PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Durham in September 2011

Our Vision

‘To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision’

This is the report of an investigation into the circumstances of the death of a man in September 2011 at HMP Durham. He was 39 years old. I extend my condolences to his family and friends.

A clinical reviewer was appointed to conduct a review of the man's healthcare in prison. The prison cooperated fully with the investigation. I apologise for the delay in issuing this report.

The man had been at Durham for only two weeks when he died. On reception, he received treatment for drug and alcohol dependency. Over the following two weeks, he withdrew from alcohol and was treated for his drug dependency. He was prescribed methadone and chlordiazepoxide. He appeared to be progressing but became unconscious during a morning in September and died at midday. The post-mortem report indicated that he died from the toxic effects of methadone, in combination with chlordiazepoxide.

When his cell mate and another prisoner first raised concerns about the man that morning, their anxieties appear to have been dismissed. I consider the governor needs to examine carefully the response of those involved. However, once it was clear that he was unconscious prison staff made every effort to save him. Although it would not have affected the outcome for him, there was a delay in admitting an ambulance to the prison and lines of communication during the emergency response were confused. These arrangements need to improve to help prevent failings in future emergencies.

The man died on a specialist drug treatment wing and is one of a number of deaths apparently due to methadone toxicity which this office has noted. Last year I drew this issue to the attention of the Chief Executive of the National Offender Management Service. I am pleased that he took the matter seriously and commissioned work to identify the extent of the problem. In my view, the introduction of the Integrated Drug Treatment System in prisons has increased safety for those dependent on opiates and ensured that provision for this vulnerable group is now more equivalent to that in the community. However, there has also been a rapid increase in the prescribing of methadone in prison and there is a need for further appraisal of the associated risks, and to ensure that all staff who work with drug users are aware of, and able to spot, the common symptoms of drug intoxication and drug-induced unconsciousness.

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 **November 2013**

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SUMMARY

1. The man, a prisoner at HMP Durham, died from the effects of methadone and chlordiazepoxide medication in September 2011. Medical staff had assessed him on his arrival at Durham, two weeks earlier on 26 August. A doctor prescribed chlordiazepoxide, a medication for his alcohol dependency and a maintenance dose of methadone for his heroin addiction. She also prescribed medication for depression and neurological pain and referred him to drug treatment specialists in the prison.

2. A few days later, a specialist drug addiction doctor reviewed and adjusted the medication. She explained to the man the risks of combining drugs and emphasised the increased risks of taking drugs in addition to those prescribed. Staff monitored him as he went through the expected withdrawal symptoms but had no concerns. After his death, his friends reported that he had taken illicit drugs and abused those prescribed. They believed he was under the influence of them on the day before his death but this was neither noticed by, nor brought to the attention of prison or medical staff.

3. The man was given medication in the late evening of 7 September. A night patrol officer spoke to him at around 5.00am and he went back to bed. He appears to have become unconscious between then and 9.35am. During the next hour and a half, some prison staff saw him but thought he was asleep. His cell mate tried to rouse him so that he could collect his medication. He then reported his concerns to a prison officer and a nurse, who took no action. Another prisoner also said that he drew the officer's attention to the situation but was ignored. Just after 11.00am, his cell mate noted he stopped breathing and raised the alarm.

4. Prison staff responded quickly to the emergency but communication between them was confused. Resuscitation attempts were undertaken initially by prison nursing staff and then an ambulance crew but this was unsuccessful and he was certified dead at 12.10pm.

5. After the man's death, a debrief was held and his family was notified. A post-mortem took place the following day and toxicology tests were conducted. The subsequent reports concluded that he died from the toxic effects of a combination of the prescribed drugs methadone and chlordiazepoxide.

6. The funeral took place on 20 September and HMP Durham met the cost. Prison staff attended the funeral and residents of D wing donated money for a wreath.

7. We make four recommendations as a result of this investigation. These relate to the apparent failure of a prison officer to exercise his duty of care, delays in emergency vehicles gaining entry to Durham, establishing lines of communication during medical emergencies and raising officers' awareness of symptoms of drug-induced unconsciousness.

THE INVESTIGATION PROCESS

12. The investigator first visited HMP Durham on 10 October 2011. He was given a full briefing about the circumstances surrounding the man's death by the duty governor and the Safer Custody Liaison Officer. He visited relevant parts of the prison, including D wing where the man had lived. He also met a representative of the Prison Officers' Association. No one from the Independent Monitoring Board was available.

13. Notices were issued to staff and prisoners, inviting anyone who might have information relating to the man to make themselves known to the investigator. One prisoner responded immediately and two others were interviewed later in the investigation. The investigator also interviewed relevant members of prison and healthcare staff.

14. One of the Ombudsman's family liaison team contacted the man's mother to tell her about this investigation and to offer the opportunity to ask any questions or raise any concerns that she wished to be considered. No specific issues were raised.

15. HMP Durham provided copies of the man's prison and medical records. A clinical reviewer was commissioned to provide a clinical review on behalf of the local PCT. The final version of the clinical review report was delivered on 12 February 2012. The delay in issuing this report was initially partly due to the delay in receipt of the clinical review but subsequently by workload pressures in this office.

16. The investigator was aware of a police investigation into the man's death at the outset and was in contact throughout with a Senior Investigating Officer of Durham Police. The police had no objections to the Ombudsman's investigation taking place at the same time.

