

**Investigation into the death of a man
whilst in the custody of HMP Brixton
in October 2010**

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

January 2013

This is the report of an investigation into the death of a man at HMP Brixton. He died in October 2010. The man's cause of death was found to be due to the combined toxic affects of methadone and chlordiazepoxide. I extend my condolences to his family and friends.

The investigation was carried out by one of my investigators. An independent clinical review of the man's medical care was conducted by a clinical reviewer, supplemented by a specialist report from a doctor (Dr A) into the detoxification medication he received at Brixton. HMP Brixton cooperated fully with the investigation. I apologise that this report has been delayed so long.

When the man arrived at Brixton the substance misuse staff were unaware that he had received opiate based painkillers and diazepam while in police custody. He was given methadone and chlordiazepoxide, based mainly on his own account of his withdrawal and previous drug use, together with the results of his urine test. Dr A concluded that, while it was clinically appropriate to prescribe detoxification medication, too much weight was given to his reported and subjective signs of withdrawal rather than the objective signs that the substance misuse staff should have noticed. She considers that the man was administered too much methadone and this was increased too quickly.

Since the man's death, Brixton's role has changed and it no longer holds prisoners on remand. However, the findings and recommendations made in this report in relation to detoxification practice should be of relevance to other local prisons. This case and its findings also need to be taken into account by the National Offender Management Service and the Department of Health in their ongoing work into deaths involving methadone (sometimes in combination with other drugs) which has been undertaken as a result my raising the concern in other death in custody investigations.

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

January 2013

CONTENTS

Summary

The investigation process

HMP Brixton

Key events

Issues

Conclusion

Recommendations

SUMMARY

1. The man was of a Somali origin and lived in London. On 13 October 2010, he was taken into custody at Shoreditch police station. He was charged and remanded to HMP Brixton on 15 October. It was not his first time in prison. When the man arrived at Brixton there were no medical notes from his time in police custody. During the reception process, he told a nurse that he used heroin and cocaine on a daily basis and consumed up to 3.5 litres of vodka each day.
2. During the evening of 15 October, the man was seen by a prison doctor and prescribed ibuprofen, hyoscine butylbromide¹ and prochlorperazine² to treat the symptoms of opiate withdrawal. He was also prescribed vitamin B strong compound and chlordiazepoxide for alcohol withdrawal.
3. On 16 October, a Clinical Institute Withdrawal Assessment for Alcohol (CIWA-ar)³ was completed by a substance misuse nurse to determine the man's level of alcohol withdrawal. His score was recorded as four. A further assessment took place the following day when the man's score had increased to seven. At a further assessment on 18 October, his overall score was recorded as 29. The nurse who completed the CIWA-ar on 18 October said her score was based on the man's reported subjective responses to the assessment questions, rather than her clinical observations.
4. At approximately 9.40pm in October, the man was found unresponsive in his cell. An emergency alert was called and healthcare staff administered cardio-pulmonary resuscitation until paramedics arrived. The man was pronounced dead at 10.25pm. The investigation found that the emergency response to the man's collapse was good.
5. Following the results of the post-mortem, we requested a specialist review of the man's detoxification prescription. This review concludes it was reasonable to prescribe the man an opiate and alcohol detoxification. However, there is concern about the amount of methadone administered to the man, that the dosage was increased too quickly and about the level of training given to staff completing detoxification assessments.
6. When the man was found collapsed in his cell the emergency response was swift and it was apparent that it was too late to save him.

¹ Hyoscine butylbromide is an antispasmodic medicine used for the relief of abdominal pain.

² Prochlorperazine is used to treat dizziness and problems with balance, and for nausea and vomiting.

³ A CIWA-ar is a common measure used to assess and treat alcohol withdrawal syndrome and for alcohol detoxification. This clinical tool assesses 10 common withdrawal signs. A cumulative score between 0-7 indicates that no medication is necessary. A score between 8-14 indicates that medication is optional. If a patient's cumulative score is over 15 they would require treatment with medication. A score over 20 poses a strong risk of DVTs. The maximum cumulative score is 67.

However, emergency procedures could be improved further by ensuring that ambulances are always called immediately in a serious emergency and that appropriate equipment is taken to an incident. After the man's death, there was a delay in informing his family because the prison had not collected details about his next of kin.

