of healthcare and IDTS:

> "The process of selecting a new healthcare provider has left staff in a state of flux for some months with concerns as to how this would affect them as individuals. The IDTS delivery at Wayland has now been located on one wing with a dedicated dispensing suite. Also located on the wing are the agencies who work in partnership to ensure good clinical interactions and psychosocial support throughout treatment. Wayland actively employs a reduction/detox policy. Whilst the number of prisoners on the IDTS programme has averaged around 60, there are grave concerns that with numbers increasing, the clinical team will be unable to provide the necessary care that supports reduction and detox."

22. There were no direct similarities in the man's death to that of the last natural cause death at Wayland in 2010.

KEY EVENTS

23. The man was born in 1965. He was single with grown up children. He had a long history of substance misuse, which included heroin. His offending behaviour, from the age of 14 years, was linked to his drug misuse.

24. In 2001, the man was seriously injured in a road traffic accident sustaining injuries to his legs, hip and ankle. He underwent surgery for a replacement hip although he still experienced pain in his leg and ankle as a result of this accident.

25. While living in the community, the man received methadone through a community drug action team. Methadone is one of a number of synthetic opiates, also called opioids, that are manufactured for medical use and have similar effects to heroin. It is similar to heroin, although it lasts a lot longer in the body. If you take methadone, you are unlikely to get withdrawal symptoms if you stop heroin (or the withdrawal symptoms are much less severe).

26. The man's personal officer at Wayland said he had known him for around four months. (A personal officer is assigned to a prisoner to offer support, guidance and advice on a face to face basis.) The officer noted that he was polite to staff and abided by the prison regime. He had several friends on the wing and regularly attended art and pottery classes.

27. On 6 June 2011, the man was taken to Bedford following an appearance at Crown Court. He saw healthcare staff and was placed on IDTS with methadone prescribed as per his community drug action team plan. The following day, he was sentence to 30 months imprisonment. This was not his first time in prison.

28. Healthcare staff saw the man for a full medical assessment. He told staff that he had poor mobility following a road traffic accident in 2001 and he regularly experienced pain in his legs. It was recorded in his medical notes that he was prescribed 60mls of methadone per day in the community, but he told staff that he would like to increase the dosage to 80mls per day, which was agreed by staff. He said he took temazepam and was benzodiazepine dependent. (Benzodiazepines are addictive drugs used to treat depression and anxiety.) It was recorded that he was a smoker and suffered from asthma.

29. The man had another healthscreen following his transfer to Wayland on 17 June and his electronic medical record, transferred from Bedford, was updated. It was noted that he was prescribed 80mls of methadone per

day. He was also prescribed diazepam, and ibuprofen and paracetamol for pain relief. Finally, he was prescribed Gaviscon for indigestion.

30. Nurse A saw the man as 'special sick' on 24 June. (Special sick are appointments for prisoners who deem themselves to be in need of urgent medical assessment.) The nurse noted that he had been seen the previous night by paramedics who had been called to see him in his cell. He had reported swelling to his right leg, and the paramedics advised that this may be cellulitis (a bacterial skin infection) and that he should be seen by a doctor during the morning surgery.

31. A nurse practitioner examined the man's leg following a discussion with the nurse. It was agreed that he should be escorted to hospital for assessment in the accident and emergency department. On arrival at the hospital, he had an ultra sound scan (a scan that takes internal images of the body). He returned to Wayland the same day, without any medical instructions for further treatment or medication

32. Nurse B assessed the man on 27 June in the IDTS clinic and a care plan was completed. He would remain on 80mls methadone per day with a prescription for diazepam and referred to the Counselling, Assessment, Referral, Advice and Throughcare service (CARATS.) (CARATS provides drug misuse intervention services in prisons.)

33. Later that day, a nurse practitioner examined the man's leg and noted that he had been seen in hospital. The nurse practitioner arranged for him to have a full blood test and prescribed antihistamines for his hay fever. A doctor also examined his leg that evening and prescribed penicillin and anti-biotic. The doctor noted he would review his leg in two days time.

