A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the circumstances surrounding the death of a man at HMP Preston in July 2012

Our Vision

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

This is a report into the death of a man at HMP Preston in July 2012. He collapsed and died in his cell in the early hours of the morning. He was 28 years old. A post-mortem examination found that his death was caused by bronchopneumonia. I offer my condolences to his family and friends.

A clinical review was carried out of the man's medical care at Preston. The prison cooperated fully with the investigation.

The man was remanded to HMP Preston on 18 July. He was prescribed methadone in the community but also used heroin. He had prescriptions for other medications, including pregabalin, an anti-epilepsy medication, which is also used for certain types of pain relief. On his first night in custody, he saw the substance misuse team and was given a maintenance dose of methadone. The next day, his medications were confirmed and his prescriptions were continued. He was given an increasing daily dose of methadone between 19 and 21 July.

Shortly after 5.00am on 22 July, the man collapsed in his cell. The emergency response was swift and resuscitation was attempted, but was ultimately unsuccessful. A toxicology report found that traces of drugs in his body were consistent with the levels that he had been prescribed. The pathologist concluded that these drugs were not a causal factor in his death.

The clinical reviewer considers that the man's clinical care was appropriate and equivalent to that he could have expected in the community. Nevertheless, the report makes recommendations aimed at improving healthcare record keeping and ensuring caution in prescribing sedatives alongside methadone. Sadly, it does not appear that his death could reasonably have been foreseen or prevented.

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 **October 2013**

CONTENTS

Summary

The investigation process

HMP Preston

Key events

Issues

Recommendations

SUMMARY

1. The man was remanded to HMP Preston on 18 July 2012. At a reception health screen, he told the nurse that he had used cannabis and heroin within the past month, but did not use drugs intravenously. He reported difficulty walking on his right leg because of swelling to his knee. He said that he was prescribed methadone (a synthetic opiate used in the treatment of heroin dependency), pregabalin (an anti-epilepsy medication also used in the treatment of neuropathic pain), tramadol (a pain relief medication) and amytriptyline (an antidepressant).

2. A substance misuse nurse assessed the man and indicated he had moderate withdrawal symptoms from drugs for which a doctor prescribed 10ml of methadone for his first night. He was allocated a shared cell on C wing, the drug dependency unit.

3. The next day, 19 July, a nurse completed a more comprehensive medical assessment. The man said he had been smoking 9-10 bags of heroin daily in the community and had last used heroin on 17 July. He said he was prescribed 28ml of methadone daily and that this was due to rise to 40ml. At interview, the nurse said that he looked flushed, with flu-like symptoms, and that his clothes were saturated with perspiration which he attributed to withdrawal from drugs. The nurse drew up a recovery plan, and confirmed his medications with his community GP and drug team.

4. On 20 July, a nurse completed blood pressure and temperature checks when the man had a slightly high temperature. A doctor prescribed pain relief medication for his knee. On the afternoon of 21 July, he attended the treatment hatch on the drug dependency unit to receive his daily dose of methadone. The nurse noticed that he did not look well and later recalled that he was perspiring heavily and "puffing and panting". A doctor saw him, who said he felt tired and light-headed. On examination, he appeared weak and sleepy, and his speech was slightly slurred. His pupils were small but not pin point. He was able to walk. The doctor thought he might be over-sedated with medication. The immediate plan was to omit his dose of tramadol that night and to reassess him the next morning.

5. CCTV coverage shows that around 5.00am the next day, the man grabbed the bin in the cell and appeared to vomit into it. He then passed urine and sat on the bed. Shortly after sitting on the bed, he got up quickly and appeared to be retching. He fell backwards and hit his head on a chair. He sat up two minutes later and then collapsed. Alerted by the noise, prison officers went to his cell and two nurses were summoned. They could not obtain a response from him and an ambulance was requested. Efforts to resuscitate him continued till 5.40am but were unsuccessful. A post-mortem report concluded that he died from bronchopneumonia.

6. The investigation has covered the man's drug treatment, his undiagnosed bronchopneumonia, and the emergency response. We make two recommendations about record keeping and prescribing sedatives alongside methadone.

