PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP Northumberland, in December 2011

Report by the Prisons and Probation Ombudsman for England and Wales

January 2013

This report considers the circumstances surrounding the death of a man at HMP Northumberland. He was found collapsed in his cell in December 2011. He was 27 years old. I offer my condolences to his family and all those who knew him.

The investigation was conducted by an investigator. A review of the man's clinical care was commissioned by the local PCT and produced by a clinical reviewer. Staff at HMP Northumberland cooperated fully with the investigation. I am sorry that the report has been delayed.

The man was remanded to HMP Durham in September 2010. He had previously been prescribed medication for epilepsy and this continued in custody, although he evidently did not always take these tablets and some of his medication – which he held in possession - cannot be accounted for. He also began a methadone maintenance programme for opiate dependency. This continued after his transfer to HMP Northumberland in November 2011. In the view of the clinical reviewer, the administration of his methadone and the management of his epilepsy were both properly managed. Sadly, he suffered an epileptic seizure in December and died, despite a sustained resuscitation effort.

The investigation found that the man received a standard of healthcare during his time in custody equivalent to that which he could have expected in the community. However, it also identified some scope for improvement, including the need for officers to check on the wellbeing of prisoners when unlocking cells and the need for improved post-incident support for staff.

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.

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Prisons and Probation Ombudsman **January 2013**

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SUMMARY

1. The man was remanded to HMP Durham in September 2010. He was already prescribed Tegretol for epilepsy before he entered prison, and began a methadone maintenance programme to address opiate dependency. In March 2011, he was sentenced to four and a half years in prison.

2. He suffered epileptic episodes in October 2010, January 2011 and April 2011. He declined to attend a medical review of his condition.

3. Following his transfer to HMP Northumberland in November 2011, the man was reviewed by a nurse and a doctor. His medication, both Tegretol and methadone, continued. He was located on Houseblock 12, which primarily accommodates prisoners on drug treatment programmes.

4. On 1 December, he did not attend an appointment to review his epilepsy management. Six days later, he received a new prescription for Tegretol and took possession of a month's supply. This was standard practice because he was allowed to have his medication in his possession and take it as prescribed.

5. The man saw a doctor on 15 December. He said his daily dose of methadone was not sufficient to maintain him and that he was waking early in the mornings. His dose was increased as a result.

6. A few days later he attended a rescheduled epilepsy review appointment. He said he usually had two to four fits per month, but had not suffered any episodes since his arrival at Northumberland. He told the nurse that he sometimes forgot to take his medication. The nurse gave him a box to help him manage his medication.

7. The next morning, shortly after 7.30am, the man collected his breakfast and returned to his cell. The cell was later unlocked for him to collect his methadone but the officer who unlocked it did not see him. Shortly afterwards, at 9.20am, an officer discovered him in a collapsed state. Other members of staff attended quickly and a resuscitation effort got underway almost immediately. This continued for more than half an hour and involved officers, nurses and paramedics, though it was ultimately unsuccessful.

8. We are satisfied that the man was managed appropriately. While he should have been discovered as soon as his cell was unlocked, he was found shortly afterwards. It appears there was little that could have been done to prevent his death. We make two recommendations, about post-incident support and about the need to check prisoners when opening cells.

THE INVESTIGATION PROCESS

9. An investigator conducted the investigation. Notices about the investigation were sent to HMP Northumberland for distribution and display, giving staff and prisoners the opportunity to contact him with any relevant information. Nobody came forward in response.

10. He visited the prison on 5 January 2012. He visited areas of the prison where the man had spent time, and also collected records relating to his time in custody.

11. The investigator returned to Northumberland prison on 27 and 28 February and conducted interviews with 11 members of staff. At the time these interviews were conducted, the cause of the man's death was not known.