17. The man's family received a copy of the draft report. They raised a number of issues/questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP DURHAM

18. HMP Durham is a local prison serving the courts of Tyneside, Durham and Cumbria which holds up to 1017 in seven accommodation wings. E wing is the first night centre and induction unit and D wing accommodates prisoners on the Integrated Drug Treatment System (IDTS). The IDTS aims to deliver an evidence-based, individual focused, treatment system for substance users.

19. Healthcare at HMP Durham is provided by a private company on behalf of the NHS. Medical services are delivered by a full-time medical director and a general practitioner (GP), both based at the prison. A local GP practice provides on-site support from 5.00pm to 8.00pm daily and remotely until 10.00pm, when the NHS out of hours service takes over until the following morning. There is also a pharmacy service.

20. In the event of a medical emergency in the prison, a radio code system is used to summon help. Code Black is used when a prisoner is unconscious or there is no response.

21. Due to the high number of prisoners prescribed methadone at Durham, medical staff use Methasoft, an electronic drug administration and recording system, to administer the medication.

HM Inspectorate of Prisons

24. HM Inspectorate of Prisons carried out an announced inspection of Durham in October 2011. The Inspectorate reported that the most troubling problem facing the prison was the availability of drugs and commented:

> "The demand for substance use treatment was very high. Methadone was the only opiate substitute treatment, and test results pointed towards Subutex as the main drug used illicitly. Treatment for most prisoners did not start on their first night and methadone doses were raised to the prescribed amount too slowly, even when community prescriptions had been confirmed. Many prisoners received their methadone late, disrupting participation in the regime. Since the change in provider, many substance misuse nurses had left, resulting in a lack of experienced clinicians. There was no dual diagnosis service for prisoners with mental health and drug or alcohol problems. Drug availability was still too high. One in five prisoners tested positive following mandatory drug tests. Positive suspicion tests had improved, but in the previous three months about half of all requests for suspicion testing had not been met. The supply reduction strategy was out of date. Overall, there had been a degree of complacency and lack of rigour in attempts to tackle drug use."

Independent Monitoring Board

25. Every prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who monitor standards to help ensure prisoners are

treated fairly and decently. In the last published IMB report for the period November 2010 to October 2011 the Board noted that the objective of the provision of prisoner health and mental health services was to achieve equivalence with community services and that this was a demanding challenge because of the higher than average levels of mental health ill-health and drug and alcohol abuse. The Board reported that substance use, drugs and alcohol misuse, psychology, drug testing, detoxification and CARATs seemed to be working satisfactorily.

Previous Deaths at Durham

26. There were seven deaths at HMP Durham in the year before the man's death, including another on the day he died. Of those on which we have already reported, two were linked to drug misuse.

KEY EVENTS

27. The man was released from HMP Wealstun on 21 April 2011, on licence, following a four year sentence. On 25 August 2011, he was arrested for robbery, theft and assault and remanded into custody at Durham the following day. A few days later, on 30 August, his licence was formally revoked.

28. The man had a long history of heroin and crack cocaine use but said he had not used them some time. He was also a very heavy user of alcohol and smoked. He was on a methadone programme at the time of his return to custody. On arrival at Durham the reception nurse referred him to the IDTS specialists for drug and alcohol misuse. He was also referred to a community psychiatric nurse (CPN) for mental health problems and later scheduled for assessment on 9 September. He did not appear to be at risk of self-harm and was assessed as suitable to share a cell and to retain his medication in his cell. He signed the Durham Medication Compact and took part in a substance misuse assessment.

29. Later on 26 August, the man provided a urine sample which tested positive for methadone and benzodiazepine. A GP saw him that evening and noted that within the past day he had taken a prescribed dose of methadone (110ml) and had been given diazepam while in police custody. Also, that there appeared to be no additional drug use (this was consistent with his assertion that he had not taken heroin or crack cocaine for many months) and he was stable on that methadone dose. The doctor also noted that he was a heavy drinker and was feeling unwell as he had not had alcohol for the previous two days. There were, however, no immediate concerns about his withdrawal.

30. The doctor prescribed 10ml of methadone as the start of a stabilisation regime which increased daily (known as titration) until 6 September. He would then take 110ml daily thereafter. He was also prescribed a nightly tablet of mirtazapine for depression and gabapentin, three times daily, for continuing pain from a previous accident and thiamine, a vitamin. At 6.50pm, in addition to the methadone, he was given chlordiazepoxide for alcohol withdrawal, a ten day course reducing until 6 September.

31. As part of the IDTS, following the start of methadone, patients are clinically monitored and reviewed after five days. Staff monitored the man twice daily for symptoms such as sweating, cramps, diarrhoea, sleep problems and thoughts of self-harm. He was located on E wing in first night accommodation.

32. On Tuesday 30 August, the man saw a doctor in the IDTS clinic. By then, his methadone prescription had risen to 40ml daily and his chlordiazepoxide had reduced to 80 mg. The doctor reviewed the medication prescribed to him on 26 August and concluded that he should continue taking the chlordiazepoxide until the end of the course. He signed a ‘Treatment Contract between Patient and Healthcare for the supervision of Methadone and/or Diazepam/Chlordiazepoxide’, setting out the conditions under which these drugs would be administered.

