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

Report by the Prisons and Probation Ombudsman for England and Wales

March 2012

This is the report of an investigation into the death of a man. He was found slumped in his bed at HMP Durham in May 2011. He had been recalled to prison just three days earlier. He was 22 years of age at the time of his death.

I extend my condolences to the man's family. I hope that my report goes some way to answering any questions they may have.

The investigation into the man's death was undertaken by a senior investigator from this office. In addition, a clinical review was conducted by a clinical reviewer on behalf of the local Primary Care Trust (PCT). I am grateful to the Governor and staff of HMP Durham for their co-operation with the investigation.

The man arrived at Durham just three weeks after having been released from HMP Acklington on licence. He told clinicians that he had been taking illicitly obtained buprenorphine, used to treat withdrawal from heroin, while on release and had been drinking heavily. He was subsequently treated for substance misuse. During his fourth night in custody, he died in his cell while watching television.

The post mortem into the man's death concludes that he died from pneumonia. However, the clinical review undertaken by the clinical reviewer raises a number of serious concerns with regard to the detoxification treatments provided to him while at Durham. In particular, she finds that his healthcare was not equitable with that he would have received in the community and that there may have been a link between his detoxification regime and his death. The report also identifies weaknesses in staffing levels and staff training which the prison needs to address, and sets out a number of recommendations to support this improvement process. A further recommendation addresses required improvements in the emergency response by staff on the discovery of him.

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
Prison and Probation Ombudsman **March 2012**

CONTENTS

SUMMARY

1. The man was released from HMP Acklington on licence on 21 April 2011. (A licence sets rules and guidance to which a prisoner must adhere to whilst living in the community. The licence is supervised by the Probation Service.) Having breached the terms of his licence, he was recalled into the custody of HMP Durham on 13 May. He told the reception nurse that he drank excessive amounts of alcohol on a weekly basis, and used illegal drugs. Later that day, he told one of the prison doctors that he had recently attended a drug clinic. He explained that he was not receiving any treatment, but he had been using 'street' Subutex (buprenorphine) along with cocaine and cannabis.

2. The man's urine tested positive for buprenorphine (Subutex). The doctor observed no acute withdrawal symptoms. Nevertheless, with his consent, the doctor prescribed both opiate and alcohol detoxification treatments. That evening, he started a standard detoxification regime, a low dose of methadone for his substance misuse and chlordiazepoxide to assist with the effects of alcohol withdrawal.

3. Over the following days, the man's methadone prescription was gradually increased in line with the standard detoxification regime. He was observed for signs of withdrawal by healthcare staff on a number of occasions. On 16 May, he was seen by another of the prison's doctors. He complained of stomach cramps, vomiting and feeling sweaty but the doctor observed that he seemed comfortable and alert at the time of his assessment. The doctor advised him to contact healthcare staff if he felt unwell.

4. On the evening of 16 May, the man told a prisoner in the cell next to his that he felt unwell and that he did not take heroin out of prison. The prisoner said that he told him that he felt 'horrible' and that he had only said yes to the methadone treatment offered in order to 'get through his sentence'.

5. In the early hours of the following day, the man was discovered by an officer. Unable to solicit a response, the officer sought urgent assistance from other members of staff, including the duty nurse. They entered his cell and the nurse checked for signs of life but there were none. Cardio pulmonary resuscitation (CPR) was not attempted.

6. This report into the man's death makes a number of recommendations about his detoxification, and one further recommendation about the emergency response.

THE INVESTIGATION PROCESS

7. A senior investigator from this office was appointed to conduct the investigation into the circumstances surrounding the man's death. He visited the prison on 1 to 2 June and 19 July to conduct a number of interviews with staff. He also spoke with the prisoner to whom the man had complained of feeling unwell the evening before his death. The investigator met with a representative from the prison's Independent Monitoring Board (IMB) and offered to meet with representatives of the Prison Officers Association (POA). (IMB members are independent and unpaid. They monitor day to day life in the prison to ensure that proper standards of care and decency are maintained. The POA is the trade union for prison officers.)

8. Notices announcing the investigation and its terms of reference were issued to both staff and prisoners at Durham. The notices were displayed around the prison and invited staff and prisoners to contact the investigator with any information relevant to the investigation. No one came forward to speak with the investigator.

9. The investigator was shown the cell in which the man spent the last days of his life. The investigator reviewed his prison and health records, and other documentation relating to the time that he spent at Durham. During the course of the investigation he provided verbal feedback to the Governor of Durham, which he later confirmed in writing.

10. A clinical review was commissioned from the local Primary Care Trust (PCT). A clinical reviewer completed this on behalf of the PCT and accompanied the investigator during some of the interviews with healthcare staff.

11. The investigator also liaised with a Detective Sergeant (DS) from Durham Constabulary. The DS kindly provided information to assist his investigation. The investigator has also been in contact with the Coroner's Office and a copy of this report will be sent to the Coroner to assist him with his enquiries.

12. One of the office's family liaison officers contacted the man's family to inform them of the Ombudsman's role and investigation. He invited them to raise any concerns or questions about the man's time in custody that they wished to be addressed as part of this process. The man's mother had one issue, asking why her son was given methadone whilst in prison. I trust that our report answers these and any other questions that the family may have.