12. One of the Ombudsman's family liaison officers (FLOs) spoke to the man's father to explain the purpose of the investigation and provide him with an opportunity to ask any questions about the care that his son received in prison. His father wanted to know whether his son was cared for appropriately by the prison and whether his son was taking medication for epilepsy. He also sought clarity on the position in which his son was found in his cell in December.

13. The local PCT commissioned a review of the man's clinical care while in custody. This was undertaken by a clinical reviewer. The purpose of a clinical review is to determine whether the standard of medical care that a prisoner received in custody was equivalent to what might have been expected in the community. The clinical reviewer consulted the man's medical records to inform his review. He attended two interviews with the investigator and had access to all of the interview transcripts.

14. The post-mortem report was made available to our office on 16 May 2012. The delay was due to the additional toxicological analysis that was carried out in trying to determine the man's cause of death. We apologise that this, along with workload pressures in our office, has resulted in our report being delayed.

Responses to the draft report

15. As part of the consultation period, a draft version of this report was considered by the man's family, and by the National Offender Management Service (NOMS) and HMP Northumberland.

16. The response from NOMS and Northumberland was that the report was factually accurate. The two recommendations were accepted, and the response to these recommendations can be found in this report.

17. The man's family members raised a number of matters after reading the draft report, and we have responded to these in a separate letter. Most significantly:

- They remained doubtful that the man left his cell the day before his death.
- They were disappointed that information they received from the prison about the position in which he was found differs from the account in our report.
- They believe that, due to his suffering from epilepsy, he should have been located in a shared cell or closely monitored in a single cell.
- They feel that his medication should have been administered daily so that he took his tablets as prescribed.

HMP NORTHUMBERLAND

18. HMP Northumberland was formerly two separate prisons, HMP Acklington and HMP Castington. The merger of the two prisons was announced in 2010, and work began to integrate all of the functions in April 2011. On 31 October 2011, the merged prisons became known as HMP Northumberland.

19. HMP Northumberland accommodates adult male prisoners. The man was located in the area of the prison which was formerly HMP Acklington. Medical services at the prison are provided by a private healthcare company.

Her Majesty's Chief Inspectorate of Prisons

20. HMP Northumberland was inspected in June 2012 but at the time of writing the report had not been published. HMP Acklington was last inspected in 2009. The inspection team found an energised and much better managed prison than when they had inspected 18 months earlier. Concerns remained about the level of purposeful activity in the prison and the opportunity for prisoners to use their time constructively. Health services were judged to have improved and there was a practice nurse who took the lead for prisoners with life-long conditions.

Independent Monitoring Board

21. Every prison has an Independent Monitoring Board (IMB) made up of unpaid local volunteers, appointed from the local community, who monitor standards to help ensure prisoners are treated fairly and humanely. In the most recent IMB report for HMP Acklington covering the period July 2010 to December 2011 the Board reported that:

> "The period covered by this report has been a very difficult one for Acklington/Castington, but the staff have worked very hard indeed to make a success of the change that they face. The possibilities for imaginative and constructive regimes to help to reduce reoffending are legion. The IMB meets with much goodwill among the staff, with officers who work very hard at their jobs. It is to be hoped that as the future becomes clearer there will be more staff stability and the promise of the establishment may be realised."

22. In relation to healthcare, the IMB noted that there had been some difficulties as the provider of services moved from the NHS to a private healthcare provider, but were pleased to note the than an experienced healthcare manager with wide NHS and Prison Service expertise had been appointed.

Previous deaths at HMP Northumberland (Acklington site)

23. The Ombudsman's office has been responsible for investigating deaths in custody since April 2004. Before the man's death, we have investigated 15 deaths from natural causes at Acklington. None of these deaths involved epilepsy.

KEY EVENTS

24. The man was remanded to HMP Durham in September 2010. On arrival at Durham, he saw various medical professionals as part of the reception process. He had already been prescribed Tegretol, a medication used in the treatment of epilepsy. This prescription continued while he was in prison. He also began a methadone maintenance programme. Methadone is a synthetic opioid which is used medically for patients with a dependency on opiates such as heroin.