33. In a statement dated 29 December 2011, the doctor said that the man expected her to prescribe a daily dose of 110ml of methadone immediately because his prescription outside prison had been confirmed. She explained to him that although he was showing signs of opiate withdrawal he was not in a desperate state and that he was on a high dose of chlordiazepoxide, which in combination with methadone, would be dangerous. He agreed to the doctor's suggestion to increase his methadone by 10ml daily until 6 September, by which time the chlordiazepoxide would have reduced. Afterwards, the methadone would be maintained at 110ml daily. The doctor issued the methadone prescription as well as repeat prescriptions for mirtazapine and gabapentin. He was further warned by the doctor that to use drugs in addition to the prescription was extremely dangerous. The doctor said that he appeared to understand and agreed to her plan.

34. Over the following days, healthcare staff continued to monitor the man twice daily and entered the results on a withdrawal record. On 2 September, an entry made by a nurse and a Counselling, Assessment, Referral, Advice, and Throughcare Services (CARATS) worker, recorded his five day IDTS review. (CARATS provide specialist support for substance users in prisons). On examination, he was alert and appeared to have some mild withdrawal symptoms but said he was feeling a lot better and that his sleep had improved. They also noted that he was not using drugs in addition to those prescribed and had no thoughts of suicide or self-harm. The treatment contract was revisited and he said he fully understood it. There are no further daily monitoring entries on his withdrawal record.

35. One of the CARATs team saw the man in his cell on E wing on 5 September as he was preparing to move to D wing. She was aware that he was on a high dose of methadone. He had now almost reached the prescribed maximum of 110ml daily and wanted to begin a reduction from that level. The conversation was normal, generally positive, light and good humoured and he was looking forward to the future. They spoke about his wish to stop taking methadone, 'get clean' and take appropriate courses and they planned to start that process at their next session. By the time of his death three days later she had not yet taken action on this because she wanted to involve another staff member specialising in alcohol dependency, which he also felt would be good for him. She completed an initial CARATS Care Plan.

36. On 5 September, the man moved to cell D2-34 on D wing which he shared with Prisoner A, who was already living there. The prisoner told the interviewer that because the man appeared sleepy all the time, he had asked him how much methadone he was taking and was told 110ml daily in the morning. He said that after the man took his methadone he would become very drowsy and sleep in the cell for most of the day. He would be alert again by the following morning and ready for his medication and the cycle would start again. During the afternoon of 5 September, he received his final 10mg dose of chlordiazepoxide for his alcohol withdrawal symptoms.

37. On 6 September, the CARATS worker went to see the man on D wing but he was attending a learning skills session and not available. She completed her

notes and included a reminder to call on him again on 8 September to complete a further assessment.

38. Prisoner B lived in cell D2-36 with his brother. Both had known the man since childhood. On 7 September, he and the man were in the queue at D wing dispensary waiting to collect their gabapentin prescriptions. He said he heard someone asking the man to sell him some gabapentin tablets. He refused, saying that he was keeping them for himself. He then returned to his cell and heard no more of the conversation.

39. Later that afternoon, Prisoner C, Prisoner B's brother, returned to their cell after work. He told his brother that on the way up he had looked through the spy hole in cell 34 and had seen the man, who he described as looking "wasted". About an hour later, at tea time, Prisoner B walked back to their cells with the man, who he said was swaying about and appeared "out of it". He asked him what was wrong and he replied that he had taken seven gabapentin tablets. He told the investigator that he was aware that he had bought five gabapentin tablets earlier in the week from someone on E wing. He did not know the identity of the person.

40. At around 10.00pm on the evening of 7 September, night medications began to be dispensed on D wing. The man was given his mirtazapine prescription around 10.30pm. Nothing in his demeanour at that time caused any concern.

41. At about 4.30am in the morning the man fell out of the top bunk. The noise of the fall woke his cellmate and, because he was unable to get up from the floor, he got out of bed to help him. He asked that his cellmate help him to the lavatory, which he did and went back to bed. He estimates that the man was sitting on the lavatory for about thirty minutes and vaguely remembers him having a conversation with the night patrol officer.

42. Officer A went round the cells on D wing counting the prisoners for a roll check at about 5.00am. When she reached D2-34, the man was sitting on the lavatory and he told her that he was stuck. She said she would get help and that it would take a few minutes. As the situation was not urgent, she completed the count and then telephoned the night orderly officer who said he would send the night duty nurse. A few minutes later, a nurse arrived on the wing and they went to the cell, where they found he had returned to his bed, was asleep and snoring loudly. He appeared to be all right so they left without speaking to him.

43. Officer A reported the events to the night orderly officer, but did not document it, regarding the matter as minor because the cell was not opened and no action was taken. Between 6.15am and 6.45am, she was relieved by the oncoming day staff member, Officer B. She gave a handover report to him but did not mention the incident with the man.

44. Officer B then carried out a roll check on D wing to confirm the number of prisoners. He told the interviewer that if there was sufficient daylight from the cell window he did not always need to switch on the cell light to check prisoners

were there. He did not remember putting the light on in cell D2-34 that morning and nothing drew his attention to the occupants.

45. Prisoners are given methadone at the wing dispensary in the connecting corridor between D and E wings. Normally about 170 men receive methadone daily on D wing. The treatment routine is that at about 8.15am, employed prisoners are released from their cells and issued their methadone at the dispensary before they go to work. Prisoners who remain on the wing are released from their cells at about 9.00am, to collect their methadone.

46. Officer C was on duty on D2 landing that day. He first unlocked the men requiring medication before work and then, straight afterwards, unlocked prisoners who were going to work but did not require medication. Neither the man nor his cellmate was unlocked at that stage. Just before 9.00am, the officer began cell fabric checks on D2 landing. (Fabric checks are daily physical inspections of the door locks, walls and window bars of each cell for safety and security reasons.) When he went into the man's cell he was on the top bunk. His upper body was naked and he was snoring very loudly. He remained asleep throughout. The officer made a comment to the cellmate about the snoring, who said this was normal and that he did it all night.