13. In response to the draft report the man's family commented that they found the report very helpful and informative and that in reading it they felt that the most significant finding was that the lack of doctors at weekends, they felt, represented neglect on behalf of the prison.

HMP DURHAM

14. HMP Durham is a local prison built in the early 19th Century. It serves courts in the North East of England and holds just under 1,000 prisoners. The prison consists of seven wings as well as a segregation and healthcare unit. As with all local prisons, it is under constant pressure to accommodate the large numbers of prisoners that make up its ever-changing population.

Integrated Drug Treatment System (IDTS)

15. Integrated Drug Treatment System (IDTS) is an initiative that aims to improve and increase the volume and quality of clinical treatments for substance misuse available to prisoners. Its aim is to ensure that professionals work together in the coordination of a prisoner's care, with particular emphasis on the first 28 days of their custodial experience. This is achieved by increasing the range of treatment options available in prison, which includes the prescription of drug substitutes for those with addictions to heroin and other opiates. Other aims include combining clinical and psychological treatments in prison into one system, and reinforcing continuity of care from community drug intervention programmes into prison, between prisons, and on a prisoner's release back into the community.

Buprenorphine (Subutex)

16. Buprenorphine, known by the trade name Subutex, is an opiate substitute that is used to treat addiction to stronger opiates, such as morphine, diamorphine (heroin) and methadone. Buprenorphine prevents the physical withdrawal symptoms that occur when these drugs are stopped, including physical cravings. Over time, the dose of buprenorphine is gradually reduced until it can be stopped completely. The drug is sometimes obtained illicitly by substance misusers as an alternative to stronger opiates, such as heroin. The man told staff that he used buprenorphine obtained illegally in the community before his recall.

Methadone

17. Methadone is one of a number of synthetic opiates that are manufactured for medical use to treat drug addiction. It is prescribed as a pain reliever and prevents withdrawal symptoms.

Chlordiazepoxide (Librium)

18. Chlordiazepoxide is used in the treatment of alcoholism for its sedating and anxiety-relieving effects, which help relieve the symptoms of acute alcohol withdrawal. Chlordiazepoxide is from a class of drugs known as benzodiazepines, often used to treat anxiety and help people sleep.

HM Inspectorate of Prison Report 2009

19. Her Majesty's Chief Inspector of Prisons carried out an unannounced follow up inspection by the then Chief Inspector in October 2009. At the time of her inspection she reported that,

> "Durham suffers from many of the problems of old, overcrowded local prisons. There is not enough for prisoners to do, and there are difficulties in managing a large transient population, from an area where substance misuse, particularly Subutex, is very high."

She went on to say,

> "… that the prison was relatively safe and that its resettlement work had improved significantly. However, the arrangements for the high proportion of prisoners on IDTS were extremely unsatisfactory and potentially unsafe, and illicit drug use was very high."
>
> "Over a quarter of the prison population were on the integrated drug treatment system (IDTS) programme and receiving methadone. Shortages of IDTS staff and healthcare nurses meant that there was a constant struggle to keep up with the process of methadone administration."

We draw on these and other of HM Chief Inspector's findings later in this report.

Independent Monitoring Board Report 2010

20. The Independent Monitoring Board's Report for Durham dated October 2010, reports that,

> "Substance misuse, drugs and alcohol misuse, psychology, drugs testing, Detox and CARATS all seem to be working satisfactorily, being well organised and controlled. Staff are motivated and demonstrate a good level of understanding and requirements."

Regretfully, our findings do not substantiate those of the IMB. (CARATs, or Counselling, Assessment, Referral, Advice, and Throughcare services provide drug misuse intervention services in prisons.)

Previous self inflicted deaths at HMP Durham

21. The man's death was the second death related to substance misuse to have occurred at Durham in 2011. In 2010, there were four deaths at the prison, two of which were as a consequence of natural causes. Since his death there have been a further three deaths. It would appear that none of the findings in these or the other deaths have any connection to the circumstances of his death.

KEY EVENTS

22. The man was remanded into custody at HMP Durham on 22 January 2010, for common assault and assault occasioning actual bodily harm (ABH). On 5 May, he was sentenced to 30 months imprisonment and on 27 May was transferred to HMP Acklington. He told staff at the prison that he drank 'excessively everyday' and had used illegal drugs. He also told staff that he required help in overcoming his addictions. On 21 April 2011, he was released on licence.

23. However, on Friday 13 May, having been arrested by police, the man was recalled to HMP Durham due to his 'poor behaviour' whilst on release in the community. The Northumbria Police custody record notes that he told police that he was not in receipt of any medication. During the hour and a half that he was in police custody he was not given any medication.

24. On his arrival at Durham, the man was seen in reception by a Registered Mental Nurse (RMN). She assessed him as part of his First Night Reception Health Screen. (All prisoners are given a first night reception health screen when entering prison. The aim of the screen is to identify any needs or health concerns that the prisoner might have. It includes identifying a prisoner's past medical history, including mental health.) He told the nurse that he drank excessive amounts of alcohol on a weekly basis and was taking buprenorphine, commonly known by its trade name Subutex, illicitly whilst in the community, as well as crack cocaine. During the health screen his urine tested positive for buprenorphine. She referred him for assessment by the prison's mental health team and substance misuse team.