25. In March 2011, he was sentenced to four years and six months imprisonment for robbery. He remained at Durham for the initial part of his sentence, and continued to take Tegretol and methadone.

26. During his time at Durham, the man suffered a number of episodes relating to epilepsy. His medical records shows that he had fits in October 2010, January 2011 and April 2011. Following his fit in April, he declined to attend for a medical review of his condition and medication.

27. On 21 November, he was transferred to HMP Northumberland as part of his sentence progression. A nurse completed a routine reception health screening. The nurse noted on the electronic clinical record his history of drug misuse, his diagnosis of epilepsy and his medication. He was prescribed 200mg of Tegretol three times daily, and 90ml of methadone daily. The nurse referred him to see the doctor because he was prescribed methadone and to a nurse specialising in the management of chronic conditions, because of his epilepsy. Part of the health screening involved an in-possession medication risk assessment which determined that it was appropriate for him to keep Tegretol in his cell. No concerns were raised about his mood or demeanour and he said he had no thoughts of self-harm or suicide.

28. The man told staff that he believed he should not be in a cell alone due to his epilepsy. He was told that there were no shared cells and the prison had experience of managing people with the condition. The nurse also noted that he might be living on his own if he were in the community.

29. The next day, he saw a doctor. The doctor explained to the investigator that he also worked at Durham and so had previously seen him for medical appointments. The doctor continued his methadone and Tegretol at the same levels and did not raise any concerns in the electronic clinical record. He noted that he appeared stable in mood with no thoughts of self-harm. He advised him to speak to nursing staff on the wing if he felt unwell or had any problems.

30. The man was initially placed on the prison's induction wing, then moved to Houseblock 12 (also known as E wing) on 24 November. This wing primarily accommodates prisoners on methadone maintenance programmes and other forms of drug treatment.

31. On 1 December, the specialist nurse noted in the clinical record that the man had not attended for a scheduled epilepsy review. She explained during interview that chronic disease management operates in the prison in the same way as might be expected in the community, with patients offered reviews every six or twelve months depending on the nature and severity of their condition. If patients did not attend their appointments, they could re-book them, but otherwise they would be offered an appointment at the next normal reviewing point. A note was made that he would next be offered a review on 1 June 2012.

32. Six days later, on 7 December, the man collected a 28-day supply of Tegretol. This comprised 84 tablets. The medication was issued on an in-possession basis, meaning that he collected the entire 28-day supply to keep in his cell and to take as prescribed.

33. Throughout December, he continued to take 90ml of methadone daily. Unlike Tegretol, methadone is a controlled substance and so is not issued on an in-possession basis. A nurse and the team leader for substance misuse issues explained that, in order to receive methadone, prisoners attend a treatment hatch, having their identity confirmed using a fingerprint scan, and are then given their prescribed amount of methadone and supervised as it is taken.

34. On 14 December, the man told a nurse that his prescribed dose of methadone was not sufficient and said he was waking early in the mornings. He was referred to the doctor and saw her the following day. She observed that he was slightly flushed and was perspiring. She thought he was suffering mild withdrawal symptoms and increased his daily methadone dosage to 100ml. She advised him that he would need to stabilise before a programme of reducing his methadone dosage could begin. She also referred him for a routine electrocardiogram (a test to record the electrical activity of the heart), which was carried out on 19 December.

35. The man attended for a rescheduled epilepsy review with the specialist nurse on 22 December (it is not clear whether she or he rescheduled the review). During interview, she recalled the appointment and said she had no concerns about his demeanour and that he appeared quite upbeat in mood. She noted in the clinical record that he said he suffered two to four fits per month but had not had any since arriving at Northumberland. He speculated that this was due to him receiving methadone at a regular time. He again expressed concerns about being in a cell on his own. He complained of headaches and was prescribed paracetamol.