47. A Probation Service Officer was on D2 landing at around 9.35am and went to serve licence recall papers on the man. He was still asleep on the top bunk and the cellmate made an unsuccessful attempt to wake him by tapping his feet. He said he would call back later.

48. Officer C came back to D2 and began unlocking prisoners who required methadone but were not employed. Thursday is laundry exchange day on D wing and so he combined the two tasks. The cellmate got up to exchange his and the man's laundry. The officer opened the cell door without entering and moved on to the next cell. The cellmate then left the cell to collect his medication. He said nothing directly to the officer and does not remember any other officer being present on the landing at that time.

49. At about 10.00am, the Probation Service Officer was still on the wing and saw Officer C at the door of the man's cell collecting laundry. He thought the man might now be awake so he went back to the cell and opened the door but was told by the cellmate that he was still asleep. He said he would call back during the afternoon. There are several differing accounts of what happened next.

Prisoner C

50. Prisoner C, a long time friend of the man's, told the investigator that he was unlocked from his cell D2-36 to go to the dispensary for his methadone prescription at about 9.00am. As he left his cell, he met Prisoner A, the cellmate, outside cell D2-34. He said the prisoner looked white and he appeared shocked. He told him there was something wrong with the man; that he was unable to wake him but thought that he was breathing. He remained outside the cell while Prisoner C went in. He saw him lying on the top bunk. He described him as naked and freezing cold with his eyes shut. He tried to

rouse him but got no response. His impression was that he had died. For dignity, he covered his lower body with a towel and left the cell, telling the other prisoner that he was not moving and that there was something wrong.

51. According to Prisoner C's account, as Officer B went towards cell 34 from the direction of cell 36 he told him that the man was not moving and that there was something wrong with him. He said the officer did not say anything to him but shrugged his shoulders and pursed his lips. He said that the officer's body language gave the impression that he was saying "I've already sorted it" but he did not speak. The officer did not go into cell 34, although he did glance in, and then leant on the railings outside the cell. He said that the cellmate commented at the time that he had already told prison staff but they were not bothered. He said he then went to the dispensary where he spoke to the nurse about something being wrong with the man. He cannot remember her response.

Prisoner A/Cellmate

52. Prisoner A's recollection is that at around 10.15am Officer B unlocked his cell so that he could go to collect his methadone. He said he told the officer that he could not wake the man and the officer asked if he was breathing. He responded that he was and the officer said that he was all right. The prisoner then went to the dispensary.

53. On the prisoner's return, his cell door was still open and the man was still on his bed snoring. He told Prisoner C that he was unable to wake him. Prisoner C responded by telling him that he would throw water on him if he did not get up; there was no response. He said that he and the other prisoner then told Officer B that they still could not wake him and that he did not look right. He demonstrated to the officer how he had tried to wake him by shaking his mattress vigorously, which again did not wake him. The officer responded that he was breathing and therefore all right and locked the door with the two prisoners inside.

Nurse A

54. Nurse A confirmed that at around 10.30am, at the D wing dispensary, Prisoner A told her that his cell mate had not woken up yet. She was unsure whether this meant his cell mate was not coming for his medication or that he was unwell. She asked what he meant and he repeated that his cell mate had not woken up yet. As he did not seem particularly anxious she advised him that if he was concerned he should get his landing officer to see his cell mate. He told her that he had already spoken to the landing officer on the way down from the landing. She repeated her advice and, as she heard nothing further, assumed all was well.

Officer B

55. Officer B recalls that at around 10.00am, he was standing a few yards away from cell 34 talking to a prisoner. Officer C unlocked the cell and Prisoner A

came out and told him that the man had not got out of bed to collect his methadone. He said that one of the two brothers from cell 36 (he did not know which one) was also there but said nothing directly to him. While Prisoner A went for his methadone, he went just inside the cell and heard the man snoring. He thought he was all right. During the next ten minutes or so, he passed cell 34 several times, glanced in and still heard him snoring. A short time later, Prisoner A returned from the dispensary. He said he enquired about his cell mate's methadone and the officer replied that he should let him sleep. When he closed the cell door behind him, he heard the man still snoring.

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56. Officer B said during interview that the man's condition had not changed from the first time he had seen him that morning. He had no suspicion that anything was wrong with him and so took no action.

Emergency response

57. After returning to his cell, Prisoner A made a cup of coffee and drank it while sitting on the lower bunk. During that period, the man stopped snoring which he said was not unusual. When he stood up after finishing his drink, he looked at him and saw that he was very pale and, because he was naked, saw that the veins on his chest and stomach were a pronounced purple colour. He realised that something was seriously wrong, pressed the cell call bell for attention and, a few minutes later, Officer D came to the cell door. He told him that he did not think the man was breathing. The officer told him to come out of the cell and the officer went in. Although he did not touch him, he shouted to him to try and wake him.

58. Officer D realised the situation was serious and that he needed to act quickly. He made a radio call to the prison Communications Officer using the "Code Black" message designation for summoning medical help and requested the attendance of "Hotel 1", the duty healthcare staff member responsible for responding to medical emergencies. His message was logged in the control room at 11.08am and the note indicates that an ambulance was en route.

