PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man on 15 November 2012 at HMP Belmarsh

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 the investigation report into the death of a prisoner at HMP Belmarsh who died on 15 November 2012, seven days after his arrival at the prison. He was 48 years old. A post-mortem recorded the man's death as being due to methadone, tramadol and diazepam intoxication. I offer my condolences to the man's family and friends.

The investigation was carried out by a senior investigator. An independent doctor carried out a review of the clinical care the man received while in custody. Belmarsh cooperated fully with the investigation.

The man had a history of alcohol and drug abuse and had been in prison a number of times before. He arrived at Belmarsh on 8 November. A prison doctor saw the man on 13 November, after his cellmate and healthcare staff raised concerns about him. The doctor recorded that he would stop his anti-depressant medication and that he should be monitored for signs of overdose. Neither of these happened. The next day the man moved to a different houseblock. When he got there staff noted that he appeared drowsy and confused but did not refer him to healthcare staff, even after his cellmates said that they were worried about him later that evening. On 15 November, the man's cellmates told the officer who unlocked the cell in the morning that he was unresponsive. Healthcare staff and paramedics attempted resuscitation, but it was confirmed he had died.

The clinical review concludes that the care the man received was not equivalent to what he might have expected in the community and might have contributed to his death. Indeed, the clinical reviewer considers that the clinical performance of one of the prison doctors should be thoroughly investigated in relation to the man's treatment. I agree. I am also concerned that doctors at the prison did not have specialist substance use training, although this had been identified as a problem at an inspection over a year earlier. Similarly, it is a concern that, although the man had told both staff and other prisoners that he was on the wrong medication and he appeared unwell, no appropriate action was taken. There is a need to ensure that all staff who work with drug users are aware of, and able to spot, the common symptoms of drug intoxication.

The 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**

SUMMARY

1. The man died on 15 November 2012, at HMP Belmarsh. He was 48 years old. A post-mortem recorded his death was due to methadone, tramadol and diazepam intoxication, all of which he was prescribed at Belmarsh.

2. The man was remanded into the custody of HMP Belmarsh on 8 November. During his reception health screening, it was recorded that the man had history of drug and alcohol dependency. The man was referred to the prison doctor who prescribed methadone (a synthetic opiate based medication used in the treatment of heroin addiction) and diazepam (also known as valium) to support his withdrawal from alcohol.

3. On 10 November, without seeing the man or having received any information on him, another prison doctor prescribed citalopram (an anti-depressant), sodium valproate (an anticonvulsant used in the treatment of epilepsy) and tramadol (a synthetic opiate painkiller). When interviewed the prison doctor was unable to give an explanation for these prescriptions. During his time at Belmarsh the man informed both staff and prisoners that he was on the wrong type of medication.

4. On 13 November, healthcare staff were concerned about the man's high blood pressure. They decided not to give him his methadone that day and referred him to a prison doctor. After he saw the man, during the evening of 13 November, the prison doctor recorded that the citalopram should be stopped, a urine test should be carried out and the man should be observed in case of overdose. The prison doctor did not stop the citalopram on the medical computer system, so another dose was issued the next morning. The urine test he requested was not done and neither was the man observed in case of a possible overdose. Around 5.00pm on 14 November, the man moved to a three man cell on Houseblock 4. When he arrived at the houseblock, officers noted that the man appeared drowsy and confused but did not think that his presentation was unusual as he was on the detoxification programme. He told staff and some of the prisoners that his medication was incorrect. The officers did not refer the man to healthcare staff for an assessment and he was not monitored by healthcare staff after his move to the houseblock, even after his cellmates expressed concern about him later that evening.

5. Around 7.55am on 15 November, after an officer unlocked the man's cell, his cellmates informed her that he was unresponsive. Emergency assistance was requested and healthcare staff attempted to resuscitate the man. An ambulance was called and paramedics pronounced the man dead at 8.45am.

6. The clinical reviewer considered that the general standard of care given to the man was not comparable to that he could have expected in the community and might have contributed to his death. We make six recommendations about prescribing practice, the clinical performance of one of the prison doctors, substance misuse training for prison doctors and nurses, following up actions from clinical consultations, recording information and the need for

better awareness of the signs of drug intoxification. The recommendations made in the draft report have been accepted by HMP Belmarsh.

THE INVESTIGATION PROCESS

7. The Ombudsman's office was notified of the man's death on 15 November. The investigator issued notices at HMP Belmarsh informing staff and prisoners of the investigation and asking anyone who had relevant information to contact him. No responses were received.

8. Greenwich Primary Care Trust commissioned a doctor to review the clinical care provided for the man during his time in custody.

9. The investigator visited Belmarsh on 21 November and met the Governor and spoke to staff involved in the man's care. He spoke to the prisoners who had shared a cell with the man. The investigator examined the man's relevant prison records, including his prison medical records. He returned to Belmarsh on 3 December and 21 January 2013 to interview staff and prisoners. Initial feedback about the findings of the investigation was given to the Head of Healthcare on 21 January and subsequently confirmed in writing.

10. HM Coroner for South London was informed of the investigation and provided the results of the toxicology report on 9 April 2013 and the post-mortem examination on 14 May 2013. Our investigation was suspended until the post-mortem and toxicology results were available. We regret the consequent delay. The Coroner has been sent a copy of this investigation report.