36. The specialist nurse explained during interview that the man said he sometimes forgot to take his Tegretol, and she gave him a medication box so that he could store his tablets and know whether or not he had taken them on any particular day. She went on to say that, while experiencing two to four fits per month was certainly not ideal, he had not complained of any fits since arriving at Northumberland. She explained to him that he could return to see her if he suffered any symptoms. She did not have any concerns about his

medication management, other than his admission that he sometimes forgot to take his tablets.

37. She noted in his clinical record that he would next have a review of his epilepsy on 22 June 2012, unless he presented with any symptoms before that time.

Events leading up to incident

38. Officer A completed a check one morning in December to ensure that all prisoners were accounted for. During interview, she recalled that the man appeared to be asleep in bed when she looked into his cell through the observation panel in the door. She said she did not see anything to give her cause for concern.

39. Shortly after the morning roll count, the cells are unlocked so that prisoners can collect their breakfast from a servery area on the wing. A Senior Officer (SO) recalled speaking to the man as he collected his breakfast and said he had no reason at that point to think anything was wrong. He returned to his cell. Cells on the wing were locked while prisoners ate their breakfast.

40. During interview, the SO explained that employed prisoners were unlocked to collect their methadone and then start work in other areas of the prison. After this, other prisoners on the wing were unlocked to collect their methadone. Two officers were responsible for unlocking the cells. Officer B said she personally spoke to all of the prisoners whose cells she unlocked. The other officer, who unlocked the cell, called to each prisoner that they were being unlocked for their methadone, but did not look in the cells.

41. As the man did not come to the dispensing hatch Officer B went to his cell to check. She described what she saw as follows:

> "I found him with his legs still on the bed. His feet were tangled in the bedding, body was mid air and his head was in a metal cell bin on the floor with his arms flopped at the side. His whole body weight was resting on the bin which was pressed against his neck. His feet were at the window and his head was facing towards the door and the room was dark."

42. She said it was immediately obvious from his appearance that something was wrong. She used her radio to relay a 'code blue' message. This is a specific radio call sign indicating a serious medical emergency, usually involving breathing difficulties or asphyxiation. The time of the radio message was 9.20am.

The emergency response

43. The SO and two officers were in the wing office when they heard the radio message. Although Officer B had said that emergency assistance was required on Houseblock 12, she had not specified the landing. She had, however, gone to the end of the landing to attract the attention of other

members of staff as she was aware that she would not be able to move the man by herself.

44. Officer A arrived at the cell first, closely followed by the SO. He estimated that they arrived no more than 30 seconds after the radio message. Officer A left the cell and relayed a further radio message, giving specific details about the cell, and reiterating that medical assistance was required. Meanwhile, the SO and Officer B moved the man from the bed to the cell floor. After checking for signs of life, the SO began chest compressions as part of cardio-pulmonary resuscitation (CPR). Both the SO and Officer A said he appeared blue in colour. The officer gave the SO a mouth guard so that he could administer rescue breaths. Another officer began to lock other prisoners in their cells.

45. Nurse A was based at the treatment hatch between Houseblocks 12 and 13 with his colleague. They heard the initial radio call over a colleague's radio and responded after locking the treatment hatch, taking emergency equipment including oxygen and a defibrillator (a piece of medical equipment designed to administer an electric shock to a patient if required). He estimated that they arrived around two minutes after the radio message. He told the investigator that when he arrived, the SO was carrying out chest compressions. He began to attach the defibrillator pads to the man's chest when more medical personnel arrived.

46. Nurse B was in the prison's reception area when he received the radio call. As the emergency responder, he went immediately to Houseblock 12 and took over the chest compressions. Two more nurses also arrived and began to administer oxygen. Nurse A gave the man an injection of naloxone, a drug used to counteract an opiate overdose. The cause of his collapse was not known at that point, though it was known that he was on the methadone maintenance programme. (While the drug would counteract an opiate overdose, it was unlikely to have any harmful effect if the collapse was caused by something else.)