59. At the same time as broadcasting the radio message, Officer D went to the cell door and called Officer B, who was at the far end of the landing and came immediately to the cell. Officer D remained outside with Prisoner A while Officer B went in. He saw that the man was not breathing, making any noise or movement and his eyes were closed. He shook his foot and, unsuccessfully, tried to find a pulse in his left wrist; he was warm to the touch. As he went to leave the cell, nursing and prison staff, who had responded to Officer D's initial emergency message, were at the door. Officer B returned to the rear of the cell.

60. Nurse B was the first nurse to attend. Her entry in the man's medical record notes that she arrived at 11.10am. As she went in, she used her radio to ask the communications officer to call for an emergency ambulance. She noted that the skin on his torso was discoloured but warm to the touch and that he had stopped breathing and was in a serious condition. She went to the bed and tried to locate a pulse.

61. Nurse A was immediately behind Nurse B. She had brought the emergency medical bag from D wing dispensary. It was obvious to both nurses that cardiopulmonary resuscitation (CPR) had to be started immediately. At the nurses' request officers lifted him on his mattress from the upper bunk placing it on the floor beside the beds. Officer B, who was still at the rear of the cell, then passed furniture to prison staff in the doorway to allow more room for the nurses to work on him. Nurse A supported his airway; Nurse B was on his left side and started chest compressions. Nurse B asked Officer B to time two minute intervals and inform the nurses after each interval.

62. Nurse C, the duty "Hotel 1" nurse, heard the "Code Black" radio message while on one of the exercise yards and made her way to D wing. On arrival, someone (she does not know who) called out that a defibrillator was required. (A defibrillator is an automatic portable electronic device which measures electrical activity in the heart and delivers an electric shock to the heart or advises on other action to be taken.) She shouted to other nursing staff that she wanted the defibrillator and another pair of hands. A Healthcare Support Worker (HCSW) brought the defibrillator and they both went upstairs. It was obvious to them where the incident was taking place from the number of staff standing outside the cell, which included wing managers and governors.

63. Both Nurse C and the HCSW went into the cell. Nurse C handed the defibrillator to Nurse A, who attached the machine's pads to the man's chest. She started the defibrillator which gave the instruction to stand clear while it analysed his heart rhythms. After a few seconds, it reported that no shock was required and to continue with CPR. The HCSW also handed an airway to Nurse A, which she inserted into his throat and then attached an ambi-bag (self-inflating resuscitator) which she used to force air into his lungs.

64. A note on the control room log indicates that at 11.17am a message was passed from the orderly officer reporting that the man was not responsive and there was a possibility that drugs or a cardiac problem were the cause. The information was passed to the gate staff to be given to the ambulance service paramedics when they arrived.

65. One of the nurses attempting to resuscitate the man asked Nurse C to bring a second emergency bag. She collected it and an oxygen bottle from the E wing doctor's room, returning to the cell at 11.20am. After delivering the bag, she was then asked to go back and bring a suction machine. She collected the machine and returned to the cell with it a few minutes later where she remained in support of the other two nurses.

66. Officer B also remained in the cell. When he notified each two minute period, the nurses stopped working on the man and distanced themselves from him to allow the defibrillator to monitor his heart and advise the action to take. On each occasion, it found no shockable rhythm and advised that CPR should continue. Nurses B, C and the HCSW continued CPR for what they thought was a "very long time". During that time, Nurse C asked if there was anything about him in the wing observation book the previous night. One of the staff

outside the cell went to the wing office to check and reported that there was nothing recorded. She also asked about the ambulance and was told that it was on the way. She observed later that there seemed to be no clear lines of communication to get information to and from the emergency and there appeared to be confusion as to whether the doctor had been called.

67. According to the control room log, the ambulance arrived at the prison gate at 11.21am - 13 minutes after the initial emergency call had been made. The log keeper at D2-34 noted that the ambulance crew arrived at the cell at 11.29am.

68. Officer B left the cell when the ambulance crew arrived. They were briefed by the nurses and then took over control of resuscitation attempts, using their own equipment. Nurse A maintained support of the man's airway. Nurse B and the paramedics continued with chest compressions, stopping periodically to allow the monitoring of his heart. Nurse A estimated that after about 20 to 30 minutes of continuous CPR and administering drugs through the blood vessels in his leg, the ambulance crew began to talk about stopping. They asked the nurses whether the doctor was on his way.

69. Nurse B went outside the cell for a break and told the orderly officer to ask the doctor to come to the cell. He radioed the control room at 11.40am. The control room log specifies that the doctor was requested to certify death.

70. After a further four or five minutes, Nurse B went downstairs to the wing office and telephoned the healthcare centre to find out where the doctor was. One of the administrators then went to see a doctor and told him about the emergency situation. As he did so, the Primary Care Co-ordinator in healthcare came in to ask one of the doctors to attend D wing to certify the death. (She had received a telephone call in her office from a nurse informing her that a patient had died on D wing and that paramedics were in attendance.) That conversation was interrupted by a further telephone call from Nurse B enquiring whether anyone was going to come to certify the death. The doctor agreed to go.

71. The log keeper's notes show that at 11.59am the ambulance crew had contacted their clinical supervisors by mobile telephone for advice about stopping the resuscitation attempts.