34. The man completed a complaint form on this day. He noted on the form that the queue for dispensing medication was too long, with prisoners getting restless during the wait. As he had problems with his mobility, he went on to complain that there were no chairs to rest on whilst waiting in the queue, or toilets or water to drink on hot days.

35. The following day it was written that the man did not attend an appointment with a nurse. On 29 June, a doctor reviewed the results of his blood test and noted that he should be seen by a doctor as the result of his liver function was abnormal. However, there is nothing noted in his medical record that this was followed up

36. Nurse C saw the man on 30 June, for an assessment of his IDTS prescription and it was agreed that he would continue with his methadone programme. Later, he saw Nurse A as special sick. He asked the nurse for asthma medication and requested to see a doctor for the pain and swelling in his leg. The nurse referred him for a doctor's appointment and arranged for his asthma medication to be dispensed when he next collected it from the hatch. (The appointment system to see a doctor at Wayland is similar to that in the community, when non emergency

appointments are often scheduled well in advance. He was given an appointment a week later.)

37. A CARATS worker saw the man on 6 July and a plan was completed to provide further support for his treatment for drug misuse. The worker also sent a memo to the healthcare unit to advise that he may benefit from an appointment with the mental health team. The governor who had responsibility for healthcare wrote to him in response to his complaint about the queues for medication. He assured him that plans were under development to arrange for the dispensation of medication on the wings.

38. Nurse C wrote that the man had an IDTS review on 7 July and his methadone would remain at 80mls per day until he saw the IDTS doctor. The following day, a doctor examined his leg. Although this was one week after being referred to the doctor by Nurse A, he had been seen by healthcare staff at interim times. He asked the doctor to prescribe him with pregbalin, a medication used to treat damaged nerves. The doctor did not prescribe that specific medication but authorised nefopam, a pain killer. He also gave him medication and a spray to relieve his hay fever symptoms.

39. A week later, the man had an IDTS care plan review with Nurse C. In line with the national guidelines for IDTS, he agreed to a reduction of 2mls of methadone every seven days but only if he could be prescribed pregablin for his leg and back pain. On 19 July, the doctor refused to prescribe pregablin to him and said that he should continue to use nefopam. However, the doctor noted that he should be supplied with an extra mattress and pillows in order to ensure his comfort, and ordered a spinal x-ray.

40. Later that day, a doctor reviewed the man's IDTS care plan and noted that he would now begin a reduction of his methadone. The following day, Nurse C recorded that he was told his methadone would reduce by 5mls every seven days and not two mls as previously indicated.

41. A doctor saw the man on 28 July and refused to prescribe pregablin as requested by him, but did agree to a five day prescription of zopiclone to help him sleep. He remained on his methadone detoxification which continued to reduce by 5 mls each week.

42. The man was seen by a nurse practitioner on 12 August and his asthma prescription was updated. An appointment to see a member of the mental health in-reach team was delayed on this day, as the nurse was urgently needed in Norwich. Later, a doctor assessed him. He told the doctor he was 'hearing voices' and need to be prescribed quetiapine, an anti-psychotic medication used in the treatment of schizophrenia. The doctor undertook a short mental health questionnaire with him. He told the doctor he was depressed, unable to concentrate and had some negative thoughts of self harm. The doctor arranged for him to see a mental health nurse for further assessments.

43. Six days later, a mental health noted in the man's medical record that his referral to the mental health service was an 'inappropriate referral'. It is not recorded as to whether the nurse saw him before adding this entry into the medical record. Nor does it provide further information on why this was deemed an inappropriate referral.

44. The mental health nurse saw the man on 22 August, where he asked for gabapentin to be prescribed, a drug to treat seizures, and complained about the reduction of methadone. Furthermore, he said he had not had the x-ray to his back or the extra mattress. The nurse advised that he should book an appointment with the doctor.

