PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the death of a man In July 2011 at HMP Durham

Report by the Prisons and Probation Ombudsman for England and Wales

July 2013

This is the report of an investigation into the death of the man who died in July 2011 at HMP Durham. He was 56 years old. Although he was in poor health with a long term severe lung condition, the cause of death appears to have been an overdose of the painkilling drug dihyrodcodeine. I offer my condolences to his family and friends.

An investigator was appointed. A clinical reviewer reviewed the man's clinical care at HMP Durham and a supplementary clinical review was carried out at our request. Staff at Durham cooperated fully with the investigation. I apologise for the delay in producing this report.

The man was in very poor health with lung disease and often complained about his healthcare and treatment at Durham. He was dissatisfied with his location in the prison and ultimately wanted to move to HMP Frankland. He sometimes refused food and medication in attempts to engineer the moves he wanted. He was on a high dose of dihyrodcodeine to manage his pain. He had been found secreting dihyrodcodeine tablets so his medication was administered by nurses.

One morning in July the man was discovered unresponsive in his cell. It was clear he had been dead for some time so resuscitation was not attempted. A post-mortem report initially gave the cause of death as heart disease due to narrowing of the artery and severe pulmonary emphysema (long-term degeneration of lung tissue). However, a subsequent toxicology report found that the cause of his death was actually the consumption of large quantities of dihydrocodeine.

We have not been able to establish know how the man obtained such a quantity of the medication, nor whether he took an overdose on purpose or whether he accidentally overdosed.

The man had frequent and regular contact with healthcare and, in the opinion of our clinical reviewers, he received a standard of care equivalent to that he might have expected in the community. Nevertheless, we have identified some potential learning from the case. First, his medication could have been better managed. Second, I am concerned that his ill health on the night he died was not investigated further by healthcare staff. Finally, there is a broader concern that both his health risks and wider risks were not properly or holistically considered to assess whether he was at risk of suicide or self-harm.

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
Prisons and Probation Ombudsman **July 2013**

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SUMMARY

1. The man was remanded into custody at magistrates' court on 26 July 2010 and went to HMP Durham the same day.

2. When the man arrived a nurse noted at a routine first reception health screen that he had a complex medical history. He had been diagnosed with severe chronic obstructive pulmonary disease (COPD)[1] and was prescribed many medications. He declined to take an anti-depressant medication he had been prescribed in the community and believed he did not need it.

3. The man told the nurse that he had taken a drug overdose in police custody and had been taken to hospital with respiratory problems. He said that at the time he did not want to live. The nurse was concerned that he might try to harm himself again and placed him on suicide and self-harm monitoring. Despite his recent suicide attempt the monitoring ended the next day, after he said he had no current thoughts of harming himself.

4. On 2 August 2010, the man was charged with an offence against Prison Rules for hiding his morphine tablets when they were dispensed instead of swallowing them. At the later disciplinary hearing, he said he was being given the tablets at the wrong interval of every eight hours instead of every twelve so he had tried to manage this himself.

5. Because the man was not satisfied with the restrictions on the time he was able to take morphine medication in prison, on 17 August 2010 his pain relief medication was changed from the morphine tablets he had received in the community to a high dose of dihydrocodeine administered in tablet form. He remained at Durham on remand, during which time his COPD symptoms got worse and he had a period in hospital at the end of December 2011 and the beginning of January 2012. He was not well enough to attend court for sentencing in May 2011 but, on 23 June 2011, he was sentenced to a total of 12 years 9 months imprisonment. He told the doctor at the prison that he was not expecting such a heavy sentence.

6. The man frequently suffered bouts of breathlessness and a sensation that he was going to choke. He complained about having to go up and down stairs on E wing where he lived. When a move was organised to a cell nearer the wing facilities, he said he did not want to move.

7. The man wanted to leave Durham prison and move to HMP Frankland, but sentence planning documentation had to be completed first. He said that he would not eat or drink until he was moved to Frankland or to the Healthcare Centre at Durham. He said that E wing where he was living at the time, was too noisy. An officer tried to encourage him to eat but he would not. On 16 July, he agreed to move to B wing. He moved in the afternoon, but the shared cell he was allocated was unsuitable. When he got there a prisoner with a

[1] COPD is an umbrella term used to describe a number of lung conditions such as chronic bronchitis and emphysema

disability was already occupying, and needed, the lower bunk. He was assigned the top bunk which he said he could not reach, and we agree it was inappropriate for a man with his health problems.

8. The man asked to be moved and waited in the cell in B wing. He barely spoke to the other prisoner, who said he looked unwell and appeared to be having "mini convulsions". Later that evening, he vomited and fell in the cell. He was unsteady on his feet and had difficulty communicating. At almost 11pm he was taken back to E wing helped by officers and a nurse, as a wheelchair could not be found. There is no evidence that medical observations were taken that evening or that any other assessment of his health was made.

