PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Norwich in May 2011

Report by the Prisons and Probation Ombudsman for England and Wales

July 2013

This is the report of an investigation into the death of a man at HMP Norwich in May 2011. He had been in custody for nine days when he was found dead in his cell. He was 27 years old. The post-mortem examination concluded that he died of methadone excess and an associated respiratory condition. I offer my condolences to his family and friends.

The investigation was carried out by a man. A clinical reviewer was appointed by the local PCT to conduct an independent review of the clinical care he received at HMP Norwich. The Governor and his staff co-operated fully with the investigation. I apologise for the delay in issuing this report

The man tested negative for opiates when he first arrived at Norwich and was treated for alcohol withdrawal. Over the next two days, he started to show symptoms of opiate withdrawal and he was tested again. Once it was confirmed that he was withdrawing from opiates, he was prescribed methadone. His prescription was dispensed in doses exceeding national guidelines and he was not properly monitored.

In May, the man's cell was unlocked in the morning and the officer reported hearing a groan, so assumed that he did not want to collect his medication and closed the door. Another officer inspected his cell between 9.00am and 10.00am that morning, but she did not remember seeing him and there is no record of any further checks. Just after midday, another officer went to encourage him to take his medication, but he did not respond and she noticed that he was cold. She radioed for emergency assistance, but he was pronounced dead by the prison doctor at 12.35pm.

The investigation concludes that the man's substance withdrawal was not properly managed. In addition, neither officers nor healthcare staff took sufficient responsibility to ensure prisoners' wellbeing on the detoxification unit. This led to poor monitoring of his health and a delay in discovering him on the morning of his death.

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 **July 2013**

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SUMMARY

1. In August 2009, the man was prescribed methadone for opiate withdrawal at HMP Norwich and completed the detoxification programme. He was released on licence on 3 December 2010. Five months later, on 11 May 2011, he was recalled to Norwich prison after breaching his licence conditions, and was treated for alcohol withdrawal. His urine tested negative for opiates, despite his insistence that he used heroin daily. The doctor declined to prescribe him methadone (which is used to treat opiate withdrawal).

2. During the night, the nurse was called to the man's cell because he was vomiting. She gave him medication to help him sleep and checked him through the night. The next morning, a nurse concluded that he was withdrawing from alcohol, but not opiates. Shortly afterwards, the doctor assessed him as withdrawing from opiates and prescribed him methadone. The doctor recorded his frustration about the inaccuracy of testing equipment in reception, an issue which he said he had already raised.

3. Over the next seven days, the man was observed by clinical staff, but sometimes only once a day. On 17 May, he was given paracetamol by a nurse because he complained of a cold. On the morning of 18 May, he was assessed in his cell and it was noted that he was shivering, vomiting and his pulse was racing. That was his last clinical observation.

4. There was no clinical observation on the morning the man was discovered. An officer opened his cell between 8.30am and 9.30am, and told him to get up for his medication. The officer remembered he made a slight noise but did not get up, so he left him to sleep. Between 9.00am and 10.00am, another officer went into his cell to inspect it. She could not remember whether he was in the cell. A prisoner went in to see him that morning, but assumed he was asleep and left him.

5. At 12.10pm, an officer went to ensure the man collected his medication. She called his name and, as he did not respond, she shook him. There were signs of rigor mortis, so she radioed that it was a life-threatening situation and she needed medical assistance. Resuscitation was not attempted and the prison doctor pronounced him dead. The post-mortem examination found that he died of methadone excess and an associated respiratory condition.

6. Detoxification arrangements were not adequately staffed or managed. Officers did not take responsibility for checking the man that morning. Family liaison was compromised by inadequate cover arrangements when the prison family liaison officer (FLO) was not working in the prison.

THE INVESTIGATION PROCESS

7. An investigator carried out the investigation into the man's death. On 25 May 2011, a colleague met the Governor and collected the man's documentation.

8. Notices announcing the investigation and its terms of reference were issued to staff and prisoners at Norwich. One prisoner asked to speak to the investigator and he spoke to him over the telephone.

9. The investigator reviewed the man's records and interviewed ten members of staff. The local PCT appointed a clinical reviewer to review the clinical care that he received at Norwich and she and the investigator jointly interviewed clinical staff. After the interviews, the investigator advised the Governor of emerging findings. We regret the delay in issuing this report which was caused by a backlog of cases in the office, compounded by staffing changes during the course of the investigation.