25. Later that afternoon, the man was seen by one of the prison's doctors. He told the doctor that he consumed large quantities of cider daily, 10 to 12 litres, and that his last drink had been 24 hours prior to being taken into custody. The doctor also noted that in the past he had possibly suffered from fits as a consequence of alcohol withdrawal. He told the doctor that he had recently been attending a drug clinic but was not receiving any treatment at that time. However, he told the doctor that he had been buying Subutex from 'the street' and also took cannabis and cocaine. The doctor told the investigator that prisoners would "tend to exaggerate" what drugs they took, adding that had he taken heroin he believed he would, "certainly have told me about that".

26. The doctor said the man was very relaxed and chatty and,

> "… physically looked well, there were no overt signs of acute withdrawal at that stage. His urine was positive for buprenorphine. I discussed the options which were available, which is an alcohol detox using chlordiazepoxide and a detox from the opiates using methadone. He wished to have both of those and I arranged that, and also arranged for him to be monitored and seen by the detox team."

The doctor noted that he had also admitted to previous mental health problems and incidents of self-harm, but recorded that he denied any thoughts of harming

himself at the time of the assessment.

27. Although the man showed no signs of withdrawal, the doctor, with his agreement, decided to prescribe him both opiate and alcohol detoxification to start that evening. The investigator asked the doctor if the man made any objection. He said,

> "… he was keen to take that detox and the detox is always offered to people rather than being suggested, unless people are in overt withdrawal crisis and the majority of people accept it, a few don't."

The investigator was told by the doctor that the man, "… wasn't showing signs of withdrawal."

28. The doctor prescribed the man the prison's standard regime of detoxification medication. He prescribed 10mg methadone, (a drug used to replace opiate based illegal drugs such as heroin and used to treat dependency) and 30mg of chlordiazepoxide, (a drug used to treat the symptoms of alcohol withdrawal) and Thiamine, (or vitamin B, also prescribed to those undergoing alcohol withdrawal).

29. That evening the man was checked by a Health Care Support Worker (HCSW). She wrote in his medical record,

> "He checked at 22.30pm he came to his cell door, states he is ok but feels as though he is withdrawing as he states the 10mgs of methadone is doing nothing for him. Explained he will be seen by the detox team in the morning. He appeared happy with reply."

The HCSW checked him again at 5.08am, noting that he was sleeping and that there had been no further problems overnight.

30. At 8.54am the following morning the man was seen by a Registered General Nurse (RGN). She assessed him for any signs of withdrawal. The clinical reviewer notes that the nurse assessed that,

> "There were no major objectively observable signs of withdrawal apart from a slight hand tremor but the prisoner stated he was experiencing some stomach cramps, irritability, sweating, aches and pains and disturbed sleep. His blood pressure was recorded at 116/80." (lower than the average blood pressure, which is around 130/80.)

The nurse reported that he raised no other issues but noted that clinical monitoring was to continue. At 9.40am that morning he was given a further 10mgs of methadone, which was repeated at 3.00pm. During the day he also received chlordiazepoxide at three regular intervals, morning, lunchtime and evening.

31. On Sunday 15 May at 9.28am, the man was seen by another of the prison's Health Care Support Workers who again assessed his level of drug withdrawal.

She wrote in his medical record,

> "Seen on wing this am for clinical monitoring. States he feels rough, complained of stomach cramps. To monitor and review."

She also noted that his tremor had ceased and recorded his blood pressure at 126/52. Shortly after at 9.39am, he took his methadone, which in line with the standard detoxification regime, had been increased to 15mgs. He received another 15mgs at 3.40pm. In line with the standard alcohol detoxification regime, his dose of chlordiazepoxide was reduced 20mgs, which he took three times a day.

32. The following day, 16 May, the man was seen by another of the prison's doctors. In her clinical review, the clinical reviewer notes,

> "The man told him he had been using buprenorphine, cannabis and alcohol prior to coming into prison. He told the doctor he felt a bit sweaty and had had some stomach cramps and vomiting, but these symptoms were not observed at the appointment. The doctor recorded that he was alert and comfortable and that his observations were stable. He was told to alert nursing staff if he felt unwell. His blood pressure was recorded at 121/73."

The doctor advised him that he should speak with nursing staff if his mood worsened or felt unwell.

33. In line with his prescription, the man's methadone was increased by 5mg to 20mgs and he received this at 9.30am. Later that morning he was assessed again by a nurse who took his blood pressure and recorded the same results as the doctor earlier in the day. He received his second dose of methadone that day at 3.40pm, as well as the chlordiazepoxide.

34. The same day, his previous medical records were requested from his general practitioner (GP). He was referred to CARAT services. (CARATs, or Counselling, Assessment, Referral, Advice, and Throughcare services provide drug misuse intervention services in prisons.)

35. In a statement provided after the man's death, a prisoner in the next cell said the man had told him that he felt unwell when everyone had been locked up behind their doors that evening. He described the conversation,

> "… he didn't know if he should be feeling like this because of the methadone, he said he was passed the feeling sick and itchy nose and was now feeling semi conscious … as he told me previous[ly] he was using a lot of heroin, so I thought he would be ok. He said that he fucking wonders what he will feel like tomorrow as the doctor just upped his methadone … then he asked me if he needs anything will it be ok if he give[s] me a shout, I said ok and our conversation was over."