THE INVESTIGATION PROCESS

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

8. The investigator spoke to representatives of the prison's senior management and visited HMP Preston and met various members of staff. He saw the wing where the man lived, and collected records of his time in prison. He interviewed members of prison staff and the man's cellmate.

9. One of the Ombudsman's family liaison officers (FLOs) contacted the man's family to let them know about the investigation and invited them to identify issues they wished the investigation to consider. The man's mother said that she was satisfied with the prison's treatment of her son.

10. The local Primary Care Trust (PCT) commissioned a clinical reviewer to conduct a review of the man's clinical care in custody. She consulted his medical records and attended two interviews with the investigator. She also interviewed one of the prison doctors.

11. Her Majesty's Coroner provided a copy of the post-mortem report. A copy of this report has been sent to the Coroner.

HMP PRESTON

12. HMP Preston is a local prison holding up to 842 remanded, unsentenced and convicted adult male prisoners. Healthcare is provided by Lancashire Care Foundation Trust. The Independent Drug Treatment Strategy (IDTS) for substance misuse treatment is provided by Greater Manchester West Mental Health NHS Foundation Trust. The healthcare unit has inpatient facilities which are used as a regional facility for up to 30 prisoners with mental and physical health problems. There is a full-time doctor between 9.00am and 5.00pm Monday to Friday. Between 5.00pm and 8.00pm there is a doctor in the prison's reception area and at night and weekends there is on-call cover.

Previous deaths at Preston

13. There have been 11 deaths at Preston since 2007. None of the circumstances of the previous investigations are similar to those in this case.

Her Majesty's Inspectorate of Prisons report

14. HM Inspectorate of Prisons made an unannounced short follow up inspection of Preston in April 2012. Inspectors noted that an appropriate range of health services were provided, primary care services had improved and inpatient services were satisfactory, with an improved regime for the prisoners there. They also noted that the integrated drug treatment programme (IDTS) had been fully implemented and was running well.

Independent Monitoring Board (IMB)

15. Every prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who monitor standards to help ensure that prisoners are treated fairly and humanely. In the Preston IMB's annual report covering the period 1 April 2011 to 31 March 2012, the IMB noted that there was an ongoing staff shortage in healthcare. They did not comment on the IDTS programme.

KEY EVENTS

16. The man arrived at HMP Preston on the evening of 18 July 2012 after being remanded in custody for a charge of burglary. A nurse carried out a routine health screen when he told her that he had used cannabis and heroin in the past month, but did not use drugs intravenously. He said he had difficulty walking on his right leg because of swelling to his knee. He had attended hospital earlier that day and had been prescribed co-codamol for pain relief. No further treatment had been given. He said that in the community he was prescribed methadone (an opiate used in the treatment of heroin dependency), pregabalin (an anti-epilepsy medication also used in the treatment of neuropathic pain), tramadol (a pain relief medication) and amytriptyline (an antidepressant). The nurse referred him to the prison's drug treatment team, because of his reported drug use and drug treatment in the community, and because she had concerns about his physical appearance.

17. A nurse from the prison's drug treatment team saw the man the same evening. He provided a urine sample which was positive for methadone, opiates and benzodiazepines. The nurse also completed the clinical opiate withdrawal scale (COWS), a standardised assessment to indicate whether a person is suffering from opiate withdrawal and, if so, to what extent. The results of the assessment are used to decide the appropriate medical treatment so that withdrawal symptoms can be managed. He scored 14 on the scale, indicating moderate withdrawal.

18. The nurse explained that those who score more than 12 will usually be prescribed 10ml of methadone for the first night to help stabilise the patient without the risk of over-sedation. The man told a doctor that he was usually prescribed 40ml of methadone daily and had last taken his prescribed dose two days earlier. The doctor prescribed 10ml of methadone and noted in the clinical record that he would begin methadone titration (an increasing daily dose) up to 40ml. The doctor also examined his knee. He noted a restricted range of movement but did not prescribe any treatment. He was allocated a shared cell on C wing, the drug dependency unit.