47. Nurses A and B left the cell, and two other nurses continued with chest compressions and oxygen. The defibrillator did not indicate that a shock was required at any point.

48. Another nurse had telephoned the healthcare unit to inform them that the emergency involved a patient who was prescribed methadone. Two more nurses and a doctor arrived at the cell shortly afterwards, and one of the nurses then assisted with the CPR effort.

49. While performing CPR, the specialist nurse realised that she had seen the man the previous day for an epilepsy review. She asked a colleague to check the cupboards for medication, but there were only empty Tegretol packets. If he had been taking his medication as prescribed, he should have had at least 36 tablets remaining. The three nurses continued to perform CPR.

50. The Ambulance Service recorded a 999 call at 9.22am. The ambulance arrived at the prison at 9.37am, and paramedics were with the man at 9.39am. The paramedics continued to perform CPR until 9.53am, when they stopped as there had been no response from him and he was pronounced dead.

Events after the man's death

51. The established procedures following a death in prison custody were, for the most part, followed, although a 'hot debrief' – a meeting involving all the members of staff involved in the emergency response – did not take place.

52. Prisoners on Houseblock 12 assembled in a communal area of the wing and were told of the man's death. A written notice was issued to all other prisoners and to staff. Prisoners subject to self-harm and suicide monitoring were reviewed.

53. A family liaison officer (FLO) and one of the governors visited the man's mother at home on the morning of the incident to inform her of his death. The FLO and another FLO completed further visits and attended the funeral.

54. A post-mortem examination took place on 24 December 2011. Further toxicological analysis was conducted on 10 February 2012, and the post-mortem report was completed on 3 May. The toxicological analysis found that the quantity of methadone in the man's blood was consistent with his daily dose, but there was no Tegretol present. The forensic scientist concluded that he had not taken Tegretol for at least 12 hours before his death. Although he should have had at least 36 tablets remaining and none were found in his cell, he had not taken them. The forensic pathologist concluded that death was caused by epilepsy, "most likely as the result of a seizure causing him to partially fall out of bed leading to respiratory compromise above and beyond that already experienced during an epileptic seizure".

ISSUES

The management of the man's epilepsy

55. Northumberland operates a reviewing schedule for chronic conditions in the same way as in the community. The normal review schedule for the management of the man's epilepsy was twice yearly. He did not attend for an appointment on 1 December, although he did attend on 22 December.

56. The man told the specialist nurse that he experienced two to four fits per month, indicating that his epilepsy was not well controlled. However, he also said he had not suffered any fits since arriving at Northumberland one month earlier. She was satisfied that, on the information he provided, his epilepsy was being managed properly. During interview, she gave a comprehensive account of the way in which chronic conditions are managed at the prison in the same way as is expected in a community setting.

57. During the review, the man repeated a concern that he had expressed when he first arrived at Northumberland prison, saying that he should not be in a cell alone. However, Northumberland provides only single cell accommodation, so that was not possible. In any event a medical condition such as epilepsy would not by itself be a sufficient reason for precluding sole cell occupancy. Even in a double cell there would be many occasions when a prisoner would be left alone.

58. The man was prescribed Tegretol for his epilepsy before his imprisonment. This medication continued during his time at HMP Durham and at HMP Northumberland and was reviewed during the reception processes at both prisons.

59. He received a 28-day supply of his medication. It is normal for prisoners to receive medications in this way, unless the substance is controlled or the prisoner poses an identified risk.

60. There is no explanation why he had only empty Tegretol packets in his cell at the time of his death. He had not taken the medication shortly before his death and should have had 36 tablets remaining. He had told the specialist nurse that he sometimes forgot to take his medication, and she gave him a medication box to assist with this. However, this was also empty when recovered on the day of his death.