He told the investigator, that although he did not know the man, he had talked with him a couple of times over the preceding days. He confirmed to the investigator that the man told him that he did not take heroin on "the outside", but had been given dihydrocodeine whilst in police custody. He said that the man told him that he felt "horrible" and that he had accepted the methadone in order to "get through his sentence".

36. Officer A, the officer working on the wing that night, arrived at about 8.30pm. He told the investigator that he had no interaction with the man that evening or night. He said that his cell bell was not rung and that he did not go to his cell during the night because there was no requirement to do so.

37. At approximately 5.30am, the officer was completing a roll check when he found the man slumped on his bed with his head resting on the cell wall facing his television. The officer said that he did not appear well and did not respond when he shouted his name. However, the officer told the investigator that he was not sure what was happening but was concerned because of the position he was in.

38. The officer sought assistance from Nurse A, RGN, based on the same wing. In his statement, the nurse said that the officer met him on the first floor of the wing and said that he was unable to wake the man, although he appeared to be breathing. The nurse accompanied the officer back to the cell and looked through the observation panel. He said that when he saw the man, he believed him to be dead. The nurse asked the officer to call Oscar 1 while he returned to the nurse's office, on the same wing, to collect emergency response equipment. (Oscar 1 is the radio call sign for the night orderly officer, the person in charge of the prison during the night.)

39. Officer B, Oscar 2, the assistant orderly officer, said that Officer A contacted him by radio at about 5.30am. He said he was asked to attend E wing to open a cell by the officer as a prisoner was not responding. Officer B, who happened to be on his way to the wing anyway, was met by Officer A on the ground floor before both of the officers went up to the cell. The officers were still unable to rouse the man, so went into his cell. The investigator established that Officer A did not raise the alarm by using the prison's emergency response codes. (A code sign used to alert and to seek assistance from staff about a serious incident, for example in life-threatening situations.)

40. Having collected the emergency equipment, including resuscitation aids and oxygen, Nurse A returned to the cell a couple of minutes later. The nurse told the investigator that by the time he got back, officers had already gone into the cell. He followed the officers into the cell and checked the man for signs of life, of which there were none. The nurse said that he was cold to the touch and rigor mortis had set in. Nurse B responded to the call for assistance and went to the cell. Cardio pulmonary resuscitation (CPR) was not attempted. Although an ambulance was not immediately summoned, Nurse A, on establishing his belief that the man had died, requested that the ambulance be called. Nurse B made arrangements for the attendance of a doctor to certify death.

41. A hot debrief took place shortly after the incident at which members of the care and welfare team were present. All those involved in the response attended. (A hot-debrief is a meeting held as soon as possible after a major incident to ensure the welfare of staff.)

42. The man's mother was informed of her son's death later that day. Although she was not in when staff called at her home, a telephone message was later left for her to call the prison. She telephoned the prison later that day and the news of his death was broken to her by the prison's family liaison officer. She was invited to visit the prison but declined. His property was returned to his mother and the prison offered a contribution to funeral expenses, which was accepted.

Post mortem and Toxicology reports

43. A post mortem was conducted on the man. The pathologist's findings are that he died as a result of bronchopneumonia and that there were no toxicological findings to account for his death. In her summary and conclusion, the pathologist says that,

> "Bronchopneumonia most commonly develops in patients who are debilitated or who have pre-existing lung disease. In this case there was no evidence of any of these factors. In otherwise fit and healthy individuals bronchopneumonia may arise following a period of profound unconsciousness resulting from the use of typically illicit drugs. The toxicological analysis of blood and urine does not however show any drug use out with that as prescribed for the man, namely the presence of methadone at expected therapeutic levels. Although not evident macroscopically, the pneumonia affected all five pulmonary lobes indicating that it was bilateral and therefore a significant infection. This would account for his feeling unwell the day prior to his death and would also account for his death."

In the toxicology report, the toxicologist commented on the levels of methadone found in the man's blood:

> "As in all cases involving opioid drugs, the toxicological significance of the methadone concentration will depend upon the degree of tolerance possessed by the deceased. In this case, the deceased was prescribed methadone; therefore he would have been expected to have gained some tolerance to the effects of the drug. If an individual's tolerance threshold has been exceeded by the dose ingested, typical toxic effects include sedation and respiratory depression. As the man's degree of tolerance is not known it is not possible to comment as to the significance of this finding."

ISSUES

Clinical Issues

Prescription of detoxification regimes

44. In her clinical review the clinical reviewer reports that the man's medical notes record very few objectively observable signs of substance withdrawal on or during his short time at Durham. She says that the doctor,

> "… who initially saw him on the Friday evening stated at interview that he didn't recall him having any obvious signs of withdrawal. Despite this he was prescribed opiate and alcohol detoxification programmes. This was based on his report of excessive alcohol intake, previous withdrawal seizures, his use of illicit buprenorphine and the fact that this was present in his urine.
>
> Methadone presents a very high risk when prescribed to those who do not have opiate tolerance and even 'therapeutic doses' can cause central nervous system depressions and potentially death in these circumstances. The high risk periods are on the second and third day of the detoxification regime."