19. The next day, 19 July, the nurse completed a more comprehensive medical assessment. The man told the nurse that, other than gastrointestinal problems that had been treated with medication, he did not have any physical health issues. He had previously undergone surgery for a fractured tibia and received pain relief medication. He said he experienced sleep problems, lack of energy and had been diagnosed with depression and anxiety. He said he had been smoking 9-10 bags of heroin daily in the community and had last used heroin on 17 July. He said he did not use benzodiazepines. The nurse noted that he had tested positive for benzodiazepines and suggested that they might have been used as a cutting agent in the heroin that he had used. He said he was prescribed 28ml of methadone daily and that this was due to rise to 40ml. The nurse explained that he would confirm this with the Community Drugs Team (CDT), and confirm his other prescribed medication with his community GP.

20. The nurse completed another COWS, and the man scored 16, indicating moderate withdrawal. The nurse also noted that he was perspiring heavily.

During interview, the nurse said that the man looked flushed with flu-like symptoms and that his clothes were saturated with perspiration, which he attributed to withdrawal from drugs. He was given a change of clothes. The nurse drew up a recovery plan, which included monitoring him for signs of withdrawal, monitoring his blood pressure twice daily for five days, confirming his prescription medication, including methadone, referring him to the CARAT service, and completing a review after 13 weeks.

21. Later the same day, the nurse received confirmation of the man's medication from his GP, and of his methadone prescription from his community drugs team. It was confirmed that he was prescribed 28ml of methadone and that his dose was due to increase to 40ml. A doctor noted in his clinical record that he could therefore receive 25ml of methadone that day (19 July), 35ml on 20 July, and 40ml thereafter. He received 25ml of methadone on the afternoon of 19 July.

22. On the morning of 20 July, the man saw a nurse, who completed blood pressure and temperature checks. His temperature was recorded as 37.8C on the first reading and 36.9C on the second. (The commonly accepted standard core body temperature is 37C.) He told the nurse that he felt better, but was finding it difficult to move around on the wing. As a result, he saw a doctor, who noted that the swelling to his knee was slightly improved. He prescribed omeprazole and paracetamol for pain relief, and said he would review him in two weeks. He received his prescribed dose of methadone on 20 July.

23. On the afternoon of 21 July, the man attended the treatment hatch on the drug dependency unit to receive his daily dose of methadone. The nurse who was responsible for dispensing the methadone that day noticed that he did not look well. He recalled during interview that he was perspiring heavily and "puffing and panting". The nurse therefore asked a doctor, who was on duty at the time, to see him immediately.

24. The doctor noted that the man said felt tired and light-headed. He explained that he had experienced a break in his prescribed medication and had been receiving it again only from 19 July. He said he had not taken any substances other than his prescribed medication. When examined, he appeared weak and sleepy and his speech was slightly slurred. His pupils were small but not pin point. He was able to walk. His blood pressure was recorded as 88/60 with a heart rate of 88bpm. The doctor thought he might be over-sedated with medication. The immediate plan was to omit his dose of tramadol that night and to reassess him the next morning.

25. During an interview with the clinical reviewer, the doctor said he was not aware at the time of examining the man that his temperature on 20 July had been recorded as 37.8C. He said that, even if he had been in possession of this information, he would not have been unduly concerned as it was only slightly raised. He said the man did not appear breathless and did not complain of breathing problems; he mostly complained that he felt tired.

Events of the incident

26. The cellmate, who had shared a cell with the man since he arrived on 18 July, did not recall anything unusual about the evening of 21 July. He told the investigator that since the man arrived, he had not eaten very much and had slept a lot.

27. Around 5.00am, the man grabbed the bin in the cell and appeared to vomit into it. This was captured on CCTV. (His cell happened to have CCTV coverage but he was not allocated the cell because of any identified risk.) He then went to the toilet and urinated and returned and sat on the bed. The cellmate recalled that he turned over and saw that he was up and heading towards the toilet, so he turned back over. Shortly after sitting on the bed, he got up quickly and appeared to be retching. He fell backwards and hit his head on a chair. He sat up two minutes later and then collapsed. The cellmate said he was alerted by a banging sound and when he turned over, saw that he was on the floor.