45. Two days later, the man had a meeting with a CARATS worker. During the course of the meeting, he told her he had about 300 paracetamol in his possession but no thoughts of harming himself. During an interview, she told the investigator that he gave this information in a casual manner. He said he had accumulated this amount of paracetamol, prescribed by healthcare staff, to address his pain. However, he found it was not helping and he therefore he did not take any.

46. The CARATS worker advised the man that he should take his prescribed medication and she would report that he had a large amount of paracetamol in his possession. At the end of the meeting, she went to the D wing office spoke to an officer. The officer left the office and went to the man's cell, where he handed the officer the paracetamol. The officer took the paracetamol back to the wing office and, with the CARATS worker present, counted around 100 paracetamol tablets. The officer returned the tablets to the healthcare centre. An entry was made in the wing observation book by the CARATS worker regarding his comments to her and the action taken. She also completed a security information report to inform the security department of the events.

47. On 25 August, Nurse D noted that the man had told her he was anxious about the reduction to his methadone and his inadequate pain relief. He said nefopam did not control his pain and he was unable to take paracetamol as it caused swelling to his face. The nurse advised that she would speak to the doctor although he would need to reduce his methadone as it was in line with the national guidance.

48. Nurse A wrote that the prescription for the man's diazepam had not been renewed on 27 August. A doctor was not on duty, so the nurse contacted an out of hour's medical service for a prescription. This was completed by a doctor and faxed through to Wayland's healthcare unit. The diazepam was then provided to him.

49. A doctor saw the man on 29 August and was told that he had pins and needles in his leg accompanied by chronic pain. The doctor saw that the x-ray he ordered in July had not been progressed and he was still without his extra mattress. Both matters were addressed by the doctor, who

requested the letter for an x-ray be sent to the hospital and the mattress to be supplied immediately. A referral was made for him to be assessed by a physiotherapist and he was prescribed celecoxib, an anti inflammatory medication, and pregabalin for pain relief.

50. The following day, the healthcare administration made a request to the hospital for the man's x-ray appointment. He was prescribed a cream to help his eczema symptoms on 31 August. The celecoxib medication was stopped on 2 September when he reported a blood discharge from his rectum. (This is a known side effect of the medication.)

51. A doctor noted on 9 September that the man's methadone prescription was continuing to reduce and his present prescription of 40 mls per day was confirmed. Three days later, the doctor recorded that his diazepam prescription was also reducing in line with national guidelines, despite him requesting a larger dose. The man also asked for an increase in the dosage of pregabalin and for it to be in his possession but the doctor refused both of these requests. (Prisoners are risk assessed as to whether they can hold medication in their possession or collect it daily from a dispensing hatch. Prisoners on IDTS are not allowed to have certain medication in possession.)

52. A nurse practitioner saw the man on 14 September and he told the nurse he was unhappy about the reduction in his methadone and diazepam dosages. The nurse advised him that this should be discussed with the IDTS doctor. He asked for more Gaviscon for his indigestion and some cream for cold sores and the nurse arranged a prescription for both medications. The following day, a doctor agreed to maintain his present dose of diazepam.

53. The man went to the healthcare unit on 19 September and reported as special sick. He told a nurse that he was having periods of shortness of breath in the afternoon and evenings and also had a chesty cough. He said his inhaler had not helped his symptoms. The nurse checked his blood pressure which was a bit low at 125/70 (an average reading is 130/80) and his temperature was normal. The nurse made an appointment for him to be reviewed in two days time. Later, he failed to keep an appointment with his IDTS worker. (His medical record confirms that a doctor reduced his methadone to 35 mls on 23 September and 30mls on 30 September.)

54. A complaint form was completed by the man on 20 September. He requested that he would like to collect his medication weekly as he missed his art and craft class when he collected it daily.

55. On 21 September, a nurse who is qualified to prescribe medication saw the man and he again asked for a higher dose of pregabalin to be prescribed for his lower back pain. The nurse examined his chest and noted that he may have a chest infection and Chronic Obstructive Pulmonary Disease (COPD), a progressive lung disease. The nurse

prescribed some anti biotic medication and promethazine to help him sleep. She arranged for him to be reviewed in one week's time.