THE INVESTIGATION PROCESS

7. The investigation was undertaken by one of my investigators. She first visited Brixton on 2 November 2010 and was given access to the man's prison and medical records.
8. During this initial visit, the investigator met members of the Independent Monitoring Board (IMB)⁴ and a representative from the Prison Officers Association (POA)⁵. Neither the IMB nor the POA had any specific matters to raise about the man's death. Notices to staff and prisoners were displayed about the investigation. The investigator visited the man's cell on G wing and met the Governor of Brixton, and the prison's family liaison officer.
9. A clinical reviewer was commissioned to undertake a clinical review of the man's medical care. The clinical reviewers' report is the first annex to this report.
10. The post-mortem report was received on 30 March 2011. After reading the report, it was decided to commission a further specialist review of the care given to the man focusing on the potential role of addictive substances and the quality of his alcohol detoxification. Dr A completed a report in November 2011 which is the second annex to this report.
11. The investigator visited Brixton on 19 January 2011 and interviewed two members of staff, Nurse A and the substance misuse team leader, accompanied by the clinical reviewer and the Offender Health Manager for the East of England. On 19 September, the investigator and Dr A re-interviewed and interviewed the Head of Healthcare.
12. One of our family liaison officers contacted the man's family to explain the purpose of the investigation and to invite them to ask any questions or raise any issues for consideration. The family liaison officer and the investigator met the man's family on the 22 November who subsequently instructed solicitors to act on their behalf. The man's family raised a number of issues they wished the investigation to address:
 - They wanted to know if sufficient steps were taken to investigate the man's epilepsy, particularly with regard to the detoxification care plan, and whether sufficient safeguarding measures were put in place.
 - They wanted to know why the man was only seen by a doctor once.

⁴ Each prison has an Independent Monitoring Board. IMB members are unpaid and monitor day-to-day life in the prison to help ensure that proper standards of care and decency are maintained. The IMB produces an annual report of its work.

⁵ The POA represents uniformed prison grades and staff working within the field of secure forensic psychiatric care.

- They wanted to know more about the consequences of the man's high score on the alcohol withdrawal assessment on 18 October 2010.
 - They were concerned that the toxicology report dated January 2011 reveals that diazepam and dihydrocodeine was found in the man's blood according to the medical records, were not prescribed.
 - The man's family were concerned at the delay in CPR being administered.
13. We regret the delay in issuing this report which at first was held up by the time taken to commission and complete the further specialist clinical review and then a need to seek clarification of some aspects. We apologise for the further delay in this office caused by a backlog of cases which we are striving to clear.

HMP BRIXTON

14. At the time of the man's death, HMP Brixton was a local prison serving a number of courts in South London and holding up to 798 men. Healthcare services are commissioned by NHS Lambeth and delivered by a group led by Care UK, including the South London and Maudsley NHS Foundation Trust (SLaM), with pharmacy and other services provided by Lambeth Community Health,
15. Brixton has now changed its function to a category C prison with particular emphasis on resettlement. The prison no longer accepts prisoners on remand. The prisoner population now consists of 250 vulnerable prisoners, 355 category C prisoners with short term sentences and 183 category D prisoners.

Independent Monitoring Board

16. In their 2010/2011 report, the prison's Independent Monitoring Board (IMB) noted that there an Integrated Drug Treatment Service had been introduced. The Board commented that the induction arrangements for prisoners who had been placed on G-Wing for drug treatment reasons had improved. In relation to the plans to change the function of Brixton to a resettlement prison the Board expressed some concerns about how the needs of prisoners with health related problems such as drug and alcohol would be met.

Her Majesty's Inspectorate of Prisons (HMIP)

17. An unannounced inspection of Brixton took place in December 2010. In his introduction to the report of the inspection, the Chief Inspector said:

"Brixton had improved since our last inspection. Some of these improvements were significant. However, the problems that did remain were substantial and it was clear that managers and staff would struggle to maintain what, in many respects, were the minimum of basic standards"
18. Inspectors reported that in their survey two out of five prisoners at Brixton said they had a drug problem when they arrived at the prison which was higher than comparable groups. There were satisfactory integrated drug treatment system (IDTS)⁶ procedures but, until recently, first night prescribing had mostly been limited to symptomatic relief. Inspectors saw excellent interactions between prisoners receiving treatment and IDTS nursing staff and officers.

⁶ 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). The integrated drug treatment system (IDTS) was implemented in Brixton in 2007.

Previous deaths at HMP Brixton

19. There have been twenty deaths in total at Brixton since the Ombudsman was given responsibility for investigating deaths in custody in April 2004. Seven of these deaths were due to natural causes, ten were self-inflicted, one was due to an illicit drugs overdose and two were unclassified. In one of the previous unclassified deaths at Brixton the difficulties faced by busy, overcrowded local prisons with a high number of new prisoners requiring detoxification was identified.

KEY EVENTS

20. The man was arrested on 13 October 2010, and taken to Shoreditch police station. At an initial assessment by the custody sergeant, the man said he had a history of epilepsy, sciatica and had been prescribed sleeping tablets which were at home. He was unable to remember the names of any of his medications. The man said he had consumed two cans of lager in the previous 24 hours. The sergeant considered that the man was possibly under the influence of alcohol or drugs.
21. The man saw a doctor at 9.50am on 14 October. The doctor judged him as fit for detention and that no further medical review was required. The man was prescribed diazepam⁷, ibuprofen and paracetamol. He was seen again at 4.45pm by another doctor who also considered him fit for detention with no further medical review required.
22. At 2.40am on 15 October, the man asked to see a doctor because his sciatica was causing him pain. The doctor prescribed dihydrocodeine and diazepam. During his time in police custody the man failed to provide a urine drug screen despite this being requested by the police.
23. The man arrived at Brixton later on 15 October 2010, after being remanded into custody charged with grievous bodily harm. He was due to appear at court on 21 December. When he first arrived at Brixton, the man told staff he was a heroin and cocaine user and had a severe alcohol dependency.
24. A first reception health screen was undertaken by Nurse A at 5.45pm. The man did not arrive at Brixton with any medical notes or any information from Shoreditch police station. He told the nurse he had seen a doctor in the community within the last few months because he suffered from sciatica⁸. The man said he had been prescribed diclofenac⁹ and other medication for the pain but they did not work. He also said he had suffered from fits in the past although he had not had one for a couple of months. The man said he had previously been prescribed medication for his epilepsy but was not taking any at that time. The nurse noted that the man was a smoker but had declined any smoking cessation advice. The man accepted a vaccination course against hepatitis B¹⁰.