10. One of the Ombudsman's family liaison officers contacted the man's mother to explain the investigation process. She raised the following concerns:

- Was her son's death caused by taking too much medication, and why would he have medication in his possession?

- She said that she had trouble contacting the prison's family liaison officer and he was often unavailable.

- It took three weeks for the prison to return his property to his mother, although she had requested it urgently for the burial and she received it the day before his funeral.

11. The man's family received a copy of the draft version of the report as part of the consultation period and having considered this had no further comments. The investigator reviewed the investigation findings and made changes, where necessary, to the report.

HMP NORWICH

12. HMP & YOI Norwich serves the courts of Norfolk and Suffolk. The prison holds up to 767 adult and young adult men under 21, both convicted and on remand. The prison's health services are commissioned by the NHS and since October 2010, have been provided by a private health provider and their subcontractors. There is a healthcare centre which provides 24-hour nursing cover and a dedicated detoxification unit where the Integrated Drug Treatment Service (IDTS) is delivered. IDTS is the clinical management of drug and alcohol withdrawal, designed to treat prisoners from their first night in custody. It aims to increase the volume and quality of substance misuse treatment available to prisoners.

Her Majesty's Inspectorate of Prisons

13. The Inspectorate carried out an unannounced inspection of Norwich in February 2010 and concluded that health services were improving. At the time of that inspection, IDTS was rated as good and continuing to develop. The Inspectorate found that access to treatment for new arrivals was effective, but demand was increasing and there was a risk that resources would be overstretched.

14. The most recent inspection of Norwich took place in January 2012, after the man's death. The Inspectorate found that "opiate dependent prisoners had prompt access to clinical support, first night prescribing and comprehensive assessments on weekdays". Staffing of the clinical substance misuse service had improved, and there was evidence of joint working between the clinical team and staff working to support prisoners through withdrawal.

Independent Monitoring Board (IMB)

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that proper standards of decency are maintained. The annual report for 2010/11 commented that the opening of a dedicated detoxification wing had improved the delivery of the IDTS programme, but there was concern about the diversion of medication and increasing demand.

16. In 2011/12, the IMB reported that medication was still being sold by prisoners, which caused bullying on the wings. The equipment used to dispense methadone was not reliable, but there were more regular nurses and less reliance on agency staff which meant that dispensing was more controlled.

Previous deaths at HMP Norwich

17. The man's death was one of seven at HMP Norwich in 2011, six of which were natural causes. Following these investigations, this office made recommendations about joint working between healthcare staff and officers, the retrieval of community medical records and failure to hold a debrief following a death in custody. Similar issues are discussed in this report.

KEY EVENTS

18. The man went through methadone detoxification (to treat withdrawal from heroin) when he first arrived at HMP Norwich in August 2009. On 19 April 2010, at Crown Court, he was sentenced to 18 months imprisonment for assault occasioning actual bodily harm and returned to HMP Norwich. He transferred to HMP Wayland on 3 June, and was released on licence on 3 December that year. He breached his licence, which was revoked on 4 May 2011.

19. An order to recall the man to prison was sent to the police station local to where he lived and he was taken into police custody on 10 May 2011. A police risk assessment was completed at 11.42pm that evening. He said that he was feeling all right, had no mental health problems and had never tried to harm himself. He said that he was dependent on alcohol and used heroin and cannabis daily. A detained person's medical form should have been completed because of his drug use, but there is no evidence that this was done.

HMP Norwich

20. The man remained in police custody overnight and was taken to HMP Norwich the following morning, 11 May. On his Person Escort Record (PER), a document used to communicate risks between criminal justice agencies, it was noted that he was a heroin user. The police recorded that he refused a medical assessment while in their custody.

21. A nurse completed the man's first reception health screen at 11.08am that next day. He told the nurse he was "gutted" to be back in prison. He described himself as generally fit and well. He gave the details of his doctor in the community.

22. The nurse completed an alcohol screen to establish the extent of the man's alcohol use and whether he would need treatment. He said he drank six or more drinks daily and was showing withdrawal symptoms, such as sweating, itching, pins and needles, burning and numbness, so the nurse referred him to the doctor and the substance misuse team. He told the nurse that he regularly used heroin and had used some before he went into police custody the previous day. His urine tested positive for cannabis and cocaine, but negative for methadone, opiates and benzodiazepines.