9. The night nurse decided to check the man just before going off duty at 6.30am, but he could not see him breathing. An officer unlocked the cell and discovered that he had died. Rigor mortis was present so resuscitation was not attempted.

10. An initial post-mortem examination concluded that the man died of ischaemic heart disease due to coronary artery atheroma. However, subsequent toxicology results showed that he had died of the effects of dihydrocodeine.

11. We make three recommendations about the risk assessment and management of opioid medications, the assessment of prisoners found unwell and the holistic and appropriate assessment of risks in relation to suicide and self-harm.

THE INVESTIGATION PROCESS

12. The Ombudsman's office was informed of the man's death on 17 July 2011. The investigator sent notices to staff and prisoners at Durham announcing the investigation and inviting anyone with any information to contact her. No responses were received.

13. The investigator visited HMP Durham on 28 July and obtained some of the man's prison records, including his medical record, statements from staff about his death and other documentation. The prison was unable to find his security record or any security information reports about him. She met representatives from the Independent Monitoring Board and the POA (prison officer's union).

14. The investigator visited Durham in October 2011 and February 2012, and interviewed a number of staff. She also conducted a telephone interview with a prisoner.

15. The local PCT appointed a clinical reviewer to carry out a clinical review of the healthcare the man received at Durham. He was given the man's clinical record and visited the prison and interviewed healthcare staff. After the amended post-mortem and further enquiries by this office, a further clinical reviewer carried out a supplementary clinical review.

16. HM Coroner for Durham and Darlington was informed of the investigation and he provided the investigator with a copy of the post-mortem report and subsequent toxicology report. A copy of this investigation report has been sent to the Coroner.

17. One of the Ombudsman's family liaison officers contacted the man's partner to explain the investigation process and to give her the opportunity to raise any relevant matters she wished the investigation to consider. Following receiving the amended cause of death, she told us that she had had thought that he had died of natural causes and had been was shocked to learn of the possibility that he could have taken his own life. She had no specific issues for the investigation.

18. The man's partner received a copy of the draft report as part of the consultation period. She said that she had found the report informative but distressing to read. She agreed with a number of the findings and welcomed the recommendations made.

HMP DURHAM

19. HMP Durham serves the courts of North East England and Cumbria. It holds around 1,000 unconvicted and sentenced adult male prisoners including a small number of young adults under 21. There are nine residential wings, including an in-patient healthcare centre.

20. Health services at the prison are commissioned by the NHS and, since April 2011, have been provided by an independent health and social care provider. General Practitioners come from a local surgery and are based in the healthcare centre during weekdays backed up by an out of hours on-call service.

HM Inspectorate of Prisons (HMIP)

21. HMIP carried out an inspection of Durham in October 2011. The report commented that the standard of health care was satisfactory overall and clinical governance arrangements were robust. However, the report highlighted a problem of over-prescribing analgesia (pain relief medication). Inspectors expressed concern about the high use of illicit substances and the lack of integrated work across the prison, including the security department, to reduce the level of misuse.

Independent Monitoring Board (IMB)

22. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community, to help ensure that proper standards of care and decency are maintained. In its annual report for the year to October 2011 the IMB acknowledged that "given the constraints of overcrowding, high prisoner turnover, financial pressure and old buildings, the prison does well to provide a humane and secure environment for those committed to it". The report noted that there were 70 prisoners over the age of 50 serving sentences and IMB were monitoring in particular the opportunities offered to them regarding their health, fitness, work and social support skills.

Assessment, Care in Custody and Teamwork (ACCT)

23. ACCT is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations and interactions are set according to the perceived risk of harm. Part of the ACCT process involves drawing up a caremap to identify the prisoner's most urgent and pressing issues, set goals to help resolve the issues and identify who is responsible. The ACCT plan should not be closed until all of the actions on the caremap have been completed.

Previous deaths at Durham

24. The Ombudsman has investigated the death of 11 prisoners at Durham from 2009 before the death of the man. Two were as a result of drug toxicity. Since then we have carried out a further four investigations, one of which was a result of drug toxicity.

25. In a previous investigation from January 2011, we found some similar issues to those in this investigation. At that time we examined Durham's policy of allowing prisoners to be responsible for keeping their own medication and the role of Security Information Reports in assisting staff to identify prisoners who are misusing medication, particularly dihydrocodeine.

KEY EVENTS

26. The man was born in May 1955. He was arrested in July 2010 and, on 21 July while in police custody, he was taken by ambulance to hospital due to shortness of breath (which was diagnosed as an exacerbation of COPD). While in hospital on 24 July, he took an overdose of prescribed medication.