⁷ Diazepam is a type of medicine called a benzodiazepine. Benzodiazepines are used for their sedative, anxiety-relieving and muscle-relaxing effects.

⁸ Sciatica is a set of symptoms including pain that may be caused by general compression and/or irritation of one of five spinal nerve roots that give rise to each sciatic nerve or by compression or irritation of the left or right or both sciatic nerves. The pain is felt in the lower back, buttock, and/or various parts of the leg and foot.

⁹ Diclofenac is a non-steroidal anti-inflammatory drug used for pain and inflammation in rheumatic disease, and in disorders of the joints, muscles and tendons

¹⁰ Hepatitis B is irritation and swelling (inflammation) of the liver due to infection with the hepatitis B virus (HBV).

25. The man told Nurse A that he was taking anti-depressants for his mental health problems but was unable to remember the name of the medication. The man was noted to be shaking and he expressed concerns about his own physical wellbeing.
26. The medical records show that the man said he was a heavy drinker, and consumed up to 3.5 litres of vodka per day. The man told Nurse A that he used heroin and cocaine daily. He also said he had a history of using crack cocaine. The man completed a medical sharing information agreement as part of the reception process.
27. During the evening of 15 October, the man was seen by Dr A, a prison doctor who was employed on a locum¹¹ basis. The man discussed his substance and alcohol abuse and said his last alcohol consumption was in the early hours of 13 October. The man said he had a history of sleep walking and, during a previous time in custody, he had attempted to strangle two other prisoners. On the cell sharing risk assessment form the doctor noted that there was clear indication that the man might assault his cell mate and recommended the man should be given a single cell on G wing.
28. G wing was used as the first night induction and stabilisation area to allow staff the opportunity to carry out a full assessment of a prisoner's immediate needs before they moved into the main prison. Brixton did not have a dedicated stabilisation unit to observe vulnerable prisoners during the first five days of being received into custody.
29. There is nothing in the medical records to suggest that Dr A sought further information about the man's epilepsy. The doctor prescribed the man ibuprofen, hyoscine butylbromide and prochlorperazine, and 10ml of methadone to treat the symptoms of opiate withdrawal¹². He was also prescribed medication for alcohol withdrawal, namely vitamin B strong compound, and chlordiazepoxide.
30. On 16 October at 2.18pm, the man was seen by Nurse B from the Counselling, Assessment, Referral, Advice and Throughcare team (CARATs)¹³. The man complained of experiencing cramps and aches and pains. The nurse noted that the man was displaying some signs and symptoms of withdrawal, such as fine tremors. The man told the nurse he regularly injected both heroin and crack cocaine. However, Dr A notes that there is no evidence of any attempt to verify this, such as checking for needle marks.

¹¹ A locum doctor is not employed on a permanent basis by the PCT and will undertake duties on a contract basis.

¹² Opiate withdrawal refers to the wide range of symptoms that occur after stopping or dramatically reducing opiate drug after heavy and prolonged use (several weeks or more). Opiate drugs amongst others includes heroin.

¹³ Prisoners who have been identified as having problems with drug or alcohol misuse must be referred to CARATs. The service provides low intensity, low threshold, multi-disciplinary, drug misuse intervention services.

31. The man said that he had last used heroin on 14 October (although he was actually in police custody at that time.) He also said he drank approximately 3.5 litres of vodka a day. The man's urine tested positive for opiates, cocaine, cannabis and benzodiazepines.
32. Nurse B completed a substance misuse clinical management plan, including a methadone and alcohol detoxification programme. The plan indicated a review should take place after a week of treatment.

