PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the death of a man from HMP and YOI Altcourse, at the University Hospital, Aintree, in July 2010

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This is the report of an investigation into the circumstances surrounding the death of a man at University Hospital, Aintree in July 2010. The man was found collapsed in his cell at HMP Altcourse, five days after he came into prison. He was taken to hospital but died a few hours later. The post mortem examination showed no conclusive cause of death.

I offer my sincere sympathy and condolences to the man's family and friends for their sad and untimely loss. I am sorry that my report has been delayed.

The investigation was conducted on my behalf by one of my investigators. I would like to thank the Director of Altcourse and his staff for their help and cooperation. I owe special thanks to the investigation liaison officer for his help in the role of investigation liaison officer.

I commissioned a clinical review of the management of the man's health needs while he was in custody at Altcourse. I am grateful for his contribution to my report.

I make a number of recommendations to the Director and Head of Healthcare at Altcourse which I hope will help to minimise the risk of similar shortcomings happening again. I am concerned about shortcomings in the assessment and documentation of the man's mental health needs during the reception procedures and managing his medication.

I am also concerned that inappropriate terminology was used to alert staff when the man was found to have collapsed. This led to a failure to bring appropriate emergency first aid equipment promptly to the cell and confusion about deploying specialist and discipline staff. Furthermore, I am alarmed that there was a significant delay in calling an ambulance. That said, I have no evidence that any of these issues contributed to the man's death.

I also cite good practice in relation to family liaison procedures and particularly the prisoner custody officer (PCO) appointed as family liaison officer and the chaplain for the way in which they discharged their responsibilities.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was an unemployed. He was remanded in custody by a Magistrates Court on three charges and ordered to appear at a Crown Court on 16 July for sentencing. The man was taken to HMP Altcourse, arriving in the early evening. This was not his first time in custody.

2. After undergoing the routine reception procedures during which he admitted to a doctor that he had recently taken heroin, he was placed on a methadone based detoxification programme which started straightaway. Although he admitted to healthcare staff that he had been diagnosed with schizophrenia and had tried to hang himself some years earlier, he said he had no current concerns about his physical or mental health. After completing the reception procedures, the man went to the induction unit (which is known as Furlong Green) and was allocated to a cell which he shared with another prisoner.

3. On Friday 9 July and Monday 12 July, the man completed elements of his induction programme. The weekend was uneventful. However, on the morning he died, he failed to appear in the treatment room in his unit to collect his medication. A prisoner custody officer (PCO) checked his whereabouts and, at about 7.30am, found him apparently asleep and snoring unusually in his bed. The man's cellmate told the PCO that he had been trying unsuccessfully to wake him for about 15 minutes.

4. The PCO summoned assistance from two nurses who examined him and found that he was unconscious. They asked for emergency first aid equipment to be brought to the cell. At 8.05am, an ambulance was called and a paramedic crew arrived four minutes later. The paramedics, assisted by prison healthcare staff, tried to revive him until 8.44am, when he was taken, still unconscious, to a nearby hospital. He died in the hospital at 5.38pm. A subsequent post mortem examination found no clear cause of death.

5. The investigation found shortcomings in the management of the man's medication at Altcourse, some of which arose as a result of unclear communication between primary care agencies in the community and the prison healthcare department. There is evidence that one of the drugs given to the man may have been taken from another prisoner's allocation.

6. My report also draws attention to the use of inappropriate terminology for raising the alarm when the man was initially found in a collapsed state which delayed the deployment of emergency first aid equipment to the cell. I express my concern that an ambulance as not called until 8.05am, approximately 13 minutes after the alarm was first raised and at least 25 minutes after the man was found collapsed.

7. Although there is no evidence that any of the shortcomings l have listed in this report contributed to the man's death, they nevertheless fall short of the standard of healthcare I would expect a prisoner to receive. I make a number of recommendations that I hope will prevent their recurrence.

8. I congratulate the prisoner custody officer who decided to look for the man after he had failed to collect his medication on the day he died and than writing “did not appear” in his record. I also draw attention to an example of good practice in relation to the provision of a “grab bag” for use by family liaison officers. Finally, the prison’s family liaison officer and the chaplain diligently discharged their responsibilities to the man’s family in the aftermath of his death.

THE INVESTIGATION PROCESS

9. The investigation was conducted by one of my investigators. On 20 July, the investigator met the Acting Director of Altcourse and other key managers, together with the chair of the local Independent Monitoring Board, to brief them on the nature and scope of the investigation. Notices were displayed around the prison to inform both staff and prisoners of the investigation and invite anyone with information about the man's death to make themselves known to him. No-one came forward.

10. One prisoner and nine members of staff were interviewed. One other member of staff who was due to be interviewed was unable to attend because of ill health. A further member of staff, who no longer works at Altcourse, failed to appear for his interview.

11. I commissioned a clinical review of the management of the man's healthcare needs while he was in custody at Altcourse. The review was undertaken by the clinical reviewer. The clinical reviewer was able to join the investigator in some of the interviews conducted.

12. On 16 August 2010, one of my family liaison officers contacted the man's father in order to explain the purpose of my investigation and provide him with an opportunity to raise any questions or concerns about the care which his son received. However, at the time, the man's father was ill and could not take the call. His sister therefore agreed to be the contact point for all enquiries from my office. She confirmed that her family had no concerns to raise.

13. The investigator met with the Coroner's Officer during the course of the investigation and was passed a copy of the toxicology report.

14. The investigator gave the acting Director of Altcourse regular verbal feedback as the investigation developed.

15. The man's family, the Prison Service and the PCT received this report in draft for consultation. The report reflects the response to our recommendations.

HMP ALTCOURSE

16. Altcourse opened in 1997. It is managed by a private security company known as G4S. Situated near Aintree, some six miles from Liverpool city centre, Altcourse serves the Magistrates' and Crown Courts in Cheshire, North Wales and Merseyside. At the time of the investigation, Altcourse held up to 1,108 male prisoners including 160 young offenders.