27. The man appeared at magistrates' court on 26 July. The Person Escort Record (PER) risk indicator form noted that while in hospital a friend of his had given drugs to him. The PER listed his health risks as asthma, lung disease and heart problems, and noted he was on medication. It also reported that he had taken an opiate overdose in hospital while in police custody.

28. The man was remanded into custody and taken to HMP Durham the same day. A nurse carried out his routine health screen assessment (this identifies any immediate mental or physical health problems and whether a referral to a doctor or other specialist service is needed). He told the nurse that he had a history of chronic obstructive pulmonary disease (COPD). He said that he had taken an overdose on 24 July and did not want to live so the nurse opened an ACCT plan.

29. The man told the nurse he did not have thoughts of deliberate self-harm but after observing his low mood and poor eye contact, the nurse wrote in his clinical record that a referral to a doctor was needed that day. He said that he did not want his partner to be informed that he was being monitored as a risk of suicide and self-harm, but would want her to be contacted if he harmed himself. He was housed on E wing, which is the induction wing at Durham.

30. A doctor examined the man on 26 July and noted that he was suffering from COPD but was 'relatively well at present'. He recorded that the man did not have any drug or alcohol misuse problems and had said that he had no intention of harming himself. The doctor also noted that he was in possession of duloxetine (an anti-depressant) but had said that he did not want or need it. He referred him to the mental health team in view of his history of depression. He prescribed carbocisteine (a treatment for patients with respiratory problems to make mucus easier to cough up) and theophylline (which aids breathing by opening the air passages of the lungs).

31. The prison requested the man's medical records from his community doctor. His community records indicated he had been prescribed a number of medications for COPD including two strengths of morphine tablets – a 30mg modified-release tablet to be taken twice a day and two 10mg modified-release tablets to be taken twice a day. A prison doctor did not see him but agreed that the medications he had received in the community should continue to be prescribed.

32. The man spent the night in the first night centre, (E wing) which is a residential unit dedicated to meeting the needs of prisoners new to Durham and providing an induction on how the prison is run.

33. An officer carried out an ACCT assessment interview with the man at 11.20am on 27 July. He noted that the man had attempted suicide several days before. He told the officer that he was concerned about how his partner and children would cope with him returning to prison. He said he was not happy but did not feel low or depressed and had no current thoughts of harming himself or attempting suicide. He did not wish to speak to someone from the mental health team, but wanted pain relief. (Nevertheless an appointment was made for him to see someone from the mental health team on 16 August.) There was a case review meeting at 11.50am the same day attended by the unit manager, an officer and the man. (The notes indicate another attendee but it is not clear who this was.) No caremap actions were identified. The review agreed that he was not at risk of suicide and self–harm and the ACCT plan was closed.

34. The man moved to A wing on 30 July. On 2 August, records show that he was given morphine by a nurse, which he did not appear to swallow and he "acted suspiciously when walking away". The nurse asked an officer to check whether he had hidden the tablets. All three tablets were found in his pocket.

35. The man was placed on a disciplinary report and a hearing was conducted on 3 August by an operational manager. According to her written record of the hearing, he said that the tablets should have been given to him 12 hours apart but the healthcare centre was dispensing them at eight hour intervals which he found too frequent. He told her that his intention was "to start my own regime". He had prepared a written statement for the hearing which said:

> "I have asked on more than one occasion could the times of my meds be changed. I did ask the nurse on the day could they keep the tablets so the times could be changed. I have been getting woken up at 10.30pm to be given my meds and because they are morphine based, I am then awake all night. All they needed to do was keep those tablets and re-issue at 7.30-8.00 problem solved. I have had problems with my meds since I arrived here. At first I was being given them at 7.30 ish then again 3.30 ish. They are supposed to be given 12 hours apart. They wouldn't listen to me then. I think I should speak to my solicitor."

36. The unit manager found the charge proven and gave him a punishment of 10 days cellular confinement suspended for a month and 10 days loss of association (time during which prisoners are unlocked from their cell and able to mix with other prisoners).

37. The same day the man had an ACCT post-closure interview when he said he was no longer suicidal but was still very sad. He said he needed to keep up family contact as it was his family that was keeping him going. He also said he would feel happier if he was moved to F wing with one of his co-defendants as he felt alone on A wing. There was no mention of his attempt to hoard tablets.

38. A prison doctor wrote to the man on 9 August about his pain relief. The letter said that he was concerned that he still required such a high dose of an opiate, and he was upset to learn that he had pocketed his morphine. As a result, he wanted to see him to discuss his pain management.