61. The investigator has established that there was no security information concerning the man and the use of his medication, or about him being bullied. However, some epilepsy prescriptions are known to be traded illicitly in prison and the community. It is not clear whether Tegretol has any such value but the possibility cannot be discounted.

62. Overall, the clinical reviewer concluded that "the clinical nursing management of the man's epilepsy was appropriately provided".

Methadone maintenance

63. The man was prescribed methadone at Durham and this continued during his time at Northumberland. The team leader explained the process for correctly identifying prisoners, ensuring that they are given the prescribed dose, and checking that they take it at the treatment hatch.

64. There were no concerns in relation to the administration of the man's methadone. He was able to attend the treatment area and collect his medication daily. When he said that his prescribed dose was not maintaining him properly, he saw a doctor and the issue was addressed.

65. While we are surprised that he continued to be maintained on methadone, and at such a high dose, so long into quite a lengthy sentence, the post-mortem report indicated that methadone was not a contributory factor in his death. The clinical reviewer had no concerns, concluding that the methadone maintenance was appropriately provided.

The emergency response

66. The man was not immediately discovered when his cell was unlocked for the collection of his methadone, because the officer responsible did not look into the cell. The morning roll count had been completed without incident, and he had been seen outside his cell collecting his breakfast. However, for their own safety, officers are supposed to talk and make contact with a prisoner through the observation hatch before opening a locked cell door. This is a security precaution, in case the prisoner is waiting to assault them. It is also supposed to be a check on the prisoner's wellbeing.

The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

67. When Officer B discovered the man, she immediately raised the alarm by relaying a 'code blue' message over the radio. Although she specified that assistance was required on Houseblock 12, she did not mention the landing or the cell number. However, this did not delay the emergency response, and another officer quickly relayed a further message with more specific details about the location of the emergency.

68. The response from members of staff was swift, with medical personnel arriving quickly. The CPR effort began quickly and continued until paramedics took over. Emergency medical equipment was taken to the cell promptly and used appropriately, and emergency services were called, and responded, appropriately.

Events following the man's death

69. Although the contingency plan was, for the most part, followed, a 'hot debrief' did not take place. Such a debrief provides a forum for the members of staff involved to reflect on the incident, for questions to be asked and answered, and for mutual support. It is part of the contingency plan for all prisons and should take place.

70. During interview, some members of staff said they felt well supported, but others did not. A number of staff members felt there was an expectation that they would simply continue with their shifts and their normal work despite having witnessed and been involved in a serious and traumatic incident.

The Governor should ensure that a same-day debrief takes place following a death in the prison and that staff involved are appropriately supported.

CONCLUSION

71. The man arrived at HMP Northumberland on 21 November 2011. He was already prescribed Tegretol for epilepsy and was on a maintenance methadone programme. These interventions continued.

72. The administration of the methadone and the management of his epilepsy were appropriate. He reported that he had not experienced any fits during his time at Northumberland and a review of his condition took place the very day before his death.

73. He was found collapsed in his cell one morning in December. He had already left his cell earlier that morning to collect his breakfast. The officer who unlocked his cell did not check on him but he was discovered shortly after and there was a swift response from members of staff. Resuscitation was attempted for more than 30 minutes but sadly it was unsuccessful. A post-mortem report concluded that an epileptic seizure caused his death.

74. One of our recommendations is to help ensure that members of staff at HMP Northumberland are properly debriefed and supported following traumatic and upsetting incidents. The other recommendation identifies the need for officers to check on prisoners when unlocking cells. In this case he was found very shortly after his cell was unlocked. In other cases identifying an emergency situation immediately could save a life.

RECOMMENDATIONS

1. The Governor should ensure that when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   The recommendation was accepted. A notice to staff will be issued to ensure that members of staff observe prisoners when unlocking cell doors.

2. The Governor should ensure that a same-day debrief takes place following a death in the prison and that staff involved are appropriately supported.

   The recommendation was accepted. The contingency plan was updated to include the debrief as part of the checklist of actions to be completed.