56. Later, a Healthcare Support Worker (HCSW) spoke to the man regarding his IDTS prescription. She told him that there would be a continued reduction of his methadone. He told her that he would agree to this as long at his prescription of pregabalin continued. Two days later, a doctor wrote in his medical record: "Many previous medications but most have been appropriately stopped. Continues with methadone detox and Pregabalin until 28 October".

57. The Healthcare Manager replied to the man's complaint made on 20 September. He wrote to him that he was not allowed to have his medication in possession. However, he wrote that he would look for an alternative way of dispensing his medication so that he did not miss his classes.

58. At 7.40pm on 25 September, an officer made an entry in the D wing observation book related to the man: "Activated cell bell to tell me he was suffering discomfort from not being able to breathe properly. He has informed me he has had problems with his lungs". He told the officer he just wanted staff to be aware of his problem and did not need medical help. The officer told him that if he needed any assistance to use his cell bell again.

59. An officer made an entry in the man's personal case notes to record that he rang his cell bell at 7.09am on 27 September and complained of extreme pain. The officer told him he would inform the day staff when they came on duty so that this could be passed to the healthcare staff. There is nothing recorded in his medical record to indicate that healthcare staff saw him on 27 September.

60. A nurse saw the man on 28 September. He told the nurse that he felt better, had no shortness of breath and had reduced his smoking. However, he said he experienced difficulties when walking to the healthcare unit twice a day to collect his pregabalin. He also said that he still suffered from disturbed sleeping. The nurse prescribed some cream for a sore mouth, nefopam for pain relief, zopliclone to help sleep and renewed his pregabalin prescription.

61. Prisoner A told the investigator that around 4.20pm on 3 October he was at the medication hatch observing prisoners collect their medication in his role as a prisoner representative on the healthcare group. He had known the man for around three weeks and heard his verbal complaints about his medications on several occasions. The man had told him that " … his medication was being reduced without him being told".

62. The prisoner said: "When he [the man] went there [medication hatch] and asked for his heart tablets they [healthcare staff] come back, we ain't got them". Seemingly his prescription was not available for dispensing. The

prisoner said that the man was not dispensed any medication that afternoon. (He went on to say that the system had since changed and there was now a month's supply of prescribed medication for prisoners to be dispensed with.)

63. Prisoner B said in a statement that the man told him he was unhappy about not getting his medication during the afternoon of 3 October. However, he said that he saw him at 6.30pm eating his meal and he seemed to be his usual self.

64. Officer A was on night duty on 3 October on D wing. At around 3.00am, the man rang his cell bell and the officer responded to the call and spoke to him through the cell door observation panel. He told the officer: "I can't sleep and my knees are aching gov". The officer told him that there was little he could do and advised him to speak to the day staff in the morning to see if healthcare staff could visit him. He replied: "Ok governor, sorry to disturb you, I'll try and get some sleep". The officer checked him a few minutes later and saw that he was having a drink and about to climb back into his bed.

65. The officer left D wing to carry out duties at the main gate at around 5.25am and handed over responsibility to an Operational Support Grade (OSG). Prisoner C was located in a cell near to the man. He told the investigator that he woke up around 5.30am and heard a moaning from a nearby cell. He said that this moaning was intermittent and roughly occurred every 10 to 15 minutes for around one hour. Although he was unable to name the person at that time, in hindsight he believed it may have been the man.

66. A daily roll check of prisoners commences at 5.30am on C and D wing. This check counts the number of prisoners in their cells which is around 250, depending on how full the wing is. Prisoner C told the investigator that, although he was awake at the time, he did not see a member of staff look through his observation hatch to check he was in his cell. He also told the investigator that the officers do not speak or ask for a response from the prisoner.