45. The clinical reviewer makes reference to the guidance set out in the Department of Health's publication, Clinical Management of Drug Dependence in the Adult Prison Setting. Section 5.4.1 states,

> "Fatalities from Methadone poisoning have been reported at doses as low as 20mg and that the risk is exacerbated when the simultaneous prescribing of a benzodiazepine is necessary. Methadone deaths tend to occur on the second or third day of treatment due to result of cumulative toxicity. These deaths occur as a consequence of inadequate assessment, failure to confirm previous opiate use by clinical testing for drugs, failure to confirm dependence (such as treatment in the absence of withdrawal symptoms) and a lack of monitoring."

46. The man was prescribed methadone and chlordiazepoxide (a benzodiazepine) when he arrived at Durham. According to this policy, he was at particular risk without the safeguards described.

47. Durham's own Protocol for the Treatment of Opiate Dependence, Durham Cluster Prisons, January 2009, states on page two that,

> "For the prescribing of methadone to take place on the first night the following must be present:
>
> 1. Opiate positive supervised screen
> 2. A history of use which indicates dependence may have occurred
> 3. Observation of objective signs of withdrawal"

The protocol goes on to say that,

> "… if there are no objective withdrawal symptoms present, provide symptomatic medication should be provided for the first night and the patient be observed several times for the onset of withdrawal symptoms and if these become apparent a medical review should take place and opiate substitute treatment commenced."

48. During interview, the doctor said that it was not unusual for prisoners to exaggerate the accounts of their substance use on arrival at prison. However, as the man's urine had tested positive for buprenorphine, and on explaining the detoxification regime for both opiates and alcohol, he confirmed with the doctor that he wanted to be prescribed the detoxification medication. The doctor told the investigator that he understood that there was an increased risk associated with the prescription of methadone and chlordiazepoxide, but explained that it was "standard practice to run them concurrently here [at the prison]".

49. The second doctor, who saw the man on the day of his death, told the investigator and the clinical reviewer that in hindsight, if he had assessed him the previous Friday, he would have waited for observable signs of withdrawal before commencing a full detoxification regime. He said that, once a detoxification regime had been prescribed by one of his medical colleagues, it was difficult for him to stop the treatment plan three days after its commencement. He explained that the patient's presentation could be due to lack of withdrawal symptoms generally, or the efficacy of the treatment that he has received over the preceding days.

50. The doctor told them that there was a "default prescribing" system in the prison regarding detoxification. He said that if someone reported opiate dependence upon arrival, and it showed in their urine, then they would be prescribed a detoxification regime, despite the levels of withdrawal exhibited. He felt the need for more robust clinical guidance to be developed.

51. In her clinical review the clinical reviewer concludes,

> "There does not appear to have been robust objectively observed evidence to support the man being prescribed alcohol and opiate detoxification on the night of his admission to the prison. This is stipulated as a requirement in the national and local guidance…
>
> Ideally he would have been observed for a while and if signs of withdrawal became apparent, a medical review could take place, in line with prison policy. However, it is acknowledged that the prescribing GP was in a difficult position as it was Friday evening and he knew there would be no doctor available with knowledge of detoxification until the Monday morning."

52. Since April 2011, healthcare services at Durham have been provided by Care UK, an independent provider of health and social care. Healthcare at the prison

had previously been provided directly by the local PCT. Although Care UK have been providing the healthcare at Durham since April 2011, the investigator and clinical reviewer established that the protocol, used by the previous provider of healthcare at the prison, Treatment of Opiate Dependence for the Durham Cluster of Prisons dated January 2009, was still being used as the basis of IDTS policy at the prison and this had not been reviewed since the change in healthcare provider.

53. During interview, both doctors explained that it was the practice at the prison to prescribe detoxification medications when prisoners presented in such a manner as the man. Although we make no personal criticism of the first doctor, current policy does not appear to be being delivered and as such current practice does not reflect the policy and other guidance available from the Department of Health. Given the lack of observable signs of substance withdrawal on the man's arrival at Durham and in light of the clinical reviewer's conclusions, we make the following recommendation.

    The Healthcare Manager for Care UK should update the local protocol for the Treatment of Opiate Dependence for the Durham Cluster of Prisons and ensure its effective implementation.

Prescription of methadone for potential buprenorphine withdrawal

54. The Department of Health's publication, Clinical Management of Drug Dependence in the Adult Prison Setting. Section 5.5 states that,

> "Methadone should generally be used for opiate detoxification unless an exception is in the patients' 'better interests' i.e. mild cases of dependence of the type that may be found in younger non injecting heroin users, and patients who state they're currently prescribed buprenorphine [Subutex] in the community."

55. The clinical reviewer in her clinical review says,

> "The man said he'd been taking illicit buprenorphine in the community. This is a drug used for opiate withdrawal and is often felt to be less addictive than methadone so it may have been beneficial to prescribe him a titrated dose of buprenorphine to wean him off its use rather than being prescribed methadone."

56. The clinical reviewer and the investigator were told by clinicians at Durham that prescribing buprenorphine was not a prescribing option within the prison. I note that in her inspection HM Chief Inspector of Prisons commented similarly on this issue. She noted that,

> "Subutex (buprenorphine) was not widely used or offered by clinical staff as an opiate-substitution treatment. In the previous six months, only one prisoner had been prescribed Subutex. Substance misuse staff said that there would be a significant risk of diversion of prescribed Subutex to illicit use if it were widely prescribed. The drug

> testing evidence pointed to Subutex as the most widely abused drug in the establishment, sourced illicitly from outside the prison."