Alcohol detoxification and withdrawal assessments

33. On 16 October at 9.15 am, a Clinical Institute Withdrawal Assessment for Alcohol (CIWA-ar)¹⁴ was completed by Nurse C. This assessment tool assesses the severity of symptoms and provides the basis for treatment of patients undergoing alcohol withdrawal. Based on Nurse C's clinical observations of the man, he was given a total score of four. A further assessment took place on 17 October when the man's score was recorded as seven. It is unclear from the assessment chart what time of day the observations were made. The maximum cumulative score is sixty seven and provides the basis for treatment of patients undergoing alcohol withdrawal. The man's scores on these occasions indicated that his symptoms of withdrawal were mild so he did not require any medication.
34. At 9.22am on 18 October, the man was seen by Nurse D, a substance misuse nurse, to complete the alcohol withdrawal assessment chart for that day. The man's overall score was then recorded as 29. A score of over twenty indicates that a patient poses a strong risk of delirium tremens¹⁵ and should be seen immediately by a doctor. (Nurse D based this score on the man's own account of his symptoms, rather than her objective observation of his withdrawal symptoms.)
35. From the alcohol detoxification prescription chart Dr A noted that, on 15 October, the man was prescribed vitamin B strong compound, thiamine 100mg and chlordiazepoxide 40mg in reception. On 16 October, he received chlordiazepoxide 40mgs three times a day. On 17 October, he received chlordiazepoxide 40mgs three times a day. On 18 October, the man's dosage was reduced to chlordiazepoxide 35mgs three times a day.
36. Dr A notes that the man's general observations were undertaken between 10pm and 6.30am. Over the three nights of observations, it

¹⁴ A CIWA-ar is a common measure used to assess and treat alcohol withdrawal syndrome and for alcohol detoxification. This clinical tool assesses 10 common withdrawal signs.

¹⁵ Delirium tremens is a severe form of alcohol withdrawal that involves sudden and severe mental or nervous system changes.

appears that the man was asleep for the majority of time for the recorded observations.

Opiate detoxification and withdrawal assessments

37. On 16 October at 2.55pm, the man's blood pressure was 133/80 and he had a pulse of 90. The man did not display any signs of opiate withdrawal. There was no evidence of dilated pupils, running nose, yawning, perspiration, running eyes, goose-flesh, drug seeking behaviour or muscle twitches. However, he had suffered vomiting and diarrhoea. The man reported that he was also suffering from hot and cold flushes, aching bones and muscles, abdominal cramps, restlessness, irritability, nausea and anorexia. He was prescribed 20ml of methadone.
38. On 17 October at 3.32pm, the only objective signs of opiate withdrawal were vomiting and diarrhoea. The man's blood pressure was 146/82 and he had a pulse of 89. He continued to report that he was suffering from hot and cold flushes, aching bone and muscles and abdominal cramps. He denied any feelings of restlessness, irritability, nausea and anorexia. Dr A notes that the man was given a further 30ml of methadone.
39. On 18 October at 2.30pm, again the only reported objective signs of opiate withdrawal were vomiting and diarrhoea. His blood pressure was 145/90 and he had a pulse of 104. The man complained of hot and cold flushes, aching bones and muscles, abdominal cramps, restlessness, irritability, nausea and anorexia. He received a further increased dose of 35ml of methadone. The man's medical record shows that, on 18 October, he collected his detoxification medication (35mgs of chlordiazepoxide) in the morning, lunchtime and evening.
40. Dr A considers that the quality of entries made by the nursing and medical staff were of a good standard. The entries were sufficiently detailed and made in a clear chronological order. However, Dr A considers that prison Dr A should have provided a brief formulation about the man's presentation and plans for management. She considers that this would have been useful for other staff when they were carrying out follow up assessments. Dr A concludes that the man's management was clinically appropriate at this point.
41. The man's initial assessment by the CARATs team took place within five days of being received into custody. Dr A notes: "It is very encouraging to see that this did indeed happen and demonstrates a good coordinated team approach to their clients."
42. Dr A also comments positively on the withdrawal assessments carried out by Brixton staff:

“Furthermore the alcohol withdrawal assessments were done each morning at around 9am, apart from one day when the time was not recorded. The opiate withdrawal observations were done of an afternoon at a consistent time of day at around 3pm. The observations were clearly recorded on a daily basis in line with policies and protocols.”

Events on the evening of 18 October 2010

43. At approximately 9.40pm on 18 October, the first nurse on the scene, an agency substance misuse nurse, began his routine checks on all G wing prisoners. When the nurse reached the man’s cell, some minutes later, he looked through the cell window and saw him in a praying position with his right hand resting on the bed. The nurse attempted to get the man’s attention by calling out his name and kicking his cell door. The man did not respond.
44. The first nurse on the scene telephoned the control room and requested immediate assistance. A code 2¹⁶ call was made over the radio. At approximately 9.50pm the second nurse on the scene, who held the emergency response radio for healthcare staff, went to the man’s cell. The records show that the man’s cell door was opened by Officer A, a G wing officer who used his emergency cell key which is carried in a sealed pouch at night. They found the man lying on the floor of his cell in a praying position. The second nurse described the man as “kneeling on the floor with his forehead almost touching the floor.” He noted that the man had vomited, and there were clear signs of rigor mortis. The man was placed on his back and the second nurse on the scene began to carry out cardiopulmonary resuscitation (CPR)¹⁷.
45. The control room log shows that an ambulance was requested at 9.58pm. At approximately 10.00pm the second nurse on the scene used his radio to request that the emergency bag be brought to G wing. The control room log shows that the third nurse on the scene arrived with the bag at approximately 10.10pm and found the first nurse on the scene and the second nurse on the scene carrying out CPR. The defibrillator¹⁸ pads were placed on the man’s chest but the machine was unable to detect a shockable rhythm in his heart.
46. The log shows that an ambulance arrived at the prison at 10.12pm and paramedics were escorted to G wing. The paramedics started advanced life support but were unable to revive the man. At 10.25pm, the paramedics confirmed that the man had died.