17. The accommodation at Altcourse comprises six main house blocks each divided into two units. Each of the units is named after one of the fences on the Grand National course at Aintree and is allocated a colour code for easy identification. Furlong, where the man was located, has two units, named Furlong Red and Furlong Green. Both units operate as induction and detoxification facilities. Young offenders and adult prisoners are held together in all residential units, although they do not share cells.

18. The prison is on a large site, divided by buildings containing the healthcare centre, rehabilitation unit, college, sports centre and segregation unit. Healthcare is provided by G4S. The healthcare centre has 24 hour nursing facilities and beds for up to 11 inpatients.

Emergency calls

19. The investigation found that there are two different systems in place at Altcourse for summoning assistance in the event of an incident: one is the First Response system and the other is the Code system.

20. The First Response system is used to alert staff to an incident, such as an assault, which may require more staff than are immediately available at the scene. As this type of incident is not initially treated as a medical emergency, first aid equipment is not deployed straightaway. The alarm can be raised by any member of staff carrying a radio. An alarm can also be raised by telephone. On each radio set is a red button, which, when pressed, will send an automatic signal to the control room. The controller will know which call-sign raised the alarm and the location of the member of staff concerned if he or she is occupying a fixed post. Staff should report their location to the control room if their job requires them to move around the prison. Upon receipt of a First Response alarm, the controller will block all other radios and inform all call-signs on the radio net that a First Response call has been received from a particular call-sign. Staff will then be expected to go to the incident to help their colleagues.

21. The Code system is used over the radio to alert staff to a medical emergency for which specialist help may be required. In order to assist healthcare staff decide which emergency first aid equipment should be taken to the emergency, and avoid the use of language that might distress other prisoners within earshot, the following codes are used:

Code 1 - hanging, collapse, electrocution, choking and stabbing.

Code 2 - self-harm, serious assault, serious fall, vomiting blood, chest pains and breathing difficulty.
Code 3 - convulsions.

HM Inspectorate of Prisons (HMCIP)

22. The most recent HMCIP inspection of Altcourse took place in January 2010. In the introduction to her report of that inspection, which was published in March, the then She praised the establishment. The Chief Inspector of Prisons commented that Altcourse was a safe prison with good arrangements for newly arrived prisoners. She highlighted good relationships between staff and prisoners but pointed out the need for improvements in the personal officer scheme. She also said that there was good support for prisoners at risk of self-harm and that services for substance misusers were developing. She expressed the view that healthcare provision was adequate.

Independent Monitoring Board (IMB)

23. Each prison has its own Independent Monitoring Board (IMB). IMB members are lay members of the public and are unpaid. They monitor day-to-day life in the prison to ensure that proper standards of care and decency are maintained.

24. In their annual report on Altcourse for the period July 2008-June 2009, the IMB drew no attention to any issue of relevance to this report.

Previous deaths in custody

25. None of the recommendations I have made in earlier reports about previous deaths at Altcourse are repeated in this investigation.

KEY EVENTS

Background

26. The man arrived at Altcourse on in July 2010 after appearing at the Magistrates Court. He was remanded in custody and ordered to appear at the Crown Court on 16 July. The Prisoner Escort Record (PER) was completed by the escorting staff to detail any risk indicators and log the events. The PER for the man's journey between the police station and the Magistrates' Court and onwards to Altcourse indicated that he had attempted to hang himself whilst he was in custody in August 1996. However, no current mental or physical health risks were noted on the form. The man arrived at the prison at approximately 6.00pm.

Reception procedures

27. During reception, all prisoners undergo a number of procedures. These include:

- an interview with a member of staff to ascertain basic historical information
- an initial health screen designed to identify any immediate mental or physical health needs
- a cell sharing risk assessment, the purpose of which is to assess any risk a prisoner might pose to a cellmate.

Health screen

28. Mental Health Nurse A conducted the man's initial health screen shortly after 7.00pm. The man told the nurse that he did not drink alcohol but had used heroin during the previous month. He also admitted that he had tried to harm himself 25 years earlier. It is not clear from the records which event the man was referring to.

29. The man said he had no concerns about his physical health and no outstanding medical appointments. However, he said that he had grazes on his legs. (His clinical record contains no evidence as to the extent or the cause of these grazes.) He said he had not seen a doctor for any reason during the previous few months. As far as his mental health was concerned, the man told the nurse that he had received psychiatric treatment in the community and had been diagnosed as a schizophrenic but said he currently "felt fine". (Schizophrenia is a mental disorder involving a breakdown in the relation between thought, emotion and behaviour.)

30. The man told the nurse that he had been prescribed the following medication:

Seroquel- also known as Quetiapine (anti-psychotic medication)
Pregabalin (anti-convulsant drug for the treatment of epilepsy and anxiety)
Diazepam (for anxiety)

Zimovane (for insomnia)
Subutex (for drug addiction)
Prozac (anti-depressant)
Olanzapine (for schizophrenia)
Buprenorphine (also for drug addiction)

31. During the health screen, the man underwent a urine test which showed the presence of benzodiazepines and opiates. (Benzodiazepines are a family of drugs such as diazepam and temazepam both of which are prescribed for anxiety. Opiates are drugs such as heroin.)

32. The nurse considered that the man was fit for normal location that is in a wing rather than in the healthcare centre or segregation unit. The nurse referred him to a doctor in relation to his substance misuse needs.

Cell sharing risk assessment

33. During his cell sharing risk assessment, the man confirmed that he had previously abused drugs and was dependent on them. He also said he had self-harmed in 1996. The man told his assessor that he was concerned about sharing a cell and considered himself to be a person who quickly became angry or frustrated. The assessor nevertheless concluded that the man presented a low risk of harming other prisoners. After seeing the prison doctor in reception, the man went to Furlong Green unit (an induction and detoxification unit) where he shared a cell with another prisoner.