39. The doctor examined the man on 11 August, when he complained of being short of breath, and admitted him as an inpatient to the healthcare unit for observation. On 16 August, while he was an inpatient, a community mental health nurse assessed him. He was reluctant to talk to her as he said it would not be helpful, but he told her that he had taken a drug overdose when he considered the possibility of a lengthy prison sentence, coupled with his age and health problems. He said that looking back he felt it was not the right thing to do as it would leave a terrible legacy for his children.

40. On 17 August, a doctor reviewed the man's medication and prescribed dihydrocodeine to replace the morphine he had been taking. He was prescribed a number of other medications to treat his COPD including carboscisteine, theophylline, tiotropium, salbutomol and salmeterol. He was also taking omeprazole (to reduce stomach acid) and simvastatin (to lower cholesterol).

41. A further ACCT follow-up interview was conducted on 26 August. The man said he was far happier but still wanted to move to F wing. The officer wrote on the interview summary that F wing had been contacted but it was currently full and he would be considered at a later date. He eventually moved to F wing on 27 September.

42. On 4 October 2010, the man attended Crown Court and was further remanded in custody for a pre-sentence report prepared by a probation officer. The subsequent report, written on 4 November 2010, referred to him having a lung biopsy in April 2009 which showed an "inflammatory mass" but ruled out lung cancer. Since that time, he had constantly complained of pain, been on pain killing medication and attended a pain clinic.

43. In assessing the man's risk of self-harm, the probation officer noted that his records referred to him experiencing suicidal thoughts before and after the arrest for his current offence. The probation officer wrote that he had been admitted to hospital while in police custody and while there he had attempted to overdose using his prescribed medication. The probation officer also noted that he said he had suffered depression in the past and would be likely to have general difficulties with coping, linked to his ill health.

44. After the man's move to F wing, a doctor wrote to the principal officer asking him to bear in mind that the man had a chronic and severe chest condition. He said that the man frequently would not be able to climb stairs or walk long distances and it would be impossible to predict when this could happen.

45. On 16 December, the man experienced a worsening of his COPD symptoms and, on 20 December, he was admitted to hospital, where he stayed until 3 January 2011.

2011

46. When the man returned to the prison on 3 January, he was admitted to the inpatient unit. On 5 January, he told a nurse that he had decided not to take his medication, food or water because he was being bullied by staff. He did not give any further details. On 7 January, he told another nurse, during a mental health assessment, that he was finding it distressing in the inpatient unit because of the noise other patients made. He said he felt so strongly about this that he was refusing food and drink. The nurse noted that he was a "frail, gaunt gentleman unable to get out of bed due to his physical problems" but did not think he had mental health problems. Later that day, he said he would begin to eat again. He was discharged from the inpatient unit on 12 January and went back to live on F wing.

47. An officer told the investigator that as the date neared for the man's trial, he seemed to age rapidly. He had also been observed entering the cells of suspected drug dealers. As the prison was unable to find his security file we do not know whether any action was taken as a result of this information.

48. On 1 April, the man pleaded guilty to a further offence at Crown Court and the court asked for a further pre-sentence report, which was completed on 17 May. It concluded: "The man is anticipating a substantial custodial sentence and expressed his regret about letting his family down and said that he did not expect to survive a custodial sentence due to his health".

49. On 4 April, the man's COPD worsened and his chest was wheezing. A pharmacy technician recorded that he had complained of sore lungs and coughing blood in sputum. A prison doctor examined him and recorded that he was coughing up green phlegm and had a chest infection. The doctor noted that he had to sleep upright with several pillows and was panicking about not getting enough air to breath. He advised him to increase his fluid intake and about using his medication effectively.

50. As the man was experiencing recurring breathing problems and was complaining of not being able to use the stairs, a nurse discussed with a doctor whether it would be better for him to be in a cell which had easier access to the clinic which was on the ground floor. He would have to come downstairs to the clinic which was difficult with his breathing problems. The doctor agreed that he should be as near to the ground floor as possible and asked for a move to a ground floor cell on C or B wing to be arranged.

51. The man was due to be sentenced at Crown Court on 19 May. However, a nurse said when he was about to leave Durham, he said he felt breathless and that he was going to faint. He became pale and was feeling dizzy. She advised that he should not travel and the court was informed that he was

unable to attend. The next month, on 23 June, he was sentenced to a total of 12 years 9 months imprisonment.

52. On 24 June, the man was readmitted to prison inpatient unit with worsening symptoms of COPD. A prison doctor saw him, whereupon he told her that he had not been expecting such a long sentence. He complained about his treatment stating that staff did not "get the point". The doctor recorded that his worsening COPD was probably stress-induced. The clinical record shows an entry made by a nurse prescriber on 24 June:

> "IS BEING PRESCRIBED 540MG DIHYDROCODEINE DAILY. This must be reduced and stopped especially in view of his COPD (respiratory depression) he may have simple analgesics i.e paracetamol to replace if necessary. Reduce by 60mg every 2 days."