23. A prison doctor saw him shortly afterwards and recorded that the man had a history of daily heroin use, and said he had last taken heroin two days previously. He said he used cocaine, amphetamines, cannabis and unprescribed diazepam. The doctor assessed him as clinically stable but with signs of alcohol withdrawal. He prescribed 10 milligrams (mg) of chlordiazepoxide to treat his alcohol withdrawal. The doctor did not prescribe anything for heroin, methadone or benzodiazepine withdrawal because of the results of the urine test. He said that he would self-medicate on the wing and pick up a habit to force the prison to prescribe him methadone. The doctor

explained this was inadvisable and would not result in a methadone prescription.

24. The man was given a cell on the dedicated IDTS unit to monitor his alcohol withdrawal. There is at least one member of healthcare staff on duty 24 hours a day on the unit. Later that afternoon, the doctor completed both the alcohol and opiate withdrawal scales. Despite his negative urine test that morning, he was showing signs of withdrawal according to both scales. A healthcare administrator entered the doctor's assessment onto his medical record.

25. An officer completed the man's first night interview, to identify any immediate needs and his response to being in custody. He said that he was not worried about being in custody, although he had not expected to be recalled. He told the officer that he had no thoughts of self-harm, but said he was withdrawing from heroin. The officer circled 'withdrawal' at the end of the interview.

26. At 12.02am, a nurse was called to the man's cell. He complained of diarrhoea and vomiting and said it was because he was withdrawing from opiates. The nurse recorded that she noticed the smell of vomit and believed he was genuine, administered zopiclone (to help him sleep), loperamide (to relieve diarrhoea) and ibuprofen, a painkiller, lofexidine hydrochloride (opiate withdrawal) and metoclopramide (to relieve sickness) under a Patient Group Direction (PGD). The next morning, she wrote in his medical record that she had checked him during the night and he had slept well.

27. At 10.54am on 12 May, one of the healthcare staff recorded that the man was experiencing alcohol withdrawal symptoms, but had no signs of opiate withdrawal. A doctor assessed him half an hour later, and recorded that he was experiencing symptoms of opiate withdrawal. His urine was tested again and was positive for THC (found in marijuana), benzodiazepines and methadone. The doctor wrote that he had complained about the accuracy of the urine testing kits used in reception before and he had been reassured that they were being checked. He prescribed him 15 millilitres (ml) of methadone twice daily. That afternoon, the doctor examined him after he said he had a seizure. He recorded that all his observations were normal and he had no injuries, but asked for regular checks to be continued. There are no more entries in his medical record that day.

28. The man met the CARATs (Counselling, Assessment, Referral, Advice and Throughcare service) team on 13 May, as part of the induction process. (CARATs supports prisoners with substance user problems.) Healthcare staff assessed his withdrawal symptoms, and confirmed that he was still experiencing withdrawal from opiates and alcohol. He signed to agree that the prison could request his medical records from his community GP. There is no evidence that these records were obtained.

29. The next day, 14 May, the man was given 30ml of methadone in the morning, prescribed by a doctor, alongside the medication he was taking to manage his alcohol withdrawal. That afternoon, a nurse assessed him and confirmed that

he was still experiencing opiate withdrawal symptoms. He took the same medication over the next two days.

30. A nurse gave the man paracetamol at 2.35am on 16 May, as he had vomited again and complained of a headache. The next morning, he asked for an increase in his methadone prescription because he felt that his symptoms were not under control. He did not attend an appointment with the nurse practitioner later that day to discuss his prescription and the dose remained the same.

31. According to a security information report submitted after the man's death, on 17 May, another prisoner noticed him being given tablets by the prisoner in the cell next to him. There is no other evidence of this, and no unprescribed medication was found in his post-mortem examination.

32. A doctor assessed the man's withdrawal symptoms that day. During the review, he reported that he had a cold, headache and body pain. The nurse practitioner recorded that he was not vomiting and did not have a fever, although he was nauseous at night, for which he was taking promethazine (anti-sickness medication). He said that he was coughing, but he was not coughing up blood. A nurse diagnosed him with a viral infection and suggested paracetamol to manage his symptoms.

33. A healthcare assistant (HCA) said that on 18 May, she carried out monitoring checks on all prisoners going through detoxification with an agency nurse. She remembered opening the man's door at about 9.40am and calling his name. She said that he "appeared to be asleep; the sheet covered his face, facing the wall". He did not respond, but she said that was not unusual for him because he did not sleep during the night and liked to lie-in. She said that she did not go into the cell and it was dark because the curtains were drawn, so she could not see very much. She agreed with the nurse that they would return later in the day to carry out withdrawal observations, rather than disturb him.