Doctor's assessment

34. Dr A, one of the prison doctors with specific responsibility for running detoxification clinics, saw the man later that evening. As the man admitted to Nurse A that he had used heroin in the previous month, the doctor offered to prescribe a methadone detoxification regime. The man initially asked for Subutex but Dr A told him that this was not available. The man therefore agreed to accept methadone instead. The doctor explained that he took the man's word that he had been prescribed diazepam in the community and that, in order to prevent him from withdrawing, he made sure that the man received his first dose of diazepam and methadone that night.

Other prescribed medications

35. In his clinical review, prison Dr B notes that Dr A also wrote a prescription for diazepam 15mg to be taken twice daily, Quetiapine 50mg to be taken twice daily, and Pregabilin 150mg to be taken three times daily. However, the prescription charts in the man's clinical record show that there was a delay of two days before the prescription was actually written up by Dr A.

36. At interview, Dr A said that someone from the healthcare centre would have attempted to contact the GP in the community, as soon as possible after the man's reception, to confirm the drugs he had prescribed and the reasons for the prescriptions. He explained that the delay before writing the prescription

would have been due to delays in the community surgery and the workload of the healthcare nurses. The doctor said:

> "The problem is that you could send them [the GP surgery] a fax in the morning and they don't get back to you. And then the nurses are also busy doing other things. Then they will check again in the afternoon. Then they will find it's not done. They ring back again and all they can do is wait once they've sent this information across."

37. Dr A suggested that the confirmation might have been received on 10 July, that is two days after the man had arrived. The investigation found that the fax sent to the prison by the GP in the community contained notes which were hard to decipher. As a result, there was some confusion as to precisely what drugs had been prescribed and what dosages had been administered in the community. This in turn led to discrepancies between what was thought to have been prescribed by the GP in the community and what Dr A himself prescribed.

38. Dr A's colleague, told my investigator and clinical reviewer that, had the fax been picked up by a member of the healthcare administration team, they would have telephoned the GP in the community to clarify its contents. She emphasised that no-one should make out a prescription on the basis of an illegible fax. However, the investigation found no evidence in the man's clinical record to show that anyone contacted the GP for clarification.

39. Nevertheless, the Quetiapine prescribed by Dr A to treat psychosis was administered on the afternoon of 10 July, two days after the man's reception. Dr A could not clarify why the man did not receive his morning dose. However, Dr A's colleague explained as follows:

> "[The Quetiapine] was not available on 10th, it wasn't available on 11th and it wasn't available on 12th. The pharmacist dispensed it on 12th July and he sent 52 tablets to Furlong Unit to cover that prescription. What I can only suggest is that another patient on Furlong was actually prescribed the Quetiapine 50mgs and so this nurse has actually taken 50mg Quetiapine out of someone else's box, which is not usually done. We don't encourage that at all. But that is how this man [the man] would have got his Quetiapine."

40. Dr A thought that the Quetiapine given to the man on three successive evenings had probably been taken from another patient's allocation. His colleague also suggested that whatever dosage of Pregabalin was given to the man would have been taken from another prisoner's allocation. She knew that stocks were not kept in the out-of-hours cupboard in the treatment room. Dr A confirmed that there were times between 10 and 12 July when the man received his dosage of Pregabalin and other times when he did not.

41. The clinical reviewer asked Dr A to clarify whether he assessed the man to ascertain whether the Olanzapine had been prescribed for schizophrenia and whether the Pregabalin was prescribed for epilepsy. Dr A replied that he had assessed the reasons for the prescription because the man had no pain and did not have epilepsy. He said that he therefore prescribed Pregabilin for anxiety and suggested that the drug would have the effect of calming a patient down. He was aware that Pregabalin was often misused by prisoners but was unable to say what signs a patient would display if he were withdrawing from Pregabilin addiction as he had never witnessed this.

42. Dr A and his colleague also explained that if a patient failed to appear at the treatment room to collect his medication, the nurse would normally write "DNA" [did not appear] in his clinical record. They said it was not their practice to look for prisoners up who did not collect their medication.

Induction

43. The man's prison file shows that he completed some elements of his induction programme on Friday 9 July, including the education, gym and resettlement modules. However, no information is recorded that might reveal his general well-being, demeanour and activities that day or during the following weekend.

Discovery of the man collapsed in his cell on the day he died

44. A Prisoner Custody Officer (PCO) was on duty in Furlong Green Unit on the morning of Tuesday 13 July in the role of Integrated Drug Treatment System (IDTS) officer. PCO A told my investigator that he was not trained as a nurse. His role is to administer methadone to a number of prisoners who were on a detoxification programme, of whom the man was one.

45. PCO A told my investigator that at about 7.30-7.40am, after having given medication to six prisoners, he noticed that the man had not arrived at the treatment room to take his first dose of methadone. PCO A therefore shouted the man's name down the landing, instructing him to go to the treatment room for his medication. The man did not appear and so the PCO therefore went to his cell, which was about 20 metres away.

46. The PCO A reached the man's cell a few moments later and found the door open. The cellmate was standing inside and the man was lying on the lower bunk bed, fully clothed and beneath his quilt. The PCO told my investigator that the man's left eye was slightly open and he had a "regular snore that sounded quite unusual". The man's cellmate told the PCO that he had been trying to wake him for about 15 minutes.

47. PCO A told my investigator that he initially thought the man was putting on an act. He shook the man's shoulder to try to wake him, but there was no response. At this point, the PCO thought that the man was either "taking the mickey" or "there was something wrong" with him. He said that his initial reaction to the man's condition was based on the fact that he was not

medically trained. He said that, because of this, he made no attempt to diagnose the man's condition. Instead, he went back to the treatment room to alert Nurse A and Nurse B, both of whom were there. PCO A asked them to "have a look" at the man because he could not be woken up.