¹⁶ A code 2 call is made when a prisoner is found either injured or unresponsive.

¹⁷ CPR is an emergency procedure involving chest compressions to maintain blood circulation and often mouth to mouth to push air into the patient’s lungs.)

¹⁸ A defibrillator is a machine used to shock the patient’s heart and restore the heart’s normal rhythmic patterns. It cannot however, restart the heart if a detectable rhythm cannot be found.

47. The first nurse on the scene told the investigator that, on the day of the man's death, he started work at 8.45pm and was due to begin his formal observations of the prisoners on G wing at 10.00pm. Before doing so, he went to the wing at approximately 9.40pm to undertake a quick check of the prisoners on the fourth landing. He discovered the man collapsed and unresponsive in his cell. He had not been issued with a radio because his role on the wing was to carry out routine observations of prisoners. He therefore telephoned the control room to request immediate assistance.
48. After his death, the first nurse on the scene made a note of his actions in the man's medical record. He told the investigator that he estimated the time he had discovered the man as 9.40pm but this was an approximation based on the time that he had first arrived on G wing.
49. In response to a question raised by the clinical reviewer, the investigator sought further information from the head of healthcare about the availability of defibrillators in the prison. The head of healthcare said there was a portable defibrillator on each wing and in the emergency bag. An advanced life support defibrillator was also available in the in-patients wing.

Liaison with the man's family

50. The man's prison record did not list a next of kin or other person to be contacted in an emergency. However, after examination of visits records Brixton identified the address of the man's ex-wife. At 11.30am the next morning, 19 October, the prison's family liaison officer, and the Governor of Brixton, went to the man's ex-wife's house to inform her of his death. Because nobody was at home a further attempt was made at 12.30pm. At 4.45pm the prison's family liaison officer and the Governor of Brixton visited again and were able to break the news of the man's death to his ex-wife. The man's ex-wife then contacted the man's brother and explained that he had died.
51. The man's brother came to the man's ex-wife's house and spoke to the prison's family liaison officer and the Governor of Brixton. He was concerned that Brixton had not told the man's family that he was in prison. The Governor of Brixton explained that the man had not requested that any of his family should be informed.
52. The prison met the funeral expenses in accordance with Prison Service guidance. The man's funeral took place on 1 April 2011.

Support for prisoners

53. A notice to prisoners was issued on 19 May, to inform prisoners about the man's death. Prisoners were reminded that support was available

from Listeners,¹⁹ the Chaplaincy team and the Samaritans²⁰. Brixton reviewed prisoners who were being managed under the Assessment, Care in Custody and Teamwork (ACCT) process to ensure that they were not affected by the man's death.

Support for staff

54. Following the man's death, a hot debrief²¹ was held, attended by officers and healthcare staff. Staff were offered access to the prison's staff care and welfare team.

Post-mortem report

55. A post-mortem examination was completed on 19 October 2010. A report was sent to the South London Coroner on 23 March 2011. The report indicated that the man had taken or had been administered methadone and other prescription drugs. The post mortem report said that the man had a history of opiate abuse but had not previously been prescribed methadone. He commented that, due to this, it is conceivable that the man might not have had any tolerance to methadone.
56. The post mortem report considered the possibility that the man might have suffered a fatal alcohol withdrawal. The report states that, while this could not be wholly excluded, it was relatively unlikely as the man was receiving appropriate medication at the time of his death. The cause of death was given as the combined toxic effects of methadone and chlodiazepoxide.

¹⁹ The Listener Support Scheme is a peer support scheme where selected prisoners are trained to listen in confidence to prisoners who may be experiencing feelings of distress, including those which may lead to self harm or suicide.

²⁰ The Samaritans provide confidential emotional support on a 24 hour basis and are most commonly contacted via the telephone.

²¹ A hot debrief should be held as soon as possible after the incident. The purpose of the hot debrief is to allow those involved to discuss any issues or concerns. The hot debrief should focus on reassurance, information sharing and how staff can support each other.

ISSUES

The man's general clinical care.

57. The clinical reviewer completed a clinical review into the man's medical care at Brixton. Her report appears in full as the first annex.
58. The clinical reviewer notes that the man was appropriately received in the reception department at Brixton and referred to the substance misuse team. She considers that the man's substance misuse needs were assessed correctly and he received the appropriate medications.

The findings of Dr A's specialist clinical review

59. Dr A, a qualified consultant in forensic and addiction psychiatry carried out a specialist review of the potential role of addictive substances in the man's death and the quality of his alcohol detoxification. Her report can be read in full at annex two. She agrees with the clinical reviewer that the man received a thorough first reception health screen. However, she does not agree that his substance misuse needs were assessed correctly. Her views are further discussed later in this report.