28. An officer and a Senior Officer (SO) came in response to the noise and went into the cell. Medical assistance was requested over the radio at 5.12am and the cellmate was taken to another cell. Two nurses attended with emergency medical equipment. Nurse A recalled that the man was on the floor of the cell with his head underneath the bed. She initially tried to obtain a verbal response and then checked for signs of life. An ambulance was requested at 5.22am. Both nurses began cardiopulmonary resuscitation (CPR), with Nurse A performing chest compressions and Nurse B administering oxygen and checking for signs of life. A defibrillator (a piece of medical equipment that assesses the electrical activity in a patient's heart and delivers an electric shock if appropriate) was brought to the cell. Nurse A attached the defibrillator but it did not detect a shockable heart rhythm. The nurses continued with CPR.

29. Paramedics arrived at the prison at 5.32am and assessed the man using their own equipment. They were unable to obtain any response, and resuscitation efforts ceased at 5.40am.

Events after the man's death

30. One of the operational managers at Preston told the investigator that all prisoners subject to self-harm and suicide monitoring were reviewed following the man's death. Specific support was made available for his cellmate and other prisoners on the unit.

31. A family liaison officer and a prison chaplain went to the man's mother's house at 8.30am the same day to inform his family that he had died. Although there was a short delay as it appeared that nobody was at home, they were able to deliver the news. The family members subsequently visited the prison. The prison contributed to the funeral expenses in line with national policy.

32. A post-mortem examination took place on 23 July 2012. Toxicological analysis was also carried out to determine the concentration of various drugs

in the man’s body at the time of his death. A forensic pathologist recorded that:

> “The autopsy revealed heavily consolidated lungs with abscess formation in the right upper lobe. Histological examination of sections taken from the lungs confirmed the presence of confluent bronchopneumonia with microabcess formation. Bronchopneumonia is a very serious condition of the lungs and it accounted for his death.”

33. She went on to report that tramadol, amytriptyline, omeprazole and methadone were present in the man’s blood, in quantities consistent with his prescriptions. There was also evidence of prior use of paracetamol and codeine, possibly indicating use of co-codamol. She concluded that “neither in combination or alone did any of these drugs play a significant role in the fatal outcome”.

ISSUES

Drug treatment

34. The man arrived at HMP Preston on 18 July. He had a reception health screening, and was subsequently seen by a substance misuse nurse and a GP. He was assessed for withdrawal symptoms in accordance with the Greater Manchester West Mental Health NHS Foundation Trust procedures, and also prescribed methadone in accordance with these procedures.

35. On 19 July, the man underwent a further more detailed assessment and a treatment plan was drawn up. A nurse confirmed his prescribed medication, and this was continued. He also confirmed that the man was prescribed 28ml of methadone daily and that this was due to rise to 40ml. His treatment plan in prison involved him receiving 25ml, 35ml and then 40ml of methadone over the next three days. This was administered as planned.

36. The man's temperature and blood pressure were taken twice daily. This is standard procedure for the first five days of a prisoner entering drug treatment. However, the records for this are paper-based rather than electronic, so not all of these observations were available in the electronic clinical record. When a prison doctor saw him on 21 July, he was therefore not aware that he had recorded a slightly raised temperature on the previous day. In her clinical review, the clinical reviewer made two recommendations. In the first of these she recommends that the Head of Healthcare ensures that paper records are kept in line with Nursing and Midwifery Council guidelines. In the second, which we endorse and repeat in this report, she recommends that the substance misuse team record all information electronically in order to ensure access to the information for all health professionals. While a prison doctor has told us that even if he had been aware of this information, he would not have acted any differently, it could be important in other circumstances. We therefore make the following recommendation:

    The Head of Healthcare should ensure that the substance misuse team record information electronically to allow the wider health team to be fully informed when treating prisoners.

37. The man was prescribed pregabalin, a medication that substance misuse doctors acknowledge is associated with abuse and addiction, particularly among opiate-dependent patients. It is used for neuropathic pain but can amplify the effects of opiate drugs, has diazepam-type effects, and can cause euphoria in some patients. As a result, many patients have learned to describe 'shooting pains' or 'electric shocks' in order to obtain prescriptions for pregabalin.

38. The man was not prescribed pregabalin at Preston without checks being made. His prescription records were sought and it was confirmed that he was prescribed the medication in the community. Indeed, he had been in receipt of pregabalin for some time and the clinical reviewer noted in her clinical review that, had medical staff at Preston decided to withdraw this prescription, the safest course of action would have been a reducing dose.