48. Nurses A and B left the treatment room straightaway to investigate. They found the man in bed, apparently snoring. However, on closer examination, Nurse A could tell that "it wasn't a proper snore". At interview, Nurse A said, "it sounded more as if his tongue was vibrating at the back of his throat". The nurse said that he carried out basic clinical observations, including taking the man's pulse and checking his breathing. He said that the man "had a very, very clear strong pulse in his wrist, very regular as well". He also confirmed that the man was breathing. The nurse shook the man and called his name to try to make him stir. Nurse B pinched his ear against a pen to test his reflexes but the man did not respond. When my investigator asked Nurse A whether he thought the man was unconscious, he said that he was unsure. Both nurses said they found that the man was "very clammy and very sweaty". They therefore placed him in the recovery position, whereupon he began to breathe more easily. (The recovery position means that the person is placed on their side rather than back in order to prevent obstructions to the airway.)

Summoning assistance

49. Nurse B told my investigator that at this point, she decided to leave the cell to telephone the healthcare centre to ask for specialist equipment. Once she had done so, she returned to the cell. She said that she thought that the man had suffered a collapse or a drug overdose. Nurse B said he was breathing, with a pulse of about 44 beats per minute. (The normal pulse range in adults is 60-100 beats per minute.)

50. At around the same time, Nurse A asked PCO A to summon assistance. At interview, the nurse told my investigator, "I said to [PCO A] call First Response, not First Response, a Code 1." However, in an entry the nurse made later in the man's medical record, the nurse gave no indication of any confusion as to what type of call he asked PCO A to make. The nurse recorded that he asked the PCO to make a Code 1 call and that while the PCO was making that call, he, the nurse, "repeatedly took the man's pulse from his wrist whilst shouting his name and rubbing his back".

51. PCO A told my investigator that his call-sign that day was Charlie 22, which is designated to whoever in the healthcare centre was carrying out the duties in the treatment room in Furlong Unit. He said that initially he sent a First Response message. He said,

> "When I pressed the red button and called the First Response they [the control room] shouted something to the effect 'First Response Charlie 22 healthcare'. I then immediately got back on the radio and said 'my position is Furlong'.".

52. The control room log shows that the First Response call was made at 7.52am. The log contains no reference to a Code 1 call having been made at any time for the man. If PCO A's first estimate of the time of the discovery of the emergency was accurate, there was a delay of around 12 to 22 minutes before any assistance was requested. However, PCO A confirmed that officers arrived in the unit as a result of the First Response call being sent. He told my investigator that the nursing staff who arrived at the cell were there within a minute of the call. He said that, as soon as the nursing staff arrived, he stood outside the cell to prevent other staff from entering. The investigation found no evidence to show whether a log was kept of events in the cell. At this stage, an ambulance had still not been called.

Emergency first aid

53. On duty as call-sign Hotel 2 that day was Registered General Nurse (RGN) C. Hotel 2 is the call-sign allocated to the nurse responsible for providing immediate response to any medical emergency. That nurse is also responsible for ensuring that appropriate emergency first aid equipment is deployed.

54. Nurse C told my investigator that she was in Canal Unit, a few minutes' walk from Furlong Unit when the alarm was raised. She explained that the message she heard on her radio from the control room directed her to the healthcare centre, not to Furlong Unit. When she arrived at the healthcare centre gate, she was diverted by the radio to cell 45 in Furlong Green Unit. She thought that she probably reached the man's cell about four to five minutes after the initial First Response call was received. The nurse made the following entry in the man's medical record to describe what she did when she heard the call from the control room:

> Called to First Response at 7.52am on 13 July at healthcare, then diverted to Furlong Green cell 45 upper landing still as Called Control via my radio to advise them that I, Nurse C Southern (RGN), was en route as HOTEL 2. On arrival, (RMN) Nurse A and (RGN) Nurse B (IDTS) staff present in cell. On attendance, patient the man was lying in recovery position on right hand side. Advised by above healthcare staff that the patient had been like this for around 20 minutes. Pad mate [cell mate] had informed them of this. Pad mate also stated that the man was last up to use the toilet at around midnight.

55. Nurse A recorded that, when Nurse C arrived, "no Code 1 equipment" [emergency first aid equipment] had been brought to the cell. At interview, Nurse C explained that, having received a First Response call rather than a Code 1 call, she was not aware that a life-threatening emergency had been discovered. Hence, neither she nor anyone else who responded to the call took any emergency first aid equipment to Furlong Green Unit.

56. Nurse C told my investigator that she found that the man was warm and clammy, with a weak pulse (in the carotid artery in his neck). Although he was breathing, she considered him to be unconscious as he did not respond to his name being called or to any other form of stimulus. Nurse C realised that no emergency first aid equipment had been brought to the cell and that an ambulance had not yet been called. She therefore asked the Duty Operational Manager who had arrived at the cell, to arrange for an ambulance to be called. (The control room log shows that an ambulance was called at 8.05am, between 25 and 35 minutes after the man was found collapsed.)

57. At about the same time, Nurse A left the cell to collect the emergency first aid equipment. He told my investigator that, when he arrived at the healthcare centre, he met a number of staff who were on their way to Furlong Unit with some of the emergency equipment. Nurse A did not specify which equipment had been taken by whom and did not know who had asked for it to be collected. In fact, it was Nurse B's request on the telephone that was the prompt.

58. At around the same time as Nurse C heard the First Response call, Nurse D, who was in the segregation unit administering medications, received a call from the control room asking her to go to Furlong Green unit. She went there straightaway, not yet knowing the nature of the emergency. As the two units are adjacent, Nurse D took approximately two minutes to reach Furlong Green.

59. At interview, Nurse D clarified that, when she reached the man's cell, she saw her colleagues – Nurse A and Nurse B – attempting to measure his oxygen levels and blood pressure. Nurse D told my investigator that she asked Nurse A where the oxygen equipment was and volunteered to collect it from the healthcare centre. When he arrived there, he was met by a number of staff who were already on their way with some of the equipment. He and a number of healthcare colleagues took the emergency first aid bags to the cell. They contained oxygen, drugs and a defibrillator (a machine that enables a controlled electric shock to be applied to a patient in order to allow restoration of a normal heart rhythm).