72. The doctor arrived at the cell at 12.00pm. According to notes he made in the man's medical record, he arrived at the cell to find the ambulance crew and nurses giving cardiac compressions. He also noted that adrenaline had been given and the electrocardiogram (ECG) showed pulseless electrical activity (PEA). (This occurs when any heart rhythm observed on the ECG does not produce a pulse.) The doctor was told by one of the ambulance crew that CPR had been attempted for about 70 minutes. They briefly discussed the PEA and, because there was no other signs of life, at 12.05pm, one of the ambulance crew telephoned his clinical lead who advised them to stop the resuscitation. The doctor certified death at 12.10pm. Immediately afterwards, the paramedics and nurses removed their medical equipment and, at 12.17pm, the cell was sealed.

73. At 12.30pm, the staff involved in the emergency attended a debrief with Governors. They were offered support by the care team. The prison chaplain offered Prisoner A support and made him aware of help available from Listeners (prisoners trained by the Samaritans to support other prisoners during times of distress or crisis) and the Samaritans.

74. The family liaison officers were immediately briefed on the circumstances of the man's death. His next of kin was his mother and two family liaison officers went to her home just after 1.00pm, where they broke the news of her son's death to her and other family members who were present. They explained their role and gave his family information about the procedures following a death in custody as well as the support available following bereavement and their contact details. At his mother's request, the family liaison officers contacted a friend who came immediately to support her.

75. Over the following weeks, the family liaison officers maintained contact with several members of the family. The funeral was held on 20 September. HMP Durham met the cost and two family liaison officers attended on behalf of the prison. Prisoners from D wing donated money for a wreath and the family later thanked them. On 28 September, the family liaison officers met the man's mother again and returned his remaining property.

ISSUES

Methadone treatment

76. The clinical reviewer explored with the pharmacist at HMP Durham the man's methadone treatment and the monitoring of his withdrawal symptoms. They focused on the levels of his prescribed medication, methadone (for heroin addiction), mirtazapine (for his depression) and gabapentin (for neurological pain). The pharmacist's view was that the prescriptions for gabapentin and mirtazapine were appropriate. The clinical reviewer concluded that although 110mls of methadone daily was a high dose, it was not unusual. It was consistent with the man's prescription outside prison and during a previous custodial sentence.

77. The IDTS doctor checked that the medication initially prescribed when the man arrived in prison was correct in relation to his known medical history. Having established his previous methadone use, she prescribed the methadone to be titrated up until 6 September when his daily dose reached 110mls. In parallel, he was taking a reducing course of chlordiazepoxide. He wanted to be prescribed a daily dose of 110ml of methadone immediately but the doctor explained to him that to do so in combination with chlordiazepoxide would be unsafe and, additionally, warned that to use other drugs on top of those prescribed was extremely dangerous.

78. The pathologist says:

> "The man (sic) died as a result of the effects of a combination of methadone and chlordiazepoxide with the methadone the much more important of the two. The significance of any one methadone level is always difficult to interpret in light of the fact that there is extensive overlap between the therapeutic range and the fatal range and individuals do become tolerant to the effects of methadone if they are used to taking it. Given that he was on a high daily dose of methadone he must have developed some tolerance. However, we do not have a good alternative explanation for his death and methadone toxicity would fit the circumstances of his death very well."

79. It is clear that on reception the man was prescribed appropriate medication for the treatment of his medical conditions and was properly referred to a specialist in substance misuse who reviewed and endorsed it. The risks of the combination of drugs prescribed were recognised, properly evaluated and communicated. He was also warned of the heightened risks of using additional drugs. He appeared to understand and agreed to the planned medication. We are satisfied that his treatment was properly managed

80. From information given by the man's friends, it is likely that he was taking additional gabapentin in excess of that prescribed. It is known that over use of the drug can lead to breathing difficulties and that life-threatening symptoms are more likely if gabapentin is combined with other medications. Unfortunately, no gabapentin analysis is available from the toxicology report

and we do not know whether his use of this drug played any part in his death. The pathologist judges that his death was most likely from the effects of methadone and chlordiazepoxide. Although it was suggested that he also took additional illicit drugs, we have been unable to establish whether this also had a bearing on his death but this is a possibility which cannot be ruled out.

Monitoring the man's withdrawal symptoms

81. From the first day of his imprisonment, the man was subject to IDTS monitoring which indicated that he had withdrawal symptoms but was making progress. On 2 September, the five day review indicated that although he still had some mild withdrawal symptoms, he was generally feeling a lot better.

82. The clinical reviewer was concerned about the lack of monitoring of the man's condition between the five day review on 2 September and 8 September, the day of his death and made enquiries about the absence of entries in the clinical record between those dates. It was explained that because there were no concerns at the time of the five day review, daily monitoring had stopped. His next review would have been four weeks later, unless either he or healthcare staff raised concerns. No such concerns were raised.

83. Although no entries were made in the man's medical record between 2-8 September, he was seen by medical staff three times on 2 and 3 September and, thereafter, at least once daily when he received his methadone and other medication. Both his friends, Prisoners B and C, said that he appeared to be under the influence of drugs on the afternoon of 7 September, when he was in his cell and later out on the wing. Wing staff did not notice this and nor was it noticed when he received his night medication at 10.30pm, by which time he could have recovered.

84. The clinical reviewer reported that "the withdrawal scale S1 template was adhered to and had been completed comprehensively and correctly". We judge that the monitoring of the man during the time he was being treated for withdrawal from drug and alcohol dependency overall was carried out appropriately.