34. At 10.10am, a healthcare administrative officer wrote in his medical record that the man still had symptoms of alcohol and methadone withdrawal. He was vomiting, shivering and his pulse was racing. There were no other entries in his medical record that day.

35. According to an officer, the man spent the day cleaning his cell and talking to other prisoners on the wing. The officer said he had no reason to worry about him. In a security information report completed after his death, it was noted that on the detoxification unit Prisoner A told a healthcare assistant that the man told him he was going to take an overdose. He described him as unsteady when he was in the queue for his evening meal at about 4.30pm. The officer recalled him in the queue at about 4.45pm and described him as being in a good mood and chatting to other prisoners. The officer carried out a count of prisoners twenty minutes later and saw him sitting on his bed eating his meal.

36. Prisoner B said that in the treatment queue that evening the man told him that he had taken too many pregabalins (a strong painkiller), which he had not been prescribed. Another prisoner claimed that he bought some trazodone from a fellow prisoner. There is no evidence to confirm this, and neither were either of these medications detected in the post-mortem examinations. None of the prisoners told prison staff about this.

Day of the incident

36. Officer A was tasked with waking prisoners to collect their morning medication on Saturday 19 May. He remembered opening the man's cell door, between 8.30am and 9.30am, and asking him if he wanted his medication. He was in bed under his blanket and his curtains were drawn. The officer could not see what position he was in, but heard a slight grunt in response. The officer assumed that he did not want to get up, so closed the door and continued waking other prisoners.

37. Between 9.00am and 10.00am, Officer B conducted a fabric check of the man's cell. She told the investigator that she had been working on the detoxification unit that morning because the unit was short-staffed. Officer A asked her to check the cells on the second landing, including the man's cell. As part of the check, the officer had to ensure that there was no damage to the cell, the cell bell worked and the windows were secure. She said that during each check she always says good morning to the prisoner, but that prisoners are often in bed when she carries out the checks and do not always respond. She could not specifically remember checking his cell that morning and did not recall whether he was in the cell and if he spoke to her.

38. Prisoner C, who was a friend of the man, went into his cell that morning at about 10.30am. He did not respond, so he assumed that he was asleep and left the cell.

39. At about midday, Officer C was asked to help staff on the detoxification unit to dispense medication. The man was the only prisoner on his landing who had not taken his medication. She opened his cell door and shouted 'meds', but thought he was asleep. She went into the cell and called 'meds' again and shook him, but there was still no response. He was lying in the foetal position, with his head furthest from the door facing the wall. She shook him a second time, but when she got no response, she felt his head and discovered that he was cold.

40. Officer C radioed a code blue (a life-threatening situation requiring urgent medical assistance) at 12.10pm. Officer D had followed her to the cell and tried to turn the man over to begin cardiopulmonary resuscitation (CPR). However, he was stiff and the two officers could not move him. Officer D said he checked for a pulse, but could find nothing.

41. A nurse was working in the wing office when she heard the code blue. She left the office and officers outside the man's cell waved at her for assistance. She ran to the cell with a HCA. She also described him as curled up in the

foetal position facing the wall. She could not find a pulse and asked the HCA, who had also come from the wing office, to collect resuscitation equipment from an office on the ground floor of the wing and alert the doctor who was working there.

42. A doctor followed the healthcare assistant to the cell and arrived at around 12.20pm as a defibrillator was being used. The defibrillator advised staff not to shock, because there was no heart rhythm. The doctor asked staff to turn him over so that he could assess his vital signs and resuscitation could start, but there were clear signs of rigor mortis. He pronounced him dead at 12.25pm.

43. According to the incident log sheet, an ambulance was called at 12.34pm. As the man had already been pronounced dead nine minutes earlier, it was agreed with the ambulance service that no ambulance was required.

Prisoner Support

44. All prisoners who were subject to suicide monitoring arrangements were reviewed. Listeners (prisoners trained by the Samaritans to provide confidential support) were made available for those on the wing who needed extra support and members of the chaplaincy visited the wing. The Governor posted a notice following the man's death, reminding prisoners and staff of the support available to them and expressing his condolences.