60. The control room log shows that the ambulance arrived at 8.09am, only four minutes after it was requested. However, it is not clear from the records whether this was the time when the vehicle reached the prison gate or the time the paramedics arrived at the man's cell. No doctors were on duty in the prison at this time.

61. Nurse D said that the paramedics arrived before there was time to open the emergency bags and use the equipment. The paramedics put the defibrillator equipment on the man. The nurses suggested that he was moved outside the cell into the corridor where there was more space to work. The nurse thought that the ambulance crew intubated the man (that is inserting a tube into the throat to pass oxygen into his body).

62. Nurse D confirmed that chest compressions were not started until the paramedics arrived. She said that when the paramedics attached the defibrillator to the man, the machine advised to start cardio pulmonary resuscitation (CPR). Nurse D told my investigator that she helped the paramedics to administer CPR. Thereafter, the paramedics transferred the man, still alive but unconscious, to the ambulance. The control room log shows that the ambulance left the prison at 8.44am.

63. The man was taken to University Hospital, Aintree (also known as Fazakerly Hospital), which is situated about five minutes' drive from the prison. In ordinary circumstances, an assessment would be made of the risk of escape which a prisoner being taken to hospital might present and appropriate restraints such as handcuffs applied. However, a decision was made by a director at Altcourse that while the man remained unconscious, he was not to be handcuffed to the escort staff. The ambulance arrived at the hospital at about 8.50am. The man was admitted to the resuscitation room and placed on a life support system.

64. PCO B was appointed as the prison's family liaison officer very shortly after the man left the prison for the hospital. At interview, PCO B explained that his first task was to gather as much information as possible, including the details of the man's next of kin. He said that he had no difficulty finding these details which were clearly recorded on a local data base.

65. PCO B telephoned the man's father very shortly after 9.00am but the call was answered by the man's aunt as his father was ill. PCO A told her that the man had been found collapsed and had been taken to hospital "in a pretty bad way". The PCO offered to arrange for a taxi to take her and her brother to the hospital but this offer was not accepted. The man's aunt told PCO A that there were no other family members who needed to be contacted. PCO A advised her that he would contact her again as soon as there were any developments at the hospital.

66. At 9.35am, the man underwent a chest x-ray. A second x-ray followed an hour later. Thereafter, he was given a CT scan [a whole-body x-ray]. At 11.10am, the man was transferred to the Critical Care Unit, still unconscious.

67. PCO A called the family again at about the same time (11.10am), after receiving an update from the escorting staff at the hospital to the Director at Altcourse. The man's aunt asked PCO A if her nephew had taken an overdose. The PCO was unable to confirm this and told her that the man was "very poorly" and in intensive care. He then gave the man's aunt the telephone number of the hospital after learning from her that she wished to call the hospital herself.

68. At about 3.30pm, PCO A was told by the Security Manager at Altcourse that hospital staff were about to withdraw the man's life support. PCO A called the man's family again to make sure that they knew of this development and repeat the offer of a taxi to the hospital. They again declined the offer.

69. During the afternoon, the man's condition deteriorated. At 4.35pm, the prison chaplain, arrived to say a prayer for him. At 4.45pm doctors decided to stop treatment and the man was pronounced dead at 5.38pm.

70. As soon as PCO A and the chaplain became aware that the man had died, they decided to travel to the man's family address to inform the family in person. At interview, PCO A explained that the prison had what was described as a 'grab bag' in which such items as a satellite navigation, road maps and other useful equipment is stored for use by family liaison officers. PCO A collected the bag and, at approximately 6.00pm, he and the chaplain set off by car some 54 miles away, arriving at about 9.00pm. They were unsure as to whether the family had already been told by the hospital that the man had died. When they broke the news to the man's father, he became very distressed. PCO A and the chaplain stayed with the family for about half an hour, after which they courteously withdrew.

71. The following day, the Acting Director of Altcourse sent a letter of condolence to the family. At about 10.30am that day, PCO A telephoned the family to offer support in preparing for the funeral. On behalf of the Director, he offered to meet the full costs of the funeral. Regular contact was maintained with the family as the date of the funeral neared.

72. PCO A and the acting Director of Altcourse attended the funeral. Afterwards, PCO A returned the man's belongings to the family.

Support for prisoners and staff

73. The investigation found that the prisoners in Furlong Green unit were told what had happened to the man by unit managers and were offered appropriate support.

74. Those staff directly involved in the emergency response told my investigator that a debrief was convened by the Safer Custody Manager soon after the man had been taken to hospital. Members of the prison care team made themselves available to those who felt in need of close support. All those interviewed said that they were satisfied with the care and support they were offered.

ISSUES

75. Here I examine:

Whether the man's health needs were adequately assessed and met during his brief time in custody at Altcourse between 8 and 13 July 2010?

Whether he used any illicit or non-prescribed drugs at Altcourse and whether there is any evidence that this may have contributed to his death?

Whether the response to the man's discovery collapsed in his cell on the morning of his death was prompt and effective?

Whether the man's next of kin were informed promptly and sensitively of his collapse and subsequent death and whether they were offered appropriate support thereafter?

Whether prisoners and staff at Altcourse were offered appropriate care and support in the aftermath of the man's collapse and subsequent death?

Were the man's health needs adequately assessed and met during his brief time in custody at Altcourse between 8 and 13 July 2010?

76. Reception assessment

During the reception process on 8 July, The man admitted that he had attempted to hang himself in 1996, as well as saying to another member of staff that he harmed himself 25 years earlier. He said that he had used heroin during the previous month, was diagnosed as suffering from schizophrenia, and had received psychiatric treatment in the community. Nevertheless, he said he had no concerns about his physical or mental health. He also said that he had been prescribed a wide range of drugs in the community which, in the opinion of the clinical reviewer, represented a "toxic cocktail". A limited mental health and treatment history was recorded by the prison doctor. There was no documented evidence that the doctor made his own assessment of the man's claim to be a schizophrenic or considered referring him for a specialist assessment. The man's previous medical records were not available at the time when he came into prison.