Events on the morning of the man's death

85. We have explored whether staff took sufficient care to identify whether the man needed urgent medical attention. The fact that the combination of methadone, chlordiazepoxide and other drugs was potentially dangerous (mentioned in the doctor's statement), was not recorded in the prison documents. He did not report any symptoms of his drug and alcohol withdrawal and healthcare staff did not note any adverse reaction to his medication. His cell mate, Prisoner A, reported after his death that during the three days they shared a cell he was frequently drowsy after taking his methadone. Other friends disclosed that he had taken gabapentin tablets during the week of his death and was under the influence of drugs on 7 September. He recovered enough to receive his medication at around 10.30pm that evening without drawing attention to himself and was spoken to by an officer at around 5.00am the following morning.

86. The accounts of what happened before the emergency was raised differ. For ease, they are summarised below.

87. Prisoner C said that after trying to rouse the man, he told Officer B that there was something wrong and that he had not been able to get a response. He said the officer glanced into the cell but did not go in. He said he then spoke to Nurse A at the dispensary about him. Prisoner A, the man's cell mate, recalls that he reported to Officer B that he could not wake him but the officer said that as he was breathing he was all right. When he returned from the dispensary, he could still not wake him and repeated his concern to the officer, who took no action but locked him in the cell with Prisoner C. Nurse A said that the cell mate had told her about the man, although he did not seem particularly anxious and she advised him to speak to his landing officer if he was concerned. He told her that he had already spoken to him on the way down to the dispensary. She then assumed that all was well.

88. Officer B said that the cell mate told him that the man had not got up to collect his methadone. The officer then went just inside the cell and heard him snoring. He passed the cell several times in the next few minutes and the snoring continued. On his return from the dispensary, the cell mate again mentioned the man's methadone and he advised him to let him sleep.

89. The accounts mainly support a credible timeline of events but there are some potentially important inconsistencies and we were unable to establish which was the most accurate.

90. A brief conversation took place at around 8.35am between Officer C and the cell mate about the man's snoring. The first time staff directly made contact with the man on the morning of his death was at 9.35am when a Probation Service Officer wanted to speak to him but attempts to rouse him were unsuccessful. The probation service officer returned at around 10.00am but he remained asleep. At this point, there was no indication that anything was wrong.

91. There were several points between the probation officer first going to see the man at 9.35am and Officer B locking the cell mate and Prisoner C in their cell at around 10.45am, when medical help could have been summoned. However, these opportunities were missed.

92. The person who was in the best position to help the man was Officer B, who was twice approached by the cell mate because he was unable to rouse his cell mate. Regrettably, the officer relied on the fact that he was breathing as an indicator that there was no problem. He was aware of his condition over a ten minute period but because it had not changed did nothing further. He could have tried to wake him by calling to him or physically touching to rouse him, he did neither.

93. It is possible that waking him might have led to friction if he was merely deeply asleep, but that is not a reason for doing nothing when the cell mate and

Prisoner C had raised concerns about him, the cell mate more than once. The officer was aware that the man was due to take methadone. At the very least, we believe he should have taken some action himself to try to rouse him to satisfy himself that there was no problem and to ensure that he did not miss the opportunity to obtain his medication. We therefore judge that the officer did not discharge his duty of care in regard to him and make the following recommendation:

The Governor should conduct a formal investigation into Officer B's actions on the morning of the man's death to consider whether disciplinary action is required.

94. To a lesser degree, Nurse A, working in the busy D wing dispensary was in a position to help when the cell mate spoke to her. She had access to medical information that could have alerted her to the possibility that the man might need medical attention. However, as the cell mate did not appear to be particularly anxious she advised him to speak to his landing officer. She then assumed that the situation had been resolved. Her advice seems reasonable in the circumstances, but is disappointing that a nurse working on the IDTS wing, and knowing the dangers, did not make further enquiries about the man's condition.

95. We do not know exactly when the man became unconscious that morning and whether he would have survived if medical help had been given earlier. However, by 11.08am his breathing had stopped and when medical staff attended, he appears to have been beyond help.

96. The pathologist who conducted the post-mortem said "… Typically individuals who die from the effects of methadone are deeply unconscious, unrousable and are often heard to be snoring heavily prior to breathing stopping". These tell tale, warning signs have been evident in similar deaths previously investigated by this office.

97. We accept that it is not possible for non-medical staff to be trained in the signs and symptoms of a wide range of complex medical conditions. It is, however, reasonable to expect that in a prison, whenever a person is reported to be apparently unrousable, attempts are made by staff to gain a conscious and lucid response. Also, that in the event of an inadequate response, medical help is sought immediately. This is particularly important in a specialist wing such as D wing, where all prisoners are undergoing drug treatment. As the symptoms of drug-induced unconsciousness can be fairly evident and the trading of both illicit and prescription drugs in prison can lead to incidents of overdose or mixed drug toxicity, it would seem reasonable to raise awareness of such symptoms. We therefore recommend:

The Governor should ensure that all staff who work with prisoners on the drug treatment wing are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication, and know how to respond.

The Emergency Ambulance

98. We are concerned about the length of time it took for the ambulance crew to reach the man's cell. The control room log shows that an emergency telephone call for an ambulance was made after Officer D's "Code Black" message was received in the control room at 11.08am. The note states that an ambulance was en route. Two minutes later, Nurse B made a radio call to the communications officer for an emergency ambulance. The call was acknowledged although it was not recorded on the log. It is recorded in the control room log that the ambulance arrived at the prison gate at 11.21am, and the log keeper at the cell noted that the paramedics arrived there at 11.29am, some eight minutes after arrival at the prison.