67. In a statement, the OSG noted that he carried out a roll check of all prisoners on the wing starting at 5.30am. He said that Officer A had told him that a couple of cell bells had been rung during the night and "one person had been unwell and he had dealt with it". The OSG completed his roll check and noted that all prisoners were in their beds with the exception of around five who were using the toilet. He was unable to recall checking the man's cell, although he said that there were no unusual circumstances that he noted during the roll check.

68. Prisoner D, whose cell was close to the man's, told the investigator that he left his cell at around 8.00am and went to call on him, as it was their usual routine to walk together to collect medication. However, he saw that his light was not on so he walked on to collect his methadone. On his return

to his cell, he looked through his cell door observation hatch. He saw him lying face down on the foot of his bed with his legs out straight. He called him several times and was joined by Prisoner C. Having got no response from him, he ran to the gate near to the wing office to alert staff.

69. The D wing officers were having their morning briefing at 8.10am when Prisoner D shouted to them that the man was in trouble in his cell. Several officers and a Senior Officer (SO) immediately left the office and made their way to the cell. The cell was unlocked and two officers saw him slumped on his bed face down. The officers tried to get a response from him while an officer called the communications room over his radio for urgent healthcare assistance and an emergency ambulance. No code was used to indicate the nature of the medical emergency. (Emergency codes are routinely used in prisons to expedite appropriate emergency responses. A Code Blue indicates that a patient has breathing difficulties and/or non responsive. A Code Red indicates that blood is present. Emergency equipment taken to the scene of a medical emergency is dependant on the code used.)

70. Two officers turned the man on to his back and laid him on the floor of his cell. Officer A checked for a pulse and was unable to find one. Officer B began CPR with chest compressions whilst Officer A commenced mouth breaths via a face shield. The SO left the cell to fetch the defibrillator from the SO's office on the wing. (A defibrillator is a machine that sends an electric shock to re-start the heart rhythm.)

71. The SO returned to the cell and the man's t-shirt was cut to allow free access to the chest area. The SO applied the defibrillator pads to his chest. The machine indicated that no shock should be used, which indicated there was no electrical activity in his heart. Both officers recommenced CPR.

72. Officer D was aware that the communications room were struggling to contact any healthcare staff via the radio. However, a nurse and the healthcare manager arrived at the cell within a few minutes. (The nurse had heard that call for healthcare assistance from a nearby officer's radio while she was dispensing medication.) On her arrival at the cell, the nurse saw the SO use the defibrillator. She noted that the man had vomit around his mouth and his skin was blue. The nurse took over the rescue breaths whilst the officers took it in turns to administer the heart compressions.

73. At 8.23am, a first response paramedic arrived at the prison and was immediately escorted to the cell. The nurse and the officers continued with CPR while the paramedic made a medical assessment and gave the man intravenous medication. Five minutes later, two more paramedics arrived in an ambulance and took over his care from prison staff. At 8.42am, his death was confirmed by the paramedics.

74. A hot de-brief was held shortly after the man's death with all the staff involved in the emergency. (A hot de-brief is an immediate meeting after an incident to ensure all the staff involved are able to carry on with their duties and to offer support from line managers.)

75. An incident de-brief was held at 2.30pm with all staff involved, chaplaincy, the IMB, the care team and senior managers. The debrief considered all the events of the morning from when Prisoner D first raised the alarm. It was noted that there was a shortage of healthcare staff in the morning as two nurses had reported sick. A representative of the Samaritans (an organisation to support those in crisis) told the meeting that support had been made available for prisoners through the Listeners scheme. (Listeners are prisoners trained by the Samaritans to carry out their work in prisons.)

76. The nurse told the meeting that it would have been helpful if a Code Blue had been used to alert healthcare staff of the emergency so the correct equipment could have been taken. One of the officers present at the meeting said that they had been told not to use the instruction Code Blue for an emergency. There was some confusion over this matter during the meeting.

77. One of the prison's family liaison officers made contact with HMP The Mount as the man's next of kin lived near to the prison (which is some distance from Wayland). A family liaison officer at The Mount tried several times during the day to made contact with the man's next of kin, his brother. The family liaison officer visited the man's brother that evening and broke the news of his brother's death and continued to offer support to the family over the next few days. A contribution towards funeral expenses was offered to the family. Two officers and a manager attended the funeral.