77. Methadone detoxification programme

The prison doctor placed the man on a methadone and diazepam detoxification regime straightaway. The clinical reviewer comments that the man's compliance with this regime was good.

78. Other medication

The prison doctor also re-prescribed two of the drugs - Pregabalin and Quetiapine - that seemed to have been prescribed by the man's doctor in the community. The investigation found that the prescription was not actually

written up until 10 July, two days after the man arrived at the prison. Furthermore, the prison doctor told my investigator that the doses of Quetiapine that were subsequently administered to the man were apparently taken from another prisoner's allocation. If true, this is a poor practice which should be stopped as a matter of urgency.

79. The delay writing up the prescription seems partly due to the length of time it took the healthcare staff to obtain confirmation of the man's prescription from his community surgery. When the manuscript details were faxed to the prison, the handwriting was tiny and very difficult to decipher. This led to further confusion and inconsistencies between the prescriptions made out by the community doctor and the prison doctor. There was no evidence that further clarification was sought by any member of the healthcare team. All GP surgeries are computerized and it should be very simple for the prison to obtain a computer generated print out of the prescribed medication and a summary of the prisoner's medical history.

80. The clinical reviewer found that the man received a variable amount of his prescribed medication during his brief period at Altcourse. The reviewer has commented that there was little explanation in the man's drug sheets to explain missed doses. The investigation found that the normal practice was for healthcare staff to write the initials 'DNA' (did not appear) rather than chase a prisoner who had failed to collect his medication. I consider this matter further later in the report.

81. Although there is no evidence that any of the shortcomings l have listed above contributed to the man's death, they nevertheless fall short of the standard of healthcare I would expect a prisoner to receive in prison. The clinical reviewer makes the following recommendations in his clinical review:

The head of healthcare should emphasize to all members of the healthcare department the importance of good note keeping, particularly in relation to the documentation of the medical assessment of new prisoners with health needs as well as to that of documenting communication with primary care.

The head of healthcare should initiate a policy regarding communication with primary care for all new prisoners with healthcare needs. A computer generated print out of the prescribed medication and a summary of the prisoner's medical history should be requested on the next working day after arrival in prison.

82. I add the following further recommendation:

The Primary Care Trust should, as a matter of urgency, satisfy itself that the apparent malpractice at Altcourse whereby drugs prescribed for one prisoner can be administered to another is eradicated.

Did the man use any illicit or non-prescribed drugs whilst he was at Altcourse and, if so, is there any evidence that this may have contributed to his death?

83. My investigator considered the possibility that the man's death may have been caused by an overdose of either prescribed or illicit drugs or be linked to his addiction to heroin whilst he was living in the community.

84. During his interview with the man's cellmate, my investigator was told that both the cellmate and the man took three capsules of Librium (a tranquilising drug used principally to treat anxiety and alcoholism), probably before his tea meal, on the day before his death. The cellmate said that the man took three capsules himself and gave him another three which he took at the same time. The cellmate said he did not know how the man acquired the Librium which, although not an illicit drug, was not prescribed for either prisoner.

85. When asked whether he thought that the man had done something that might have caused his death, the cellmate said:

> "I think it's because he was on methadone off the doctor, diazepam off the doctor, and these Pregabalin things but when he took them it was like he was drunk. Yes he was on two of them and he was trying to get four because he said if he gets four he'll give me two but I think they'd only give him two of them."

86. My investigator asked the cellmate whether he thought that the heavy doses of prescribed medication might have had an adverse effect on the man, to which he replied that he thought this was the case.

87. The cellmate was also asked if he knew whether the man had used any drugs such as heroin, cannabis or cocaine in his cell. The cellmate said he would have seen evidence of this had the man done so.

88. My investigator could find no evidence that the man took any form of illegal drugs whilst he was at Altcourse. The forensic scientist who conducted a toxicological examination six days after the man's death concluded that, although methadone and its metabolites were detected in his blood, the concentration was within the wide range encountered in individuals who are prescribed methadone. Diazepam and its metabolites were also detected at concentrations which indicated that it was taken for therapeutic use. The examination found that chlordiazepoxide was present and the concentration might represent non-recent use of Librium. Quetiapine was detected at a concentration which was at the low end of the range associated with therapeutic use. A low concentration of the anti-convulsant drug Pregabalin was present which might indicate that the man did not take the prescribed dose. Finally, Atropine and lidocaine were detected but they are likely to have been given during the emergency medical treatment.

89. Neither the investigation nor the forensic scientist found any evidence that the man took any proscribed drugs or that his reported use of Librium the day before he died contributed to his death.

Was the response to the discovery of the man in a collapsed state in his cell on the morning of 13 July prompt and effective?

90. The investigation found that the first time anyone realised that something was wrong with the man was early in the morning of the man's death when PCO A noticed that he had not collected his morning dosage of methadone. Although my investigator was told by the prison doctor that it was not the usual practice for staff to follow up such prisoners, on this occasion fortuitously the PCO decided to check why the man has not appeared. When the PCO reached the man's cell, he found him in his bed, as if asleep and sounding as if he was snoring heavily. PCO A was told by the cellmate that he had been trying to wake the man for about 15 minutes. The PCO asked two nurses to examine the man which was around 7.30 – 7.40am. PCO A deserves congratulation for his diligence in checking the man's whereabouts and for summoning professional assistance rather than simply writing "DNA" (did not appear) in his clinical record.

91. The nurses found that the man had a strong pulse and was breathing, although he was very clammy and did not respond to any stimuli. They thought that the unusual sound he was making was probably caused by his tongue vibrating at the back of his throat. The nurse placed him in the recovery position, still on his bed. My investigator estimated that by this time, approximately five minutes had probably elapsed between PCO A discovering the man and the completion of the initial examination by the nurses. However, given the evidence provided by the man's cellmate, it is likely that the man had been in a similar state for a further 15 minutes. At this stage, no-one had called an ambulance.