Staff Support

45. After a death in custody, the Governor should ensure that a debrief is held to give staff the opportunity to talk about the incident and to offer them support. Only one member of staff interviewed by the investigator remembered attending the debrief. The duty governor said that he spoke to staff involved and noticed that they were upset so offered them reassurance and support individually. One of the operational managers at Norwich sent an email to the Governor saying that she had held a debrief, and that no concerns were raised. Despite requests, the minutes of the debrief were not given to the investigator.

46. Although there is no record that a debrief took place, all staff interviewed by the investigator said that they had been well supported after the man's death. The care team had spoken to everyone and they all knew how to get additional support if they needed it.

Family Liaison

47. An operational manager was appointed as the prison's family liaison officer. He arranged to visit the man's mother on the afternoon of 19 May, after she returned home from work. He broke the news of her son's death. He said that there had been vomit in his mouth and on his pillow. He explained that he might have choked on his own vomit, but the cause of death was unknown. (He did not choke on his own vomit, but there was vomit on the pillow.) The manager gave her his details so that she could contact him at any time.

48. Over the following week, the manager contacted the man's mother four times. He explained that the prison would contribute towards the funeral costs and arranged for her son's property to be returned to his family. He agreed to clear out her son's flat on behalf of the family, a task which falls outside the usual expected duties of a prison family liaison officer. She did not receive his property until 8 June, the day before his funeral.

Post-mortem examination and toxicology report

49. A post-mortem examination concluded that the man died from methadone excess and tracheobronchitis (a common inflammation of the lower respiratory tract).

50. A toxicology report found no alcohol in the man's blood stream, but it confirmed the presence of antihistamine, chlordiazepoxide and ibuprofen consistent with his prescribed treatment. The pathologist concluded that he had not taken an overdose of that or other medication.

51. The pathologist found the concentration of methadone in the man's blood "could be consistent with either chronic therapeutic use *or* an acute overdose of this drug prior to death". The pathologist explained that methadone can cause a depression of the respiratory system, which might have been made worse by taking chlordiazepoxide at the same time. As his lung function was already compromised by an inflamed respiratory tract, the combination of these factors caused his death.

52. The toxicology report found no evidence that the man had taken other illicit drugs, as suggested by prisoners after his death.

ISSUES

53. The local PCT appointed a clinical reviewer to review the man's clinical care at Norwich. She makes a number of recommendations about the delivery of IDTS, staffing, training and clinical leadership of the detoxification unit, and record keeping.

IDTS

54. When he first arrived at Norwich, the man was initially not prescribed methadone because his urine tested negative for opiates. When he was assessed by the doctor the next day, he was showing symptoms of withdrawal and his urine tested positive for methadone. The doctor said he had raised the matter of some inaccuracies in urine testing at reception, and established that some kits had not been used correctly. It was confirmed at interview that this matter had been resolved through the use of a different type of testing kit. The aim of IDTS is to treat alcohol and opiate withdrawal from the first evening in custody. As his urine test was negative in reception, his opiate dependence was not identified immediately and this prevented him from receiving treatment from the outset.

55. The man's family was concerned that he had his medication in his cell, and took too much. In fact, methadone and chlordiazepoxide were dispensed at the treatment hatch by nurses.

56. The man's records indicate that he was given methadone in doses of 15ml and often less than three hours apart. On one occasion, he was given 30ml. The clinical reviewer writes that he should not have been given more than 10ml of methadone at a time, and there should have been at least three hours between each dose, according to NHS local protocol for the delivery of IDTS.

57. The clinical reviewer describes monitoring of the man's withdrawal as "erratic" between 11 and 18 May. On three of the eight days he was on methadone, there was only one clinical observation in his medical record, less than required by Norwich's own IDTS policy. The toxicology report concluded that it was not possible to establish whether he had taken more methadone than he had been prescribed, or what his tolerance to methadone was. Neither is it possible to determine how he responded to methadone from his medical records, because observations were infrequent and sometimes contradictory. Despite being recorded as shivering, vomiting and having a racing pulse on the morning of 18 May, there was no clinical observation that afternoon or the next morning, 19 May.

58. The man was prescribed methadone and chlordiazepoxide to treat his withdrawal symptoms, both of which act as respiratory depressants. Such treatment requires accurate and safe dispensing and careful monitoring of prisoners' wellbeing. There was a failure to identify his needs immediately, dispense his medication in line with the local protocol, and monitor him effectively. The delivery of IDTS was therefore unsafe and we make the following recommendation:

The Governor and the healthcare provider should ensure that prisoners' substance misuse needs are appropriately identified, treated and monitored.