57. I endorse the clinical reviewer's findings, similar to those found by HM Chief Inspector. As such we make a similar recommendation made by the Inspector in her own report with regard to this matter.

    The Healthcare Manager for Care UK should undertake a comprehensive review of the prescribing options available to those prisoners considered suitable for detoxification and extend the options to buprenorphine as an alternative.

Monitoring and observation of detoxification regimes

58. In her clinical review, the clinical reviewer reports on the possible increases in risks that the prescription of both methadone and chlordiazepoxide may have upon an individual when used together in the treatment of opiate and alcohol detoxification. She refers to the Department of Health's publication, Clinical Management of Drug Dependence in the Adult Prison Setting. Section 9.15 states that,

> "In cases of co-dependency on any combination of alcohol opiates, opiates and benzodiazepines, more than one reduction programme may be required with additional caution necessary due to the interaction of these drugs."

    and that,

> "… the need for enhanced observation over the first five days of methadone treatment and specifically for a patient to be monitored for withdrawal and intoxication during stabilization is a minimum of twice a day."

59. The clinical reviewer reports that with the exception of the 16 May, when the man was seen by both the second doctor and one of the nurses, on the preceding days he was only formally monitored, whereby medical observations were made and assessment made for signs of withdrawal, once each day, although he was seen by nursing staff during the dispensing of his medication. However, as she points out, being seen does not constitute formal monitoring.

60. The clinical reviewer highlights that the man's formal monitoring for symptom withdrawal was carried out by an unqualified health care support worker on one occasion. She also notes that it appears that no action was taken when his blood pressure was reported as being extremely low on 15 May, it not being reported to a doctor or qualified nurse. She says,

> "It does not seem to be adequate for the man's only recorded withdrawal monitoring, on the second day of detoxification which is known to be a very high risk part of the process, to have been

completed by an unqualified nurse."

61. She concludes that, "The man was not observed and formally monitored / assessed for signs of withdrawal at least twice every day as is stated as necessary within the guidance for opiate detoxification." The IDTS staff nurse interviewed said she had only recently become aware of the need to monitor detoxification patients twice each day after working in the team for approximately two years and had highlighted this to her manager as it was not always happening. During interview, the second doctor expressed concern that there was less specialist nursing staff available in recent months to carry out regular monitoring and observation. He felt this was a concern as doctors relied on the specialist observations of substance misuse nurses to supplement their own input to the patients.

62. According to the prisoner's statement, the man told the prisoner in the adjacent cell, that he had told the doctor that he felt unwell. The clinical reviewer comments that this is not recorded in the clinical notes except that he should tell nursing staff if he felt worse. The second doctor who saw him on 16 May said that he did not tell him that he was unwell, and he did not appear unwell. He acknowledged he reported from feeling sweaty, with a bad stomach and feeling sick, but the doctor concluded that these were symptoms of detoxification.

    The Healthcare Manager for Care UK should ensure that standards for monitoring and actions to be taken when an increased clinical risk is observed are in line with those set out in Clinical Management of Drug Dependence in the Adult Prison Setting.

63. The clinical reviewer concludes that the man was not monitored as frequently as required in the national guidance, in particular on the second and third day of the detoxification regime which is when he was at most risk. As a consequence of her assessment and conclusions we make the following recommendations.

    The Healthcare Manager for Care UK should ensure that specialist IDTS nurses and other clinicians are competent in identifying in completing tasks such as withdrawal and vital signs monitoring and have been trained in being competent to do so.

Staffing levels - Skills and training

64. One of the IDTS nurses interviewed said that she had worked in the team for two years and came from a general nursing background with no specialist prior experience of detoxification and substance misuse. She said that she was inducted when she started at the prison, but had not received any formal training on substance misuse or its treatment since working at the prison. She also explained that the onus was on the nursing staff to update their skills and keep up to date with developments, such as National Institute for Clinical Guidance (NICE), and that she had never had clinical supervision in her current post.

65. The first doctor described a lack of knowledge about up to date national guidance regarding opiate and alcohol withdrawal and local policy. He said he

and his colleagues had little contact with professional medical colleagues or managers due to the working arrangements that were in place. He also expressed that he had no contact with Care UK since they had taken over the provision of healthcare in the prison and was not aware of some local policy. He said that there had been many changes over the past few years, but that changes in practice did not get communicated and that doctors sometimes relied on getting information from the nurses. He said the problem of isolated working had been brought to the attention of management on numerous occasions with little effect.

66. The clinical reviewer and the investigator were told by nursing staff of the recent changes in staffing levels and skill mix in recent months, with regard to the provision of IDTS nursing care. They were told that nursing vacancies and sometime shifts were covered by HCSWs rather than qualified nurses. Both of the doctors interviewed also stated that there was a reduction in nursing staff in recent times and both had concerns on how this could impact on the quality and regularity of patient observations. One clinician described a, "significant shortfall in nursing services", since the provider of healthcare services in the prison changed to Care UK.