92. One of the nurses involved told my investigator that at this point, she decided to telephone the healthcare centre to ask for "all the equipment for blood pressure and the glucose and the saturation machine." Once she had done so, she returned to the cell. She thought at the time that the man had suffered a collapse or a drug overdose. The nurse said that he was breathing, with a pulse of about 44. (The normal pulse rate is 60-100 beats per minute.) Yet again, no request was made for an ambulance to be called.

93. The other nurse said that he asked PCO A to summon assistance. At interview, the nurse seemed unsure about precisely what he said to his colleague. He told my investigator that he told the PCO A, "Call a first response, not first response, a code 1." The First Response system is used to alert staff to an incident, such as an assault, the management of which may require more staff than are immediately available at the scene. As such an incident is not initially treated as a medical emergency and no first aid equipment is taken straightaway. The Code system is used over the radio to alert staff to a medical emergency for which specialist help may be required.

94. At his interview, PCO A admitted that he called for a First Response. As a result, a number of PCOs and healthcare staff arrived in Furlong Green unit all of them unaware of the nature of the emergency. Furthermore, one of the nurses who answered the First Response call was initially directed to the healthcare centre rather than to Furlong Green and had to be redirected.

95. Furthermore none of the emergency first aid equipment normally taken to an emergency was collected at that point as the Code system was not used and it was collected later.

96. The control room log shows that the First Response call was made at 7.52am. If PCO A's first estimate of the time of the discovery of the emergency was accurate, there was a delay of around 12 to 22 minutes before any assistance was requested. The control room log also shows that an ambulance was not requested until 8.05am, some 13 minutes after the man was first discovered collapsed in his cell and, possibly, up to 28 minutes after his cellmate first tried to wake him.

97. I believe that using the First Response system rather than the Code system to alert staff to the emergency was inappropriate and misleading. It led to a delay in the provision of emergency first aid equipment and in the arrival of healthcare staff at the man's cell. Although the investigation found no clear evidence that these delays contributed to the man's death, they must not be allowed to happen again.

    The Director of Altcourse, in conjunction with the Head of Healthcare, should ensure that whenever a potentially life-threatening emergency occurs, the Code system, rather than the First Response system, is utilised. Local contingency plans and other relevant procedural instructions should make this clear. If necessary, appropriate training should be given to healthcare and discipline staff.

98. It is understandable that when the man's cellmate could not wake him up, he did not realise the seriousness of his condition. I also believe that PCO A, who was not trained as a nurse, reacted appropriately by seeking professional help for the man rather than attempting to diagnose his condition himself. However, I am alarmed by the fact that an ambulance was not called until 8.05am, particularly as at least 13 minutes earlier professionally trained healthcare staff had examined him and found him unconscious.

99. In his clinical review, the clinical reviewer comments that he feels unable to judge whether the delay in calling an ambulance contributed to the man's death. My view is that the delay was unacceptable, irrespective of the lack of clear evidence suggestive of a causal link.

    The Director of Altcourse, in conjunction with the Head of Healthcare, should review the contingency plans for the management of life-threatening emergencies in order to be satisfied that they make clear the importance of calling an ambulance at the earliest possible moment. If

necessary, appropriate training should be offered to healthcare and discipline staff.

Log of events

100. The investigation found no evidence to show that a log was kept of events in the cell. The absence of such a log would no doubt have contributed to the inability of staff to recall the timing of key decisions and developments in the managing the emergency.

The Director of Altcourse should review the contingency plans for the management of a potentially life-threatening emergency in order to ensure that, at the outset of the emergency, a log keeper is appointed to keep a chronological record of key events, decisions and developments at the site.

Were the man's next of kin informed promptly and sensitively of his collapse and subsequent death and were they offered appropriate support thereafter?

101. The investigation found that Prisoner Custody Officer B discharged his responsibilities in his role as Family Liaison Officer promptly, professionally and sensitively. He was ably assisted by the prison chaplain.

102. Within approximately 15 minutes of the man's transfer from Altcourse to hospital PCO B contacted the man's family by telephone, giving accurate details of his discovery in a collapsed state and of his admission to hospital. The PCO offered to arrange for a taxi to take the man's father and aunt to the hospital. When, at about 3.30pm that day, PCO B was told by the Security Manager at Altcourse that hospital staff were about to withdraw the man's life support, he telephoned the man's family again to make sure they knew of this development and to offer them a taxi to take them to the hospital. They again declined the offer as the man's father was too ill to travel. At approximately 4.45pm, all the man's medical treatment was stopped. By this time the prison chaplain had arrived and she said a short prayer before, at 5.38pm, the man was pronounced dead.

103. That evening, PCO B and the chaplain travelled to the man's family home, some 54 miles away, to inform the family in person, despite the possibility that the family may already have been told of the news by the hospital authorities. They arrived three hours later and broke the news of the man's death to his father who became very distressed. PCO B stayed with the family for a short while before withdrawing courteously to allow the family to grieve in private. The following day, the acting Director of Altcourse sent a letter of condolence to the family.

104. PCO B took with him a 'grab bag', specially designed for use by family liaison officers, containing such items as a satellite navigation and road maps which I consider an example of good practice.

105. PCO B maintained contact with the family to offer help and support in preparing for the funeral for which, on behalf of the Director of Altcourse, he offered to meet the full costs. The funeral took place on 23 July. PCO B and the acting Director of Altcourse attended. Afterwards, PCO B returned the man's belongings to the family.

106. I consider that the manner in which PCO B and the chaplain discharged their responsibilities in support of the man's family was in keeping with the highest standards that can be expected.

Were prisoners and staff at Altcourse offered appropriate care and support in the aftermath of the man's collapse and subsequent death.

107. The investigation found that the prisoners in Furlong Green unit were told what had happened to the man by unit managers and were offered appropriate support. Those staff directly involved in managing the emergency were debriefed by the Safer Custody Manager soon after the man had been taken to hospital. Members of the prison care team made themselves available to those who felt in need of close support.