53. A pharmacist wrote in the man's clinical record later that day about the proposed reduction in the dihydrocodeine dose, that a doctor had set out the reasons for his decision to change from morphine to an equivalent dose of pain relief on 7 August 2010 (records show this was actually 17 August) and he had been fully informed about this. She said there were no GPs available for her to discuss the nurse prescriber's proposed change in dosage.

54. On 27 June, a doctor wrote in the man's clinical record "Seems appreciably better today. I appreciate colleague's concern about the dosage of DHC [dihydrocodeine] but in the circs at the time it was and remains appropriate". He prescribed 112 tablets of 120mg dihydrocodeine modified-release tablets – two to be taken twice a day and 30mg dihydrocodeine tablets – one to be taken twice a day.

55. On 28 June, a nurse wrote in his clinical record "The man has continually asked to see the GP with regards to his medication, states that he 'should be on more pain killers'".

56. On 5 July, an officer from Durham's observation, classification and allocation unit assessed the man as being suitable for allocation to HMP Frankland because of his length of his sentence, previous convictions, offending behaviour needs and locality. However, sentence planning documentation needed to be completed before any move could be made.

57. On 13 July, the man was moved to E wing. That evening he refused his night medication. On 14 July, a doctor reviewed his medication and, after discussion with a nurse, he prescribed all his medication as "in-possession", it was hoped that this would encourage him to take it. However, the nurse confirmed to us that he was not given his dihydrocodeine to keep in his possession.

58. On the morning of 14 July, a nurse went to the man's cell to try and get him to take his medication. He refused to leave his cell to collect his medication and said he was sick of healthcare and thought he would be better off dead. Later

the same day, another nurse went to see him in his cell. She asked him if he would take his medication if he was allowed to keep it rather than have each tablet dispensed by a nurse. He said he would not and maintained that if he could not be accommodated in healthcare, or transferred to Frankland, he would not eat anything or take his medication. She told him that arrangements were being made for his transfer but the process would take some time.

59. The records show that the man refused his medication and food on the night of 14 July and all day on 15 July.

Events leading up to the incident

60. In her written statement the officer who was on duty on landing 1 of E wing during the day on 16 July said, in her written statement, that she went to the man's cell and asked him why he had not eaten anything since 14 July. He told her he was protesting about being on E wing which he found too noisy and because he had not been sent to Frankland. He said he did not want to die and he would start eating once he had moved off the wing. She said she told him she was concerned for his health. He said he was only prepared to go to the segregation and care unit (SACU), the healthcare centre or Frankland. He said he did not want his family, especially his youngest children, to visit him at Durham and that he was looking forward to seeing them when he eventually moved to Frankland. She told him it was important he stayed strong for them.

61. The officer said she tried to encourage the man to leave his cell by saying he could sit with the staff just outside his cell during the association period. He said he did not feel able to do that and she said she would organise a meal to be brought to him at lunchtime. She told him that he would be able to move into a cell on B2 landing after lunch. He asked her for a glass of water, which he drank. He said this was his first drink in three days. However, he felt sick and could not keep the water down. He left his lunch untouched.

62. At about 2.40pm, the man was taken to B wing, cell B2-01. Our investigator spoke to the prisoner who was already living in the cell. He said the cell was designated for prisoners with disabilities as it had an ensuite shower room and toilet with hand rails. He had a disability and occupied the bottom bunk. The man complained to staff that he would not be able to get onto the top bunk.

63. Later that evening Officer A was distributing medication with a nurse and Officer B. When they reached the man, he again complained that he could not get up to the top bunk. Officer A said that she would look for another cell for him.

64. The cellmate told us that the man sat and faced the wall for most of the afternoon and evening and that he seemed to have "mini-convulsions". During the evening he vomited and fell over so the cellmate rang the cell bell for assistance.

65. A Senior Officer (SO) said that he answered the cell bell of B2-01 at about 10.45pm when the cellmate told him that the man had fallen over. The SO saw him lying on his property bags, face up. He radioed for a nurse and, when he arrived with officers, they went into the cell. The SO noticed some vomit on the floor next to the bin and asked him if he was all right. He said that he did not reply, although he seemed to be attempting to do so. As he could not use the top bunk it was decided to move him back to E wing. The staff requested a wheelchair to help them move him but they were told there was not one available. As he was unsteady on his feet, they physically helped him back to E wing at about 10.55pm. Although he had apparently collapsed and been sick, there was no record that any medical observations were taken or any other medical assessment.