67. In her clinical review, the clinical reviewer comments on the perception of clinicians that there appears to have been a recent reduction in the numbers of IDTS nursing staff. She goes on to say that,

> "It is also apparent that some GPs who provide sessional out of hours cover in the prison are working in isolation without regular support, involvement in service development and decisions and access to information about managerial decisions, access to policies etc."

She also comments that,

> "Additionally, since changes in the provider for the health care in the prison, there is no access to specialist medical staff with experience of prescribing and monitoring detoxification programmes over the weekend period. We were told at interview that there are informal arrangements that specialist colleagues can be contacted if required by telephone but these arrangements appear to be goodwill based rather than formally agreed and funded."

68. With regard to the general levels of knowledge of staff with regard to the care which those undertaking detoxification require she concludes that,

> **"**It appears that some qualified IDTS nurses and doctors are not adequately trained or supervised for the roles they undertake. Additionally withdrawal monitoring is sometimes undertaken by unregistered nurses in the absence of their registered nurse colleagues. There is no evidence that they are sufficiently trained to do this."

69. We note that, in her report, HM Chief Inspector of Prisons also commented on IDTS nursing staff shortages. In light of the clinical reviewer's numerous findings and conclusions, as set out above, and which are fully endorsed, we make the following recommendations,

The Healthcare Manager for Care UK should ensure:

There is an audit of training and skills so that they meet the requirements of the IDTS Workforce Strategy and associated IDTS policy documentation.

That staff who provide out of hours sessional clinical care are appropriately supported and involved in decisions about care and service developments and of local and national policy.

That there is formal and timely access to a doctor with training in substance use detoxification prescribing over weekends.

That clinical supervision for IDTS team members and detoxification doctors takes place.

Clinical review conclusions

70. The clinical reviewer reports that the post mortem showed that the man had a lung infection when he died, and had therapeutic levels of methadone in his system. She says that the dosage that he was prescribed was not excessive for someone who had heroin or methadone tolerance and was within the prescribing guidance outlined within the prison policy. However, she reiterates that very low doses can be fatal to those without methadone or heroin tolerance and that the risk is exacerbated when prescribed alongside chlordiazepoxide.

71. She says that she is unable to,

> "… comment on whether his lung infection was caused by this or whether it pre-existed prior to entering the prison. However, it seems reasonable to assume that there was possibly a link."

Opiate overdose is characterised by constricted pupils, respiratory depression, pulmonary oedema, frothing from the lungs, sweating and unconsciousness. She suggests that the drop in blood pressure on 15 May, recorded but not acted upon, could have, "… been an initial indicator of central nervous system depression or physical fragility".

72. The clinical reviewer goes on to say that patients in the community would take part in planned detoxification programmes in which clinicians, having a clear picture of a patient's history, would decide on the most appropriate detoxification regime. She says:

> "It is also very unlikely that anyone would receive detoxification for both alcohol and opiate use at home and without high levels of observation. It is therefore concluded that the care he received was not

equitable with what he would have received in the community."

However, she acknowledges that prison clinicians will not have the same level of information which is often available to their colleagues in a community setting and as such are required to make an assessment based on what they observe and what they are told. She recognises his desire to be prescribed detoxification mediation contributed to the decision to prescribe it. However, she feels there were sufficient indicators to prompt clinicians to assess him for a longer period before commencing the treatment programme that was prescribed.

OTHER ISSUES

Emergency Response

73. Durham's Local Instruction 2.84, Nights – Opening Cells, states that,

> "Any member of staff encountering a life-threatening emergency during security state … should immediately raise the alarm, ideally by radio."

74. Durham's local policy on Summoning Medical Help requires that, if a prisoner is found unconscious or there is no response, a code black should be called. It says that the first on scene should,

> "Ring or radio the control room requesting assistance and state the location, number of people involved and the words 'code black' e.g., 'Assistance required, Bravo 4-3, one prisoner, code black'."

75. Upon the man's discovery by staff, there appears to have been a delay in both entering the cell and summoning emergency assistance. Officers must make an assessment of the risk of entering a cell, and Officer A appropriately sought support before going in because he was unsure of the man's situation. However, he should have called an emergency code black given that he could obtain no response from him. Instead he sought further assistance from Nurse A in another area of the wing. It was only on their return to the cell, and under the instruction of the nurse, that the officer sought assistance from the night orderly officer.

76. As a consequence of the emergency code black not being called, the prison's control room did not automatically summon an ambulance as set out in the same local policy.

77. In her clinical review the clinical reviewer reports that,

> "… it is good practice to call emergency services at the earliest opportunity so that confirmation of the correct clinical treatment needed, or the decision not to proceed with resuscitation, can be made as a team rather than in isolation. However, it is noted that there is no reason to believe that an immediate call to emergency services in this case would have altered the decision not to attempt resuscitation, or the outcome, in any way.

78. It is essential that ambulances are called immediately to emergency situations such as this. Any delay can have a significant impact on a person's chances of survival. However, on this occasion I appreciate that would have made little difference to the outcome. But in a similar situation speed may be of the essence. We therefore make the following recommendation to the Governor.

The Governor should ensure staff implement the emergency actions set out in Durham's local policies on Summoning Medical Help and Opening Cells at Night.