39. There is no indication that pregabalin was a factor in the man's death, and the post-mortem report specifically stated that medication was not a causal factor. Nevertheless, the clinical reviewer cautions against its use with other sedative drugs and notes that healthcare staff should be aware of its significant abuse potential. Decisions about prescribing pregabalin should be properly documented, particularly in the case of substance misuse patients and those prescribed other depressant medication. We therefore make the following recommendation:

The Head of Healthcare should ensure that clinicians are aware of the risks associated with prescribing pregabalin with other sedating drugs and that its use should be avoided where possible in patients with a history of drug misuse.

Bronchopneumonia

40. The man was not diagnosed with bronchopneumonia while at Preston, though it was this condition that caused his death. Symptoms of bronchopneumonia include loss of appetite, cough, chest congestion, coughing up thick mucus, chest pain, fever, chills, sore throat, nausea, vomiting, hiccups, weakness or fatigue, headache, and rapid breathing rates.

41. On 19 July, a nurse noted that the man was perspiring heavily. The clinical reviewer wrote in her clinical review that this is an indicator of drug withdrawal but could also be a symptom of pneumonia. When he saw a doctor on 21 July, he appeared weak and sleepy, and said he felt light-headed. Excessive sleepiness and lethargy can be a symptom of severe pneumonia, though it can also be caused by over-sedation as a result of medication. The clinical reviewer noted that, in this case, there were no other symptoms or indicators to suggest a cause other than over-sedation. There is nothing in his medical record to indicate that he complained of, for example, chest pain, shortness of breath, chest congestion or a cough. His temperature, when taken on 20 July, was only slightly above normal and would not by itself be a cause for concern.

42. The man's cellmate reported during interview with the investigator that the man was not eating properly. Loss of appetite can be a symptom of bronchopneumonia, but medical staff were not aware that he was not eating properly, and there is no record that he mentioned it to them. His cellmate also recalled that he slept a lot.

43. The clinical reviewer concluded that:

> "He received satisfactory, equivalent and appropriate healthcare from HMP Preston's healthcare department. I do not believe that his death could have been prevented by any changes in the care he received."

Emergency response

44. Staff on the unit were alerted that something was wrong by the noise from the man's cell. Medical assistance was summoned and arrived quickly. The ambulance was called around ten minutes after the alarm was initially raised, due to the fact that the severity of the incident was not immediately known. The ambulance arrived at the prison 11 minutes after being requested by the nurses in his cell. Despite the quick response, he showed no signs of life and attempts at resuscitation ceased at 5.40am. It does not appear that anything further could have been done to change the outcome.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that the substance misuse team record information electronically to allow the wider health team to be fully informed when treating prisoners.

2. The Head of Healthcare should ensure that clinicians are aware of the risks associated with prescribing pregabalin with other sedating drugs and that its use should be avoided where possible in patients with a history of drug misuse.

NOMS response and action plan

No	Recommendation	Accepted/Partially accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
	The Head of Healthcare should ensure that the substance misuse team record information electronically to allow the wider health team to be fully informed when treating prisoners.	Accepted	The Head of Healthcare has shared this PPO report with Greater Manchester West and for them to implement any actions relating to their service delivery. *Update @ 12.03.13 from GMW:* *All observations will be recorded on SystmOne with immediate effect; hence they will be visible to all healthcare staff.* *All new prisoners on DDU are required to have their observations recorded for the first 5 days, as per the original agreement LCFT nurses are responsible for those required at night.*	LCFT completed GMW awaiting response	
2	The Head of Healthcare should ensure that clinicians are aware of the risks associated with prescribing pregabalin with other sedating drugs and that its use should be avoided where possible in patients with a history of drug misuse.	Accepted	LCFT do not commence any prisoner on pregabalin or gabapentin. We continue inline with community prescribing with an aim to reduce these medications. Patients located on C1 are seen and assessed by GMW ITDS substance misuse specialists this action needs to be a shared action with GMW LCFT can provide assurance that this is the procedure for them however awaiting confirmation that GMW are compliant.	LCFT completed GMW awaiting response	