The lack of information from external sources

60. Prison Service Order 3030, on continuity of healthcare for prisoners, states that when a prisoner enters reception efforts should be made to retrieve any information required from the prisoner's GP or other relevant service they might have been in contact with. Examples given of other sources for retrieving from include escort services and the police.
61. Before being remanded to Brixton, the man was held at Shoreditch police station between 13 and 15 October. While he was there he was prescribed medication but did not provide a urine sample. At no stage did he suggest he used illicit drugs or was withdrawing from them. Dr A comments that this made the man's management more difficult because it was unclear if he had been abusing opiates illicitly at this time.
62. The man's medical records from Shoreditch police station did not go with him to the prison. While the substance misuse team has systems to verify clinical information from community doctors this does not appear to extend to getting information from police custody suites.
63. Dr A writes:

"The team did not have the relevant information from Shoreditch police station which would have been extremely important from a pharmacological management perspective. Without this information his tolerance to opiates and alcohol was unknown."

64. It is important that prisons have the correct information when making decisions such as the prescription of medication or prisoners withdrawing from drugs or alcohol.

The Governor should ensure that when a prisoner arrives from police custody all relevant healthcare information is obtained from the police station.

65. During his interview with Dr A and the investigator, the Head of Healthcare said that information is sought from GP practices in the community between 24 and 72 hours after the prisoner's arrival. Medical information related to substance misuse issues is usually obtained within 24 hours. A faxed request for medical information was not sent by the prison until 21 October 2010, which was three days after the man had died. (When received this information revealed that, contrary to what he had said, the man had not been prescribed methadone in the community. This would have been important information for the substance misuse team in the prison.)

The Head of Healthcare should ensure that healthcare staff request GP records within 24 hours of a prisoner's arrival.

66. The man's family asked if sufficient steps were taken to investigate his history of epilepsy. During his first reception health screen the man told Nurse A that he had suffered from fits in the past for which he had previously been prescribed medication. The man said he had not had a fit for the previous few months. Dr A told the investigator that, while it is good practice to explore all aspects of a prisoner's medical history, there is no evidence to suggest that the man's death was caused by epileptic fit. This is supported by the results of the post mortem report.
67. The man's family also expressed concern that the toxicology report of January 2011 showed that diazepam and dihydrocodeine were found in the man's blood but according to the medical records were not prescribed. However, the medical records from Shoreditch police station show that the man was prescribed both substances while he was in police custody.

The decision to prescribe the man detoxification medication

68. The man was prescribed chlorthalidone and methadone as symptomatic relief when he arrived at Brixton on 15 October, based on his own account of his substance usage. He was seen the following day by a member of the CARATs team. At this point, he provided a urine sample which tested positive for opiates, cocaine, cannabis and benzodiazepines. He told the member of staff that he used heroin and cocaine. Dr A notes that, on 16 October, the man did not display any of the usual signs of opiate withdrawal such as dilated pupils, running nose, yawning, perspiration, running eyes, goose-flesh, drug seeking

behaviour or muscle twitches which are common signs of opiate withdrawal. There were, however, signs of vomiting and diarrhoea. The man also reported hot and cold flushes, aching bones and muscles, abdominal cramps, restlessness, irritability, nausea and lack of appetite, all of which are indications of withdrawal. He therefore began an alcohol and opiate detoxification programme and was prescribed chlordiazepoxide and methadone.

69. However, the man denied a history of dependence on drugs while he was in police custody, where he had been prescribed dihydrocodeine. Dr A confirmed to the investigator that this medication could have resulted in the positive opiate result in the urine test at Brixton. Therefore, Brixton relied too much on the man's own, possibly unreliable, accounts of his substance misuse history, unclear symptoms of withdrawal (which could have been caused by his alcohol withdrawal or an unrelated condition) and a positive urine sample that could have been caused by prescribed medication in police custody. Dr A comments on the lack of information from the police station:

"The situation was further complicated by not having information from Shoreditch police station. It was therefore unclear at this time to the clinical team in October 2010, as to what his true tolerance to opiates and alcohol was."

70. It is possible that staff at Brixton staff would have acted and prescribed differently if they had known the man had not mentioned a history of opiate usage and if they had known he had been prescribed opiate medication while he was in police custody. Nevertheless, Dr A believes that it was not unreasonable for the man to have been prescribed chlordiazepoxide and methadone for opiate withdrawal based on his positive urine sample and the subjective symptoms of withdrawal that he had described to the substance misuse team:

"On the basis of the overall clinical assessments in my opinion, it was reasonable to prescribe him an alcohol and opiate detoxification."

71. Dr A considers that the man exhibited 'mild' scores on the CIWA-ar²² for the first two days and was prescribed a standard detoxification for this. He was very inconsistent about how much he drank. Dr A comments:

"Given these discrepancies in terms of what the man was reporting to the Carat assessor one wonders whether he was deliberately over-reporting his use in order to ensure that the health-care staff would provide him with a maximal amount of medication for his detoxification purposes."

²² A CIWA-ar is a common measure used to assess and treat alcohol withdrawal syndrome and for alcohol detoxification. This clinical tool assesses 10 common withdrawal signs.