66. The SO said he checked the man at about 1.00am when he was back in his original cell on E wing. In his statement written following the man's death he said that he was awake and the television was on. He said he went back at 3.00am when he said his television was off and he saw him move.

67. The nurse was due to go off duty at 6.30am. At about 6.25am just before going off duty, he decided to check on him as he had been not taken his night medication all week. He looked through the door observation panel but could not see any signs of movement. He asked his colleague to look, but she could not see any movement either. He called the SO, who arrived moments later. They went into the cell. He did not appear to be breathing and it was evident that he had died. He was cold to the touch and rigor mortis had set in so resuscitation was not attempted. Paramedics were called and at 7.00am confirmed that he had died.

68. An unfinished handwritten letter dated 13 July to a named person called was found in the man's cell in which he set out his dissatisfaction with E wing and the healthcare he had received. The letter ends "…I know I am going to have to take drastic measures to make my voice heard. As from Thursday 14 July once again I am going to protest with a No Food No Fuilds" (sic). On a piece of paper dated 16 July, there are various written statements which end "This is not a suicide mission, it is a protest. You don't listen when I talk".

Informing the man's family

69. A prison family liaison officer was appointed the same day and, at 1.15pm, went to the man's partner's home to inform her he had died. The officer explained the family liaison their role and offered support. In line with national policy, the prison offered a financial contribution towards funeral costs.

Debrief

70. Prisons are expected to hold a debriefing session with staff involved after the death of a prisoner. This is to ensure that staff have an opportunity to discuss any issues arising, and for support to be made available to them. A debrief for all the staff involved was held at 8.00am.

Informing prisoners

71. Prisoners on E and B wings were informed of the man's death later that morning and offered support if required. All prisoners on ACCT were reviewed.

Post-mortem report

72. A post-mortem examination was conducted by a Home Office pathologist on 18 July. He noted that the cause of death was ischaemic heart disease due to coronary artery atheroma. A contributing condition was severe pulmonary emphysema

73. A subsequent toxicology report dated 8 September 2011 showed that the man's body tested positive for opiates. Analysis of post-mortem blood and urine specimens showed dihydrocodeine. The report states:

> "The concentration of dihydrocodeine measured in the post-mortem femoral blood is extremely high and would be consistent with a large overdose of this opioid analgesic drug prior to death. Furthermore, the presence of an apparent large amount of unabsorbed drug present in the stomach contents indicates recent ingestion and that the concentration of dihydrocodeine had yet to reach its maximum in the blood."

74. After the toxicology results were received the man's cause of death was amended on 3 October 2011 to "the effects of dihydrocodeine".

ISSUES

Clinical care

75. A review of the man's medical care was commissioned by the local PCT and carried out by a clinical reviewer. A second clinical reviewer, a consultant in General Medicine and Respiratory Medicine, provided clinical medical oversight. A supplementary review was carried out by the second clinical reviewer at the request of this office in relation to the high levels of dihydrocodeine in the man's body identified by the toxicology report, and the symptoms displayed by him on his last night.

76. The first clinical reviewer noted that the man had frequent and regular contact with prison healthcare services. He said in his opinion that the standard of his primary healthcare was equivalent to what he could have expected had he been living in the community. The second clinical reviewer was generally satisfied with how his COPD was managed by healthcare staff at the prison. The clinical review makes a number of recommendations about medicine management and record keeping which the Head of Healthcare will wish to note but we accept that the passage of time since his death may mean that many have already been acted upon.

<u>Prescription of dihydrocodeine</u>

77. The toxicology report states that the concentration of dihydrocodeine in the man's blood (14.9 mg/L) was extremely high and would be consistent with a large overdose of the drug before death. It is apparent therefore that he must have had access to a significant quantity of dihydrocodeine tablets. He was prescribed high doses of dihydrocodeine medication, equivalent to the dose of morphine he was taking before his arrest. Although the records indicate that he was allowed to keep some of his medication in his possession, this did not apply to the dihydrocodeine, which he had to receive in an individual dose from a nurse. The dispensing records indicate that sometimes he refused his medication, particularly in the three days leading up to his death. His last recorded dose was two 120mg tablets administered at night by a nurse on 12 July. However, we know that he had previously secreted his tablets and we cannot discount the possibility that he had built up his own store from the tablets he was prescribed. Nor can we rule out the possibility that he could have obtained further supplies of dihyrodcodeine from other prisoners.