108. I am satisfied that an appropriate level of care and support was offered to both prisoners and staff in the aftermath of his collapse and his subsequent death in hospital.

CONCLUSIONS

109. Although there is no evidence that any of the shortcomings I have listed in this report contributed to the man's death, they nevertheless fall short of the standard of healthcare I would expect a prisoner to receive in prison.

110. Neither the investigation nor the person who conducted the toxicological examination of the man's body found any evidence that the man took any proscribed drugs during his time at Altcourse or that his reported use of Librium the day before he died contributed to his death.

111. PCO A deserves congratulation for his diligence in checking the man's whereabouts and for summoning professional assistance rather than writing "DNA" (did not appear) in his clinical record.

112. The use of the First Response system rather than the Code system to alert staff to the emergency was inappropriate and misleading. It led to a delay in the provision of emergency first aid equipment and in the arrival of healthcare staff at the man's cell. Although the investigation found no clear evidence that these delays contributed to the man's death, they must not be allowed to happen again.

113. It is understandable that when the man's cellmate could not wake him up, he did not realise the seriousness of his condition. I also believe that PCO A, who was not trained as a nurse, reacted appropriately by seeking professional help for the man rather than attempting to diagnose his condition himself. However, I am alarmed by the fact that an ambulance was not called until 8.05am,particulary in the context of the fact that at least 13 minutes before then, professionally trained healthcare staff had examined the man and had found him to be unconscious. In his clinical review, the clinical reviewer comments that he feels unable to judge whether the delay in calling an ambulance contributed to the man's death. My view is that the delay was unacceptable, irrespective of the lack of clear evidence suggestive of a causal link.

114. The investigation found no evidence to show that a log was kept of events in the cell. The absence of such a log would have contributed to the understandable inability of those staff who were interviewed to recall the timing of key decisions and developments in the management of the emergency.

115. I consider that the manner in which PCO B and the chaplain discharged their responsibilities in support of the man's family in the aftermath of his collapse and subsequent death was in keeping with the highest standards that can be expected.

116. I am satisfied that an appropriate level of care and support was offered to both prisoners and staff in the aftermath of his collapse and his subsequent death in hospital.

RECOMMENDATIONS

1. The head of healthcare at Altcourse should emphasize to all members of the healthcare department the importance of good note keeping, particularly in relation to the documentation of the medical assessment of new prisoners with health needs as well as to that of documenting communication with primary care.

   Accepted. *The prison responded that all staff will have procedures reiterated to ensure all relevant information is correctly documented.*

2. The head of healthcare at Altcourse should initiate a policy regarding communication with primary care for all new prisoners with healthcare needs. All GP surgeries are computerised and it would be very simple to fax or email to the prison a computer generated print out of the prescribed medication and a summary of the prisoner's medical history. This request should be initiated on the next working day after arrival in prison.

   Partially accepted. *The prison said that there is a procedure in place where in-reach and primary care staff meet each day to discuss the previous night's admissions, as recommendation one procedures will be reinforced to ensure that records are fully documented.*

   The doctors' surgery was contacted the day following admission (Friday) the prison received the response from the surgery on Monday, however the written response was virtually illegible. In future we will insist on either an email or printed fax for all requests to GPs for information.

3. The Primary Care Trust should, as a matter of urgency, satisfy itself that the apparent malpractice at Altcourse whereby drugs prescribed for one prisoner can be administered to another is eradicated.

   Accepted. *The prison said that there are procedures in place, however these will be reiterated to all staff charged with the dispensing of medication to prisoners.*

4. The Director of Altcourse, in conjunction with his Head of Healthcare, should ensure that whenever a potentially life-threatening emergency occurs, the Code system, rather than the First Response system, is utilised. Local contingency plans and other relevant procedural instructions should make this clear. If necessary, appropriate training should be offered to healthcare and discipline staff.

   Accepted. *The prison responded that all staff are trained and aware of the procedure in place through ongoing refresher training. Local emergency procedures cover this topic.*

5. The Director of Altcourse, in conjunction with his Head of Healthcare, should review his contingency plans for the management of life-threatening emergencies

in order to satisfy himself that they make clear the importance of calling an ambulance at the earliest possible moment. If necessary, appropriate training should be offered to healthcare and discipline staff.

Accepted. *The Safer Custody team have reinforced this with all staff through annual refresher training and notices, all staff are aware anybody has the authority to call an ambulance.*

6. The Director of Altcourse should review his contingency plans for the management of a potentially life-threatening emergency in order to ensure that, at the outset of the emergency, a log keeper is appointed to keep a chronological record of key events, decisions and developments at the site.

Accepted. *The prison said that a review of contingency plans will take place following this recommendation.*

Recommendations made by the clinical reviewer in the clinical review

1. The head of healthcare at Altcourse should emphasize to all members of the healthcare department the importance of good note keeping, particularly in relation to the documentation of the medical assessment of new prisoners with health needs as well as to that of documenting communication with primary care.

Accepted. *The response to this recommendation is dealt with at the first recommendation made to the prison.*

2. The Director of Altcourse, in liaison with the head of healthcare, should liaise with the provider of training for basic life support services. The training organisation needs to review its training module in light of the problems encountered in resuscitating the man. The training would particularly need to focus on identifying when to call an ambulance.

Accepted. *The prison said that all staff are undergoing refresher training in advanced life support.*

3. The head of healthcare at Altcourse should initiate a policy regarding communication with primary care for all new prisoners with healthcare needs. All GP surgeries are computerised and it would be very simple to fax or email to the prison a computer generated print out of the prescribed medication and a summary of the prisoner's medical history. This request should be done on the next working day after arrival in prison.

Partially accepted. *The response to this recommendation is the same response as to the second recommendation made to the prison above.*

4. The Director of Altcourse should review the establishment's emergency response protocol so as to ensure that all personnel know how to summon appropriate assistance and also are aware of the location of resuscitation equipment.

   Accepted. *The prison has already covered their action point in response to this recommendation in the fourth and fifth recommendations above.*