99. Ambulance service staff cannot move beyond the gate into the prison without prison staff assistance. If the times of arrival recorded at the gate and the cell are accurate (which is likely as the control room log notes that movement around the prison was allowed to continue at 11.30am), it is unclear why it took staff eight minutes to get the ambulance crew from the gate to the wing. That is an unacceptable delay. A letter from the Chief Executive of February 2011 to all governors emphasised the need to ensure quick access for emergency services and that it was the responsibility of governors to ensure that a protocol exists at each prison to facilitate the immediate access to both the prison and the individual prisoner when emergency ambulance services are required. It is unlikely that the time taken to get the ambulance crew from the gate to the cell made a difference to the outcome on this occasion but under other circumstances it might.

The Governor ensures that ambulance services have immediate access to prisoners on arrival at the prison in an emergency.

The Doctor's Attendance at the Cell

100. There was a delay between nursing staff requesting a doctor's attendance and his arrival at the cell. Nurse A asked Nurse B to contact the prison doctor to attend the cell. Nurse B's impression was that resuscitation attempts had been going on for a long time and the ambulance crew wanted to stop. She told the orderly officer, who radioed the control room to make the request. This was logged at 11.40am and specifies that the request was to certify death.

101. The ambulance crew also contacted their clinical advisers and several telephone calls were made by nurses to the healthcare centre requesting a doctor to certify the man's death. When the doctor went at 12.00pm, he noted that CPR was still being performed and that the ambulance crew had been advised to stop resuscitation attempts. They and the doctor discussed the man's condition. As there were no signs of life, one of ambulance crew telephoned his clinical lead who again advised that resuscitation attempts should end. The paramedics stopped at 12.05pm and declared life extinct. The doctor certified death at 12.10pm, 30 minutes after a doctor was first called.

102. There do not appear to have been clear lines of communication during the incident and nurses were unable to establish from the staff outside the cell whether the doctor had been contacted. This resulted in a number of radio and telephone calls via the control room and directly to the healthcare centre by several different staff. Once a doctor was contacted he came to the scene immediately but the delay meant that CPR was unnecessarily prolonged which was stressful and upsetting for those involved in the CPR attempt and was undignified for the man.

The Governor should ensure that clear lines of responsibility and communication are established quickly at the start of a medical emergency so that all necessary personnel attend as soon as they are required.

CONCLUSION

103. The man came into prison dependent on alcohol and drugs. His healthcare needs were properly assessed and he was given appropriate treatment for his withdrawal from alcohol and to stabilise and maintain him on methadone. A specialist drug treatment doctor advised him of the risks of the combination of drugs used, as well as the increased dangers of using drugs in addition to those prescribed. He was appropriately treated and monitored but died just two weeks after his arrival at Durham. After his death, it was reported that he had obtained illicit supplies of the prescription drug gabapentin. His friends knew about this and observed the effects on him but did not draw it to the attention of either healthcare or prison staff. Staff had not noticed anything unusual while dealing with him.

104. The man's cell mate was concerned about him on the morning of his death but the officer he spoke to about this did not attempt to physically rouse him, believing he was in a deep sleep. We consider this omission constituted a failure in his duty of care to him. We cannot say whether the outcome for him would have been any different but, particularly in a specialist unit of this type all staff, must be alert to the possibility and dangers of drug overdoses and act on concerns expressed by others.

105. The alarm was raised when his cell mate found that the man had stopped breathing and there was a swift response at that stage. Prolonged and determined resuscitation attempts were made by nurses and ambulance crew members. We are satisfied that, in spite of some communication problems during the incident and a delay in getting ambulance staff to the wing, emergency treatment given to him was delivered professionally. Sadly, the resuscitation efforts were ultimately unsuccessful.

RECOMMENDATIONS

1. The Governor should conduct a formal investigation into Officer B's actions on the morning of the man's death to consider whether disciplinary action is required.

   Accepted

   A formal investigation has been commissioned.

2. The Governor should ensure that all staff who work with prisoners on the drug treatment wing are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication, and know how to respond.

   Accepted

   An awareness leaflet/sheet will be produced and distributed to all operational staff working at Durham which provides information about the common symptoms of drug induced unconsciousness and drug intoxication, and how to respond.

   The protocol for emergency access for paramedics and ambulance services provides basic first aid procedures to follow in the event of a number of medical emergency scenarios. This document is accessible to staff via the Z: drive at HMP Durham, but requires updating. This document will therefore be reviewed by relevant departments and updated.

3. The Governor should ensure that ambulance services have immediate access to prisoners on arrival at the prison in an emergency.

   Accepted

   There are procedures (and an Action Sheet) with regards to emergency access for paramedics and ambulance services. Information about this is located in the Control Room and the Gate lodge.

   HMP Durham will ensure that the emergency services are given assistance to perform their role whilst attending the establishment.

   In all cases appropriate staff will inform the Gate of the expected arrival of an emergency vehicle. Gate staff will ensure that the gate is opened to allow the emergency vehicle access to the establishment.

4. The Governor should ensure that clear lines of responsibility and communication are established quickly at the start of a medical emergency so that all necessary personnel attend as soon as they are required.

Accepted

Staff ensure that medical emergencies are reported immediately to the Communications Room either by telephone or radio.

The Communications Room will then immediately notify all appropriate staff that assistance is required, informing them of the location of the incident, and providing an appropriate colour code to signify the type of incident so that they are aware of the response that is required.