72. Although Dr A considers that it was reasonable in the circumstances to prescribe an alcohol and an opiate detoxification, she believes that too much weight was given to the man's reported subjective signs of withdrawal rather than the objective signs that the nursing staff would have witnessed:

"Throughout the brief period of time that the man was on remand at HMP Brixton, there appears to have been an over reporting of abuse of alcohol, illicit drugs and prescribed psychotropic medication on his part. He was an unreliable historian. It would appear that more weight was given to the man's self-reported problems by the clinical staff rather than balancing this against the objective signs and symptoms that form a crucial part of managing patients when first received into reception."

The Head of Healthcare should ensure that staff give greater clinical weight to objective rather than subjective signs and symptoms of withdrawal, particularly with new receptions whose histories are not established and whose tolerance is unknown.

The level and titration of the man's detoxification medication

73. Dr A considers that the man did not require as much chlordiazepoxide for his alcohol withdrawal as he was prescribed because he appeared only to be exhibiting mild to moderate withdrawal symptoms. Dr A writes:

"I have also advised that, on balance, I believe his withdrawal symptoms from alcohol did not warrant as much chlordiazepoxide as he was prescribed. ... Chlordiazepoxide when prescribed alone is a relatively safe drug. Care though must always be taken especially with prescribing other sedative medication especially opiates because of the potential dangers of respiratory depression."

74. The man did not exhibit severe symptoms of opiate withdrawal either. Dr A also comments that the symptoms were not opiate specific and concludes that the man was administered too much methadone and that this was increased too quickly:

"From viewing the clinical evidence he was, in my opinion, titrated up too fast on his methadone script, given that he was also in receipt of other sedative medication, chlordiazepoxide. IDTS endorses that both these medications can be prescribed simultaneously on the basis of clinical need, as I would also, but with careful monitoring. In this case, with an unreliable historian requiring dual detoxing, I feel that greater caution should have been exercised."

75. Methadone titration prescriptions can be modified to fit the specific circumstances of the prisoner concerned and, taking into account the man's inconsistent history and dual detoxification, further thought should have been given to a more gradual titration.

The Head of Healthcare should ensure that a smaller initial methadone dosage and smaller incremental increases at more prolonged intervals are considered for prisoners at a higher risk of mixed-drug toxicity.

Detoxification reviews

76. The man's withdrawal from opiates was monitored under the clinical opiate withdrawal scale (COWS)²³. The man's levels of methadone were increased according to a predetermined template within the policy guidelines. The man was not due for a review under the integrated drug treatment system (IDTS)²⁴ until day five of his remand. As the man was also undertaking an alcohol detoxification programme at the same time, Dr A considers that the man should have been clinically reviewed at day three of his remand:

"If an inmate were in receipt of single script i.e. only opiates, this [review at day 5] may well have been clinically safe but in combination with other sedative medication e.g. chlordiazepoxide there is the possibility for toxicity. In inmates that are more complex, requiring dual detoxification, I would recommend a review at day 3 to evaluate the progress of the detoxification and their treatment plan."

The Head of Healthcare should ensure that patients requiring simultaneous dual detoxification are reviewed at day three to observe the clinical progress of their detoxification.

The alcohol withdrawal assessment on 18 October

77. Dr A notes that the CIWA-ar scale completed by Nurse D on 18 October was significantly different from the assessments on the previous two days. The man's score increased from four on day one, seven on day two and then to 29 on day three.
78. During her interview with the investigator and the clinical reviewer, Nurse D explained that the man was allocated a score between one

²³ The clinical opiate withdrawal scale (COWS) is a clinician-administered, pen and paper instrument that rates eleven common opiate withdrawal signs or symptoms. The summed score of the eleven items can be used to assess a patient's level of opiate withdrawal and to make inferences about their level of physical dependence on opiates.

²⁴ 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 CARAT Services and reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

and seven based on his response to questions about his alcohol withdrawal symptoms. The nurse said that the man's scores were based on what he told her rather than her clinical observations. In addition, she did not follow the correct procedure of calling a doctor when a patient's total score was in excess of 20 or prescribe the recommended 20mg of chlordiazepoxide. The nurse explained that this was because the man appeared well and did not display the symptoms that were reflected in the scores on the CIWA-ar chart.

79. The investigator and clinical reviewer also interviewed the substance misuse team leader. He said the assessment form should be a combination of the patient's opinions about how they were feeling and the nurse's clinical observations of the patient. He considered that Nurse D had based her score purely on the man's response to the assessment questions rather than her clinical observations.
80. The substance misuse team leader said that following the man's death he examined the CIWA-ar charts and saw that Nurse D had assessed the man as having the score of 29. He explained that, following the man's death, he had discussed this with the nurse to determine why she had given such a high score and why further action had not been taken. He said the nurse clearly required further support and training in using the alcohol withdrawal assessment tool. He was interviewed again on 19 September, by the investigator and Dr A. He explained that, following the man's death, the nurse was given further training in the correct use of the CIWA-ar tool. He said that the nurse continued to be under supervision when undertaking withdrawal assessments. We are satisfied that this issue has now been addressed.