Staffing on the IDTS unit

59. The clinical reviewer is concerned that the number of agency nurses working on the IDTS unit led to additional pressure for permanent nurses who must train and compensate for those unfamiliar with IDTS procedures. Healthcare staff told the clinical reviewer that staffing issues meant a reduction from the required twice daily monitoring of those on the IDTS unit to prisoners being checked only once daily.

60. Nurses at Norwich do not specialise in substance misuse treatment, because the healthcare provider wants them to be a flexible resource. The lack of continuity in the IDTS workforce creates instability and lack of expertise on the unit. In its most recent annual report, the IMB reported that there was less reliance on agency staff, which had led to an improvement in the delivery of the IDTS programme. Nevertheless, the unique demands of treating withdrawal from alcohol and drugs requires expert staff and we make the following recommendation:

The Governor and the healthcare provider should ensure a dedicated team is in place to safely deliver clinical programmes for prisoners dependent on drugs and alcohol.

Medical records

61. Prison Service Order (PSO) 3050, continuity of healthcare for prisoners, instructs "efforts should be made to retrieve any information required from the prisoners GP or other relevant service he/she has recently been in contact with".

62. The man told the nurse who completed his first reception health screen his GP's contact details. Despite the confusion about his substance misuse, there is no evidence that staff contacted his GP to retrieve his records. After his death, some prisoners alleged that he said he had fabricated his symptoms in order to get methadone. His community medical records might have provided a clearer picture of his substance misuse.

63. We consider it is good practice to obtain GP records whenever possible so that healthcare staff in prisons have a full and accurate picture of a prisoner's medical history and can then refer the prisoner to any necessary secondary services. This issue was identified by our investigation into a death shortly after the man's in 2011, and the prison accepted our recommendation. His medical records should have been retrieved to confirm his medical needs.

The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners following the first reception health screen.

Officers' role on the IDTS unit

64. The man was discovered dead in May. He had rigor mortis by the time he was found, which usually sets in between two and four hours after death. During the course of the morning, an officer had tried to wake him to collect his medication, and another officer had completed the daily check of his cell. Although neither officer could be specific about the time they went to his cell, if he was alive, he must have been critically ill.

65. When Officer A tried to wake the man for his medication, he assumed that he was asleep and did not want to wake him. He told the investigator that a lot of prisoners withdrawing from alcohol or drugs have difficulty sleeping, so they are prescribed sleeping pills. It was not unusual for prisoners to sleep late in the morning. The officer had worked on the IDTS unit for two years and said that officers do not have responsibility to get a prisoner up to collect his medication.

66. Officer B did not usually work on the IDTS unit, but there was a staff shortage that morning. She said that she often carried out cell checks when prisoners were asleep in their beds. She told the investigator that the purpose of the daily check was to ensure that the cell needed no repairs and it was secure. She said that officers carrying out such checks are not responsible for checking a prisoner's welfare.

67. All prison officers are responsible for prisoners' welfare. They exercise the prison's duty of care to those in its custody. When a prisoner is undergoing detoxification, it is even more important to ensure that a prisoner is well. The clinical reviewer writes of the importance of joint working between officers and healthcare staff in the safe delivery of IDTS. It is concerning that neither officer considered it their responsibility to check the man's welfare that morning. It is not possible to determine when he died, but earlier intervention might have prevented his death.

68. It is not feasible 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 on a specialist wing where all prisoners are undergoing drug treatment, prison officers should be aware of the possibility and signs of drug-induced unconsciousness.

The Governor should ensure that officers who work with prisoners on the drug treatment wing understand their responsibility to check the welfare of prisoners receiving treatment for drug dependency, are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication, and know how to respond.

Debrief after the man's death

69. Only one member of staff remembered being involved in a debrief after the man's death. There is no record of the debrief, so the investigator was unable to confirm whether it took place, who attended and what was discussed.

70. At the time of the man's death the instructions for a prison's response to a death in custody were set out in Prison Service Order (PSO) 2710 – follow up to deaths in custody. This has now been superseded by Prison Service Instruction (PSI) 64/2011, but both documents contain a mandatory requirement for a debrief following a death in custody to be held by a senior member of staff. It is an opportunity for staff to dispel inappropriate feelings of guilt or blame and provide reassurance and support to those involved in a serious incident.