78. At interview, a doctor was asked to clarify his prescription of dihydrocodeine for the man. He said that he knew him well and they would have frank exchanges with him about his treatment at Durham. The doctor said the prison tried to accommodate his needs but he always demanded more than was realistic and so continued to be dissatisfied. He said the man had been taking morphine in the community for chest pain and the equivalent was 540mg a day of dihydrocodeine. He said the British National Formulary (a clinician's reference guide to prescribing) gives the normal maximum daily dose of dihydrodcodeine as 240mg per day, but he was satisfied that

because the man had been taking morphine previously, the high dose he had prescribed was appropriate for him.

79. There was an apparent professional disagreement between two doctors about the appropriateness of the prescribed levels of dihydrocodeine for the man. On 24 June, in contrast to the first doctor's opinion, a second doctor indicated that because of the man's COPD and the risk of respiratory depression, his prescription of dihydrocodeine should be reduced and then stopped.

80. The second clinical reviewer did not see this disagreement as clinically wrong on either part, and commented: "The first doctor was aware of the potential clinical risk but it was a managed clinical risk in favour of the therapeutic benefit of the prescription". Nevertheless, he said that best practice would have been for an alternative treatment plan where the dose of opioid-based medication was reduced due to the man's COPD and because of his previous overdose.

The Head of Healthcare should ensure that there is effective risk assessment and risk management when opioid-based medications are prescribed, with a view to reducing dosage when appropriate.

<u>The man's last night</u>

81. The prisoner, who already occupied the B wing cell when the man was brought there on the afternoon of 16 July, told the investigator that when he arrived he looked frail and was upset that he was not able to have the lower bunk. The prisoner said that he had what he described as "mini convulsions" where he would throw his arm out and it would jerk. He sat and faced the wall and did not speak to him for most of the afternoon. At about 5.00pm, the prisoner said he started vomiting into the waste bin as he could not make it to the toilet in time. The prisoner said that later in the evening, he had a convulsion, vomited and crawled on the floor against the end of the bunk, at which point the prisoner pressed the cell bell for assistance.

82. We asked the second clinical reviewer if the symptoms described by the prisoner on the 16 July could have been related to an overdose of dihydrocodeine. He states:

> "…it is likely that he had side effects of dihydrocodeine at the time of sharing the cell with the prisoner. He had symptoms of vomiting and on description looks like he was also restless and agitated. The prisoner also felt that he was 'out of it' and 'unable to get up'. These all are possible side effects of dihydrocodeine. It is difficult to comment with confidence whether at this particular time he would have toxic blood levels of dihydrocodeine."

83. The clinical reviewer also says that the main symptoms of toxic dihydrocodeine levels would have been drowsiness and the patient being "unable to sit or stand up". The man needed assistance when he was taken back to E wing. In his statement, Officer B said that a wheelchair had been

requested and was not available and that he had needed his and the SO's help to move to E wing as he was quite unsteady on his feet.

84. We also asked the clinical reviewer if, despite the man refusing his medication for several days before his death, there could have been a cumulative effect of the previous high dose of dihydrocodeine which caused the symptoms. He said:

> "Dihydrocodeine is well absorbed after oral administration. Peak plasma levels occur 1.6 - 1.8 hours after ingestion. After oral administration the bioavailability of the drug is approximately 20%, indicating that the pre-systemic metabolism plays a substantial role in reducing the bioavailability of dihydrocodeine. Dihydrocodeine is excreted in the urine as unchanged drug and metabolites. The mean elimination half life ranges between 3.5 – 5 hours".

85. Our understanding of this statement is that dihydrocodeine does not have a cumulative effect, so the dihydrocodeine found in the man's body after his death would most likely have been taken in the 24 hours before. In addition, the toxicologist found what was described as a "large amount of unabsorbed drug" in his stomach contents which would suggest he had taken this a relatively short time before his death and the concentration of dihydrocodeine in the blood had yet to reach its maximum level.

86. In view of the clinical reviewer's comments, we believe it is highly likely that the man was suffering the effects of an overdose of dihydrocodeine when he was in the cell with the prisoner on B wing. As noted earlier, we do not know where this dihydrocodeine came from and the records indicated that he had refused his prescribed dose for three days before his death. Nor can we know whether he was self-medicating and accidentally overdosed or whether he took a deliberate overdose.

87. We are concerned that, despite there being a nurse present, no one appears to have acted on the man's symptoms of vomiting, his inability to speak properly and unsteadiness. Although he was generally very unwell with COPD and his poor state of health might have masked other indicators, we believe the symptoms he had on the night of 16 July needed further investigation, yet no observations were taken or any further assessment made.

The Governor and Head of Healthcare should ensure that an appropriate healthcare assessment is made when a prisoner is found ill in a cell and that staff are aware of the symptoms of drug intoxication and know how to respond.