The emergency response

81. During the evening of 18 October, the first nurse on the scene went to the man's cell as part of his routine observations of prisoners undergoing detoxification regimes. Having found the man collapsed and unresponsive in his cell he telephoned the control room for immediate assistance.
82. Officer A's decision to break the sealed pouch containing a cell key and enter the man's cell was in accordance with Brixton's operational instructions for night staff which advises staff that where there is, or appears to be, immediate danger to life, cells may be unlocked without the authority of the night orderly officer and an individual member of staff may enter the cell on their own.
83. The second nurse on the scene responded to the emergency call and he and the first nurse on the scene immediately began CPR. Both nurses wrote an account of their actions in the clinical record, describing clear signs of rigor mortis in the man. The third nurse on the scene arrived with the emergency bag at approximately 10.10pm and a defibrillator was used. The clinical reviewer and Dr A both comment

positively on the efforts of the staff who attended the man's cell and their attempts at resuscitation.

84. We note that the ambulance was not called until 9.58pm once the nurse had assessed the man, although it was apparent before that time that there was a medical emergency involving an unresponsive prisoner. Guidance to prisons is that an ambulance should be called in all cases where there are grave concerns about the immediate health of a prisoner without waiting for a healthcare assessment. If a member of the healthcare team decides after an ambulance has been called that it is not necessary, it can be cancelled. It is prudent for part of a code system to prompt control room staff to telephone for an ambulance in a medical emergency. We also note that, although the second nurse on the scene responded quickly to the emergency call, he did not bring the emergency bag with him. It does not appear that either of these issues would have changed the outcome for the man who received swift emergency attention, but in other situations it could make a difference.

The Governor should ensure there is an effective emergency code system that alerts emergency responders to bring appropriate equipment to an incident and which prompts control room staff to call an ambulance where there are grave concerns about the immediate health of a prisoner.

Informing the man's family of his death

85. The prison's family liaison officer and the Governor of Brixton made two unsuccessful attempts to speak to the man's ex wife, as his next of kin, on the morning of 19 October. They eventually managed to speak to her at 4.45pm that day and told her that the man had died.
86. The investigator asked why the news of the man's death had not been broken to his family following his death at 10.25pm on 18 October. The Governor said that after the man's death he was telephoned and went to the prison. They were unable to inform the man's family at that stage as there was no next of kin or other nominated person to contact on the man's prison records. Eventually, further investigation of the man's visits record provided his ex-wife's details so they were able to visit the next day.
87. Prison Service Instruction (PSI) 64/2011 says:
- "Prisons must record a next of kin or nominated person to contact for each prisoner during the reception/early days process"*
88. It is important that prison's record such details so that in the event of a death or other emergency families can be informed as soon as possible in line with Prison Service guidelines.

The Governor should ensure next of kin details are obtained during the reception process to enable swift contact to be made in the event of an emergency.

CONCLUSION

89. The man arrived at Brixton from police custody. He told staff that he was a daily user of heroin and cocaine and had previously used crack cocaine. The man also said he had a severe alcohol dependency. It is possible that the man's accounts of his substance misuse were accurate or inflated to ensure he received medication. The lack of information sharing from the man's time in police custody meant that prison staff were unaware that he had been prescribed opiate medication in the police station which could have resulted in the positive opiate sample he provided at Brixton. This did not help establish a clear picture of the man's use or tolerance level to opiates. There was too much reliance on his own accounts.

90. Dr A considers that on the available information it was appropriate for the man to begin detoxification programmes for alcohol and opiates. However, in view of the uncertainty and the limited objective symptoms of withdrawal, she concludes that the man did not require as much chlordiazepoxide for alcohol withdrawal as he was prescribed. She considers that the man was administered too much methadone and the dosage was increased too quickly in view of the limited information about his previous use. The combination of the two drugs, without more frequent review, appears to have resulted in the man's death.

RECOMMENDATIONS

1. The Governor should ensure that when a prisoner arrives from police custody all relevant healthcare information is obtained from the police station.
2. The Head of Healthcare should ensure that healthcare staff request GP records within 24 hours of a prisoner's arrival.
3. The Head of Healthcare should ensure that staff give greater clinical weight to objective rather than subjective signs and symptoms of withdrawal, particularly with new receptions whose histories are not established and whose tolerance is unknown.
4. The Head of Healthcare should ensure that a smaller initial methadone dosage and smaller incremental increases at more prolonged intervals are considered for prisoners at a higher risk of mixed-drug toxicity.
5. The Head of Healthcare should ensure that patients requiring simultaneous dual detoxification are reviewed at day three to observe the clinical progress of their detoxification.
6. The Governor should ensure there is an effective emergency code system that alerts emergency responders to bring appropriate equipment to an incident and which prompts control room staff to call an ambulance where there are grave concerns about the immediate health of a prisoner.
7. The Governor should ensure next of kin details are obtained during the reception process to enable swift contact to be made in the event of an emergency.