CONCLUSION

79. When the man entered prison, he told staff that he drank excessively and took illicitly obtained buprenorphinie. As a consequence, he was referred to the drug detoxification team. Although he tested positive for buprenorphine, he showed no signs of withdrawal and, in consultation with him, the doctor placed him on a standard methadone and alcohol detoxification regime. Sadly he was found dead in his cell three days later.

80. Although the post mortem indicates that he died of pneumonia, in her clinical review, the clinical reviewer reports how those whose tolerance to methadone is low can suffer from respiratory failure which in turn can lead to death. She suggests that there may be a link between the man's detoxification regime and the circumstances of his death.

81. A number of lessons can be learned following the man's death about the delivery of IDTS at Durham. We trust that Care UK, the Governor and the healthcare team will work to ensure the appropriate prescription and monitoring arrangements are in place for those undergoing a detoxification regime, with all its associated risks.

RECOMMENDATIONS

1. The Healthcare Manager for Care UK should update the local protocol for the Treatment of Opiate Dependence for the Durham Cluster of Prisons and ensure its effective implementation.

   Accepted – *Care UK provide offender healthcare across the north east region, it is their aim to ensure uniformity of policy across the region. Therefore the Head of Healthcare HMP Durham, as part of a wider team, will contribute towards the updating of the policies/protocols for the Treatment of Opiate Dependence. The Head of Healthcare HMP Durham will ensure the effective implementation of the policy(s).*

2. The Healthcare Manager for Care UK should undertake a comprehensive review of the prescribing options available to those prisoners considered suitable for detoxification and extend the options to buprenorphine as an alternative.

   Accepted – *Care UK provide offender healthcare across the north east region, IDTS prescribing is undertaken by medical staff (The Gables medical practice) subcontracted by Care UK. Care UK's aim is to ensure uniformity of prescribing across the north east region. A comprehensive review will be undertaken by a group of senior Care UK staff at regional level and this will include the Regional Medical Director.*

   The Head of Healthcare HMP Durham will work in partnership with NOMS to ensure the safe delivery of medication within the confines of the prison regime.

3. The Healthcare Manager for Care UK should ensure that standards for monitoring and actions to be taken when an increased clinical risk is observed are in line with those set out in Clinical Management of Drug Dependence in the Adult Prison Setting.

   Accepted – *A multi disciplinary action team has been active since October 2011, with weekly meetings being held (now monthly due to significant progress being made). Outcomes have included further training for staff and improved withdrawal monitoring.*

4. The Healthcare Manager for Care UK should ensure that specialist IDTS nurses and other clinicians are competent in identifying in completing tasks such as withdrawal and vital signs monitoring and have been trained in being competent to do so.

   Accepted – *A multi disciplinary action team has been active since October 2011, with weekly meetings being held (now monthly due to significant progress being made). Outcomes have included further training for staff and improved withdrawal monitoring.*

   Medical staff are employed by the Gables Medical Practice. The Regional

Medical Director has ownership of the training and competency of GP's working within the north east prisons.

The Healthcare Manager for Care UK should ensure:

5. There is an audit of training and skills so that they meet the requirements of the IDTS Workforce Strategy and associated IDTS policy documentation.

   Accepted – *A multi disciplinary action team has been active since October 2011, a training needs analysis has been completed and recommendations have been made. A plan to deliver the training needs is under development.*

   Medical staff are employed by The Gables Medical Practice. The Regional Medical Director has ownership of the training and competency of GPs working within the north east prisons.

   Care UK Offender health annual audit calendar is followed and data collected via HARVEST.

6. That staff who provide out of hours sessional clinical care are appropriately supported and involved in decisions about care and service developments and of local and national policy.

   Accepted – *Out of hours medical services are commissioned by NEOCHU, the provider has ownership of the training and competency of Out of Hours GPs working within the north east prisons, CARE UK is not the provider.*

   The Head of Healthcare HMP Durham will ensure that Doctors' time is managed in a timely and efficient manner by first line nurse managers on a daily operational basis.

7. That there is formal and timely access to a doctor with training in substance use detoxification prescribing over weekends.

   Accepted – *Medical staff are employed by the Gables medical Practice. The Regional Medical Director has ownership of the GP work rota, training and competency of GPs working within the north east prisons.*

   The Head of Healthcare HMP Durham will ensure that Doctors' time is managed in a timely and efficient manner by first line nurse managers on a daily operational basis.

8. That clinical supervision for IDTS team members and detoxification doctors takes place.

   Accepted – *All nursing staff are offered clinical supervision (minuted at a monthly team briefing). A multi disciplinary action team has been active since October 2011, with weekly meetings being held (now monthly due to significant progress being made). Outcomes have included the development and ongoing implementation of compulsory clinical supervision for nursing staff as per Care*

UK Clinical supervision. Individual folders have now been ordered and a lockable cabinet has been procured.

Medical staff are employed by the Gables Medical Practice. The Regional Medical Director has ownership of the GP training and competency of GPs working within the north east prisons.

9. The Governor should ensure staff implements the emergency actions set out in Durham's local policies on Summoning Medical Help and Opening Cells at Night.

Accepted – *This instruction has been reiterated to all staff working within the Communications room with regards to the summoning of medical help.*

The Local Security Strategy (LSS) gives clear instruction of the requirements for opening cells at night.