Emergency response

88. The nurse decided to check on the man before going off duty at 6.30am. He and a colleague could not see any movement and called the SO to attend. The SO said he received the call at 6.25am and he arrived within a few

minutes. It was clear that the man had been dead for some time and resuscitation was not attempted. Paramedics were called and confirmed death at 7.00am. We are satisfied that the staff acted professionally and appropriately when they found him.

Self-harm and suicide risk assessment

89. When the man arrived at Durham on 26 July he was immediately placed on an ACCT plan because of his recent attempt at suicide and how he presented. After an ACCT assessment the next day, no caremap actions were identified and the suicide and self-harm monitoring plan was closed immediately. As he had attempted suicide just days before, we consider that closing the ACCT document the day after he arrived was premature.

90. Just five days later, on 2 August, the man was found to have secreted his medication instead of taking it. No one appears to have taken into account his recent suicide attempt (an overdose on 24 July) or the fact that he had recently been on an ACCT and reviewed his risk. The next day he attended a disciplinary hearing, but again no one seems to have linked his behaviour to a risk of self-harm. That same day he had an ACCT post-closure review, which also took no account of the secreted tablets and whether this had raised his risk of self-harm.

91. We believe that the man had a number of risk indicators which, taken together, suggested a heightened risk of self-harm. He took an overdose in hospital while in police custody, he received a lengthy sentence, and was in poor health. (The clinical reviewer notes there is evidence of a link between lung disease and depressive illness.) He had been prescribed an anti-depressant in the community, which he chose not to take in prison. He was unhappy at being in Durham and was refusing food and medication. He had also been observed in the cells of suspected drug dealers.

92. No one seems to have taken a clear overview of the man's health and other risk factors. The clinical reviewer believes that the prison's mental health team needs to work more closely with the primary care team to properly understand the impact of chronic disease and co-morbidities and the risks of depression and self-harm. We accept that it is not clear that he was at risk of suicide at the time of his death, and it is possible that if had been monitored longer at an earlier stage an ACCT would not have been open at the time of his death. Nevertheless, the lack of awareness of risk by both healthcare and prison staff meant that his risk of self-harm and suicide was not assessed appropriately.

The Governor and Head of Healthcare should ensure that staff take into account all risk factors, in relation to both mental and physical health and wider risk factors and liaise appropriately, to ensure a robust assessment of the risks of suicide and self-harm.

RECOMMENDATIONS (service response below)

1. The Head of Healthcare should ensure that there is effective risk assessment and risk management when opioid-based medications are prescribed, with a view to reducing dosage when appropriate.

   The National Offender Management Service (NOMS) accepted this recommendation with the following comments:

   "The Medical Director of North East prisons has implemented his Safer Prescribing Initiative, which has resulted in much tighter controls around risk and a significant reduction of opioid based medications and 'medications of abuse' in general.

   Links are now being made with community GPs to move forward on a project to ensure consistent prescribing across the prison- community interface."

2. The Governor and Head of Healthcare should ensure that an appropriate healthcare assessment is made when a prisoner is found ill in a cell and that staff are aware of the symptoms of drug intoxication and know how to respond.

   NOMS accepted this recommendation with the following comments:

   "Regular audit of record keeping is undertaken.

   Healthcare staff to be reminded of the importance of accurate and timely record keeping and care planning.

   An emergency 1st response nurse is available and present within the prison 24 hours per day. This nurse is a qualified healthcare professional registered with the NMC.

   Information around drug induced unconsciousness has been cascaded throughout the nursing team by the private health provider clinical lead for Drug & Alcohol Recovery (DART) at Durham; signage has also been placed in wing clinics. The DART clinical lead at Durham has also provided substance misuse training sessions across all 7 north east prisons.

   Narcan is readily available via Patient group direction (PGD) for use by nursing staff in cases of opiate overdose.

   All nursing staff undertake annual cardio pulmonary resuscitation training (CPR) and automatic electronic defibrillator training on an annual basis

   Prison wide awareness raising of the symptoms of drug intoxication and how to respond will be conducted by the Safer Custody manager."

3. The Governor and Head of Healthcare should ensure that staff take into account all risk factors, in relation to both mental and physical health and

wider risk factors and liaise appropriately, to ensure a robust assessment of the risks of suicide and self-harm.

NOMS accepted this recommendation with the following comments:

> "Healthcare staff will continue to work in partnership with HMPS and Tees Esk & Wear Valley F.T. mental health team HMP Durham to ensure robust delivery of the HMPS ACCT process.
>
> Primary care nursing staff provide health screening via IT clinical System 1 template, based on The Grubin Screening tool at first reception into prison.
>
> Communication channels with external agencies are also maintained e.g. self harm warning forms generated by staff; FAX from mental health workers at court and probation staff".