ISSUES

Clinical care

78. A review of the man's clinical care at Wayland was commissioned by the local PCT. A clinical reviewer carried out the review on their behalf. The man's death was found to be due to natural causes caused by acute lobar pneumonia. She noted that he had a history of taking heroin, crack cocaine, cannabis and benzodiazepines.

79. The man had been treated for a chest infection and prescribed antibiotic medication on 21 September 2011. A week later, he was seen by a nurse and it was recorded that he felt much better with no shortness of breath and was trying to reduce his smoking.

80. The clinical investigation into his death notes that the IDTS and areas of the healthcare service was lacking in focus, delivery and failed to adhere to policies, protocols and guidelines. The man was a user of IDTS and the wider healthcare services.

Primary care services

81. The man was seen by five locum doctors during his time at Wayland. There were no permanent doctors and chronic staff shortages added to the difficulties in providing a dependable healthcare service. A triage system for appointments was managed by healthcare assistants. (A triage system is based on an assessment of the patients presenting symptoms with them referred to either a doctor or a nurse practitioner for consultation and/or treatment.) The investigation found that it was unclear how appointments were allocated to the correct healthcare professional. Similarly, the clinical reviewer was unable to clarify the role of the nurse practitioner services (NP). (A nurse practitioner is one qualified as a Registered General Nurse, RGN or Mental Health Nurse, RMN.)

82. With reference to primary care services in Wayland the clinical reviewer makes five recommendations. In the light of these, and because the investigator was told that the head of healthcare is the process of recruiting permanent healthcare staff we make the following general recommendation:

    The Head of Healthcare should undertake a formal review of the appointments system, including clarifying the individual roles of the healthcare professionals.

83. The man had sustained severe injuries from a car accident in 2001, which left him with pain in his back, leg and hip. He was not referred to a local pain clinic. The clinical reviewer said:

> "It is difficult to understand why the man was not referred to the local pain clinic, given much of his discomfort seems to have been related to his orthopaedic injuries."

84. The clinical reviewer was told that Wayland took an approach to pain management as set out by the World Health Organisation. However, this could not be confirmed because the policy could not be made available for review by the clinical reviewer and we therefore recommend:

The Head of healthcare should develop clinical pathways into secondary care chronic pain management.

Response to the man's collapse

85. The man was found to be unresponsive in his cell by his friend who subsequently raised the alarm with officers. There was an immediate response by wing staff, and two officers commenced CPR. The SO fetched the defibrillator and used the machine as directed. Following the arrival of the nurse, CPR was continued until the paramedics attended. Despite the efforts of staff, his death was confirmed by an ambulance crew.

86. The wing staff response to this medical emergency was proficiently undertaken. Officers undertook CPR and the SO used the defibrillator. However, the officer did not use the code system when radioing for medical assistance. During an interview with the investigator, the officer said he was under the impression that the codes were no longer being used in a medical emergency.

87. The nurse who responded to the emergency did not take an emergency bag containing oxygen with her, as a code blue had not been called. The clinical reviewer writes: "Whilst this does not appear to have affected outcome for the man, call signs need to be clear".

88. The investigator raised this issue with the Governor during her visit to Wayland on 7 December. The Governor assured the investigator that he had sent out an instruction to all staff that the code system must be used when summoning emergency medical assistance. For that reason, we do not make a recommendation regarding this matter.

Provider partnership arrangements

89. The clinical reviewer said she found some difficulty in understanding the provider of healthcare services arrangements at Wayland, in relation to policy and accountability during the transitional process of one provider to another. The reviewer writes:

> "A transition plan was not available to the review and there appears to be a random mixture of private health provider and NHS policies currently in use."

90. Two recommendations are made in the clinical review regarding this matter. The investigator was told that the head of healthcare is currently addressing the inconsistencies that exist between the two providers of healthcare services.