71. Although staff told the investigator they felt well-supported by the prison's care team, they did not remember attending a debrief.

The Governor should ensure that debriefing sessions are held after every death in custody.

Family liaison

72. The man's mother said she found it difficult to get in touch with the family liaison officer after his initial contact. The Prison Service sets out guidance for family liaison following a death in custody and suggests that the FLO must maintain contact with the family and provide information and support where possible. Arrangements must be made for the return of a prisoner's property.

73. The family liaison officer contacted the man's mother several times during the first few days after his death. At her request, he cleared her son's belongings from his flat, a task beyond the expectations of his role. However, he was out of the prison for over a week leading up to the funeral. Although he thought he had arranged for the property to be returned in his absence, it was not sent until he had got back to the prison and made the arrangements himself. Unfortunately, the man's mother received his possessions the day before his funeral, which caused her some distress.

74. Consideration should have been given to cover arrangements while the family liaison officer was not in the prison, to ensure that the man's mother could contact the prison in his absence.

The Governor should ensure that the prison maintains appropriate contact with a prisoner's family after a death in custody.

CONCLUSION

75. The man died because he had too much methadone, which caused his respiratory system to fail. His care was undermined by poor clinical detoxification arrangements, staff shortages and inaccurate testing equipment. Despite rumours that he had taken unprescribed medication, his post-mortem toxicology report found no evidence of any illicit substances.

76. By the time officers realised the man was dead, rigor mortis had set in. Officers had gone into his cell twice that morning, and on one of those occasions he was either dead or critically ill in bed. Officers and healthcare staff should work together to ensure detoxification arrangements are safely administered and prisoners checked appropriately.

RECOMMENDATIONS

1. The Governor and the healthcare provider should ensure that prisoners' substance misuse needs are appropriately identified, treated and monitored.

   Accepted
   The reception screening identifies areas of substance misuse history, and a referral is made to the IDTS Team. The IDTS Team are based on A Wing, which is also used for first night receptions, and anyone with substance misuse needs are assessed and treated where required. Monitoring is not always completed twice daily as per policy due to staffing issues with regards to a HCO being available to unlock prisoners. This is currently being looked into and discussions into how to adjust staffing to ensure availability of an officer on A Wing will be completed by February 2013.

2. The Governor and the healthcare provider should ensure a dedicated team is in place to deliver safely clinical programmes for prisoners dependent on drugs and alcohol.

   Accepted
   The IDTS Team very rarely uses agency staff members, and when agency is used due to severe staffing issues (i.e. sickness) they are agency staff members who have been trained on A Wing, and have had an induction including shadowing on the unit. They are also used to dispense rather than conduct observations, and work alongside permanent members of staff.

3. The Head of Healthcare should ensure that community GP records are routinely requested for all prisoners following the first reception health screen.

   Accepted
   Following reception screening, consent is gained from the prisoner to contact their GP surgery for all relevant information. If consent is given, and GP surgery is known, a consent form is signed, and an information request sent to GP via fax by the Appointments Clerk requesting all prescribing and/or medication history, any relevant medical history, and any outstanding appointments. Medication is also now provided by one local provider, rather than multiple non-local providers, which has resulted in a dramatically decreased waiting time for medications.

4. The Governor should ensure that officers who work with prisoners on the drug treatment wing understand their responsibility to check the welfare of prisoners receiving treatment for drug dependency, are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication, and know how to respond.

Accepted
Awareness Training will be provided for officers working on the Drug Treatment Wings by the Prison and Healthcare staff so that everyone working with prisoners understand their responsibilities when managing them on a daily basis. The training will cover awareness of symptoms that could confront the officers, and resources will be made available, so that they can regularly refresh their knowledge.

GNC 098/2011 will be re-issued to remind staff of their duties in line with PSI when checking prisoners on all wings during and after unlock

5. The Governor should ensure that debriefing sessions are held after every death in custody.

Accepted
Carrying out a Hot Debrief is part of the Governors duties on the Contingency Plan for deaths in Custody which is available in the "Z" Drive for all managers to use. A reminder has been sent to all Duty Managers informing them of this requirement.

6. The Governor should ensure that the prison maintains appropriate contact with a prisoner's family after a death in custody.

Accepted
All Family Liaison Officers have been reminded of their duties in line with the PSI 64/2011 Chapter 13.