Integrated Drug Treatment Service (IDTS)

91. In June 2011, Her Majesty's Chief Inspector of Prisons (HMCIP) found the provision of IDTS at Wayland in need of intervention to address his concerns raised in the report. The clinical reviewer finds that the man's involvement with the IDTS reflected the concerns raised by the inspection report. In early September 2011, a new Head of Healthcare was recruited and he recognised that a review of healthcare services, including IDTS policies and procedures, needed to be addressed.

92. The clinical reviewer makes 15 recommendations relating to IDTS. The man was a user of this service although his death was not directly related to any substance misuse. Nevertheless, the shortcomings of the IDTS system at Wayland came to the attention of the clinical reviewer and the investigator.

93. It was noted that prisoners agreeing to IDTS were not reminded of their responsibility when participating in treatments. It was recorded that the man asked for pain relief medication when he was told his methadone was being reduced. He would only agree to this reduction if he was prescribed named medications. Healthcare staff did not always challenge him about this. The clinical reviewer notes this as non-compliance with the compact (contract) signed by prisoners who agree to the guidance for IDTS. He should have been spoken to about his attitude to the IDTS and reminded of the compact he had signed.

94. Information sharing and a joint working approach is essential to ensure the provision of an IDTS. The clinical reviewer writes:

> "D wing staff who spoke to the review said they have little or no time to attend meetings or participate in group work. There is no evidence in the clinical record to suggest multidisciplinary working was taking place."

95. The man did not have a 13 week multidisciplinary review. Furthermore, the clinical reviewer noted that the clinical protocol did not include advice for prisoners sentenced to longer than 26 weeks. Prisoners would not normally be treated with prescribed methadone over a long period, which is why the 13 week review is so important. This oversight added to a lack of advice for prisoners sentenced to longer than 26 weeks raises the possibility of prisoners being prescribed methadone for a long time. Furthermore, training and staff competencies regarding IDTS were found to be in need of updating.

96. The recent increase in methadone related deaths investigated by this office is a concern. We understand that the Prison Service shares this view and is undertaking work to learn more about the dangers of methadone interacting with other medications. While this was not contributing factor in the man's death, the variety of medication he was prescribed at the same time as methadone reflects the need for this work to continue. We therefore endorse the following recommendation focusing on protocol and policy for the head of healthcare and the Governor:

The Head of Healthcare and Governor should undertake an immediate formal review of the clinical protocols, policies and compacts relating to IDTS and ensure that a full multidisciplinary approach to the service is established.

Record keeping and the clinical system

97. The clinical reviewer notes that the man's medical record contained several duplicate entries and errors. Furthermore, she identifies that there were no 'super users' to help clinical staff. (A super user is a trained member of the healthcare staff who has technical training in electronic medical recording.)

98. There was a lack of expertise in prescribing and three monthly prescriptions were not recorded on a repeat template. The man told a CARATS worker in August that he had a large amount of paracetamol in his possession. An officer retrieved the medication and returned it to healthcare staff. It seems that he had been prescribed paracetamol with no record of it being dispensed. This is of concern as he possessed a large amount of this medication on a wing dedicated to IDTS.

99. The following recommendation encompasses the five recommendations the clinical reviewer makes in relation to record keeping and clinical systems.

The Head of Healthcare should ensure all record entries adhere to NHS code of practice for record management.

Issues raised by the man's family

100. One of the office's family liaison officers spoke to the man's brother and invited him to raise any points he would like the investigation to consider. He raised the following issues:

- He wanted to know what his brother's steroid medication was for and the dosages he was prescribed.
- He wanted to know if the combination of methadone and steroid prescriptions could have affected his brother.
- He wanted to know of any other medication that his brother was prescribed.

- He wanted to know if his brother had taken any illicit drugs.

101. The clinical reviewer notes that the man was prescribed Clenil Modulite of 200 micrograms, one dose twice daily on 31 August 2011. This is a steroid medication to help prevent asthma attacks. A new prescription of budesonide (a steroid inhaler) was due to be started on the day he died.

102. The man had gained considerable weight since he had been in prison. The clinical reviewer noted that on his arrival at Bedford on 26 July 2010, his weight was recorded at 58.6kilograms. At his post mortem examination his weight was noted at 88 kilograms. Healthcare staff were unable to re-call, at interview, if he ever reported this as a concern to them. Weight gain is a possible side effect of taking steroids.

103. The clinical reviewer notes that on 21 September, the man was prescribed amoxicillin to treat an infection. A week later, his prescription was recorded as zopiclone to treat insomnia, pain relief of pregabalin and diazepam to treat anxiety. Additionally, he was prescribed asthma medication and a cream to treat fungal infections. The clinical reviewer writes: “There is no indication on the post mortem report to suggest that the medication he had been taking directly related to his death”.

104. Following the man’s death, a number of security incident reports (SIRs) were submitted to the security department. (SIRs are forms on which information of a sensitive nature relating to prisoners, the security of the prison and its staff is collated and noted.) Those SIRs contained information from prisoners which referred to his non prescribed illicit drug use. However, the post mortem examination report confirmed that no illicit drugs were found to be present in his body other than prescribed methadone.

CONCLUSION

105. The man was a substance misuser treated on an IDTS prescription with methadone. He was also prescribed medication for anxiety, asthma and pain relief for his injuries sustained in an accident in 2001. Two weeks before his death, he had been treated with anti biotic for a chest infection, of which he seemed to recover. When he collapsed, staff responded professionally but, despite the actions of officers, he was declared dead by paramedics. The post mortem examination found that his death was due to pneumonia with no trace of any unprescribed medication.

106. During the course of the investigation, the investigator and clinical reviewer noted the issues raised in the HMCIP 2011 report on healthcare services and IDTS. The man was a recipient of both services. We found similar problems and have recommended that the policies and procedures that govern the healthcare services and IDTS should be reviewed.

RECOMMENDATIONS

For the attention of the Head of Healthcare

1. The Head of Healthcare should undertake a complete review of the appointments system, including clarifying the individual roles of the healthcare professionals.

   Accepted. The prison responded that a review of the appointments system has been completed and a revised system fully implemented. A triage nurse now allocates appointments to offenders and the roles of those involved are defined and understood.

2. The Head of Healthcare should develop clinical pathways into secondary care chronic pain management.

   Accepted. The prison responded that the WHO analgesic pain ladder has been adopted and is used in every clinic. Evidence of this is held in clinical records.

3. The Head of Healthcare should review the use of the electronic medical systems and ensure all entries adhere to NHS code of practice for record management.

   Accepted. The prison responded that all appropriate staff have received SystmOne training. There are two super users in place. The pharmacy staff undertake a weekly medication audit and a full medication audit is undertaken once a month by SERCO managers.

For the attention of the Head of Healthcare and the Governor

4. The head of healthcare and Governor should undertake an immediate formal review of the clinical protocols, policies and compacts relating to IDTS and ensure that a full multidisciplinary approach to the service is established.

   Accepted. The prison responded that at the time of the investigation in October 2011, the new Head of Healthcare had only been in place for two weeks. Since he has been in post, the prison reported a significant improvement in healthcare delivery and notably in IDTS. They reported the following improvements:

- In October 2011 there was no permanent IDTS GP and Locums were being used, there now is designated, permanent IDTS GP.

- Since October 2011 all Standard Operating Procedures (SOPs) have been reviewed updated and implemented.

- In October 2011 all ITDS staff were agency staff and provision was inconsistent. All staff are now directly employed.

- In October 2011 there was no clinical lead for IDTS; there is now a clinical lead.

- Audit processes were not in place in October 2011 and therefore quality of provision suffered. A full audit process is now in place.

- Since October we have delivered all 13 week reviews, introduced an ongoing Prisoner led User Support Scheme (PLUS), created better links between healthcare/CARATS/Wing staff and have been recognised by PCT Commissioners as leading the way with 'reduction' of prisoners to detox.