11. One of the Ombudsman's family liaison officers contacted the man's daughter as she was unable to contact his partner, who he had nominated as his next of kin. The Ombudsman's family liaison officer informed the man's daughter about the purpose of the investigation. His daughter wanted to know what medication had been prescribed and whether there were any delays in an emergency ambulance attending. His daughter was also concerned about some issues relating to the man's property and the prison's family liaison about which we have written separately. The man's family received a copy of the draft report. No further representations were made in response to the findings.

12. As the draft report is critical of the actions taken by a prison doctor it was advanced disclosed to him under our disclosure policy. The prison doctor's representative raised a number of points which were not factual inaccuracies and have been addressed in separate correspondence to him. His representative raised two points concerning factual accuracy, which we address here and which do not require amendment of this report:

    - The prison doctor believes that the man was prescribed diazepam on his arrival at prison as a reducing dose as part of a detoxification regime for diazepam withdrawal. We asked the clinical reviewer to comment on this, they said that there was no history of benzodiazepine usage, and that the man's urine tested negative for such drugs on arrival at the prison.

- His representative said following the prison doctor's assessment of the man on 13 November he discussed his management plan with a nurse "in the expectation that his instructions to monitor would be followed". A nurse was present during the consultation and as the prison doctor provided verbal instructions he did not "anticipate that a task on SystmOne would need to be set". However, when we interviewed the nurse he said that the man was seen by the prison doctor while he continued with other duties reviewing new prisoners who had arrived at Belmarsh during the evening of 13 November.

HMP BELMARSH

13. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds up to 933 adult male prisoners. Care UK provides healthcare services. There are healthcare facilities on all the houseblocks, as well as in reception, and the first night centre. The healthcare centre includes facilities for outpatients and inpatients and provides 24-hour care.

14. New prisoners who have drug and/or alcohol problems are seen by a substance misuse nurse. Treatment for prisoners dependent on alcohol and benzodiazepines is started immediately. Opiate dependent prisoners are given only symptomatic relief on their first night until a treatment plan is arranged by a prison doctor. Prisoners experiencing severe alcohol withdrawal are admitted to the healthcare centre. Others go to the induction spur on Houseblock 3, which is also the prison's stabilisation unit for those dependent on drugs and alcohol. After a five day stabilisation period, most prisoners in treatment then move to the second stage spur on Houseblock 4.

Integrated Drug Treatment System (IDTS)

15. The Integrated Drug Treatment System aims to increase the volume and quality of substance misuse treatment available for prisoners, with particular emphasis on:

- early custody;
- improving the integration between clinical and the Counselling, assessment, referral and throughcare scheme (CARATS)[1]; and
- reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

16. Methadone is used to treat people who enter prison with a dependence on opiates such as heroin. Prisoners requiring a methadone prescription need to provide evidence of opiate use (a urine sample, evidence of withdrawal, or both). If it is unclear what amount was being used in the community, or in the absence of an existing prescription, the dose of methadone is gradually increased until a level safe for methadone maintenance is reached. The prison can check with the pharmacist in the community to verify that the person was on an observed administration schedule and that the most recent dose was within the previous 72 hours.

17. Prisoners are reviewed after 13 weeks and, unless there are specific reasons such as being on remand, on a short sentence or health reasons, they are gradually detoxified by slowly reducing the amount of methadone prescribed.

[1] There are drug workers based in most prisons from organisations specialising in the treatment of substance abuse. Counselling, assessment, referral, advice and throughcare scheme (CARATS) workers can run programmes, and offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATS is voluntary.

HM Inspectorate of Prisons (HMIP)

18. HMIP last inspected Belmarsh in April 2011. The inspection report acknowledged that Belmarsh is a large and complex prison, having to meet high security standards while supporting the majority of lower risk prisoners. It found that looking after the needs of both these populations had got better since the previous inspection, two years earlier, but that there were still improvements to be made.

19. The Inspectorate reported that, despite the large range of prisoners received at Belmarsh, early days in custody were generally well managed. The Inspectorate noted that the prison provided a flexible prescribing regime for prisoners detoxifying or being maintained. Inspectors described the first night treatment for opiate-dependent prisoners as inadequate. They found that the induction and stabilisation unit did not have designated 24-hour cover and the regime on the second stage unit was poor. Prisoners on the second stage unit spent much of the time locked up and said that the officers there had a poor attitude towards drug users. Not all clinical substance misuse doctors and nurses had completed the necessary training and specialist clinical leadership was lacking.

Independent Monitoring Board (IMB)

20. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. In their latest published annual report the IMB noted: “The regime for prisoners has remained broadly satisfactory; prisoners are safe, treated humanely and fairly and are prepared for release within the funding constraints”.

21. The IMB also recorded that delays in recruiting suitable healthcare staff had been an “overriding problem” and some of this had been attributable to the terms of conditions being offered by the private healthcare service compared unfavourably to those of the NHS.

Previous deaths at Belmarsh

22. Since 2010, the Ombudsman has investigated eight deaths at Belmarsh. None of the previous investigations identified issues similar to the man’s death.

KEY EVENTS

23. At around 2.00pm on 7 November 2012, the man handed himself into the police, who had an outstanding warrant for his arrest for failing to attend court for an offence of common assault. At around 2.45pm, the custody nurse recorded that when he entered the man's police cell he was asleep but was easily woken. The nurse recorded that the man's observations were satisfactory. Although he smelled of alcohol, he said he had not had a drink that day and said that his girlfriend had spilt a drink on him. The man appeared to be tired and his eyelids were drooping. He was given no medication while he was in police custody. The next morning, 8 November, he was taken to a local magistrates' court. During the afternoon of 8 November, the man transferred from court custody to HMP Belmarsh. It had been 15 months since his last time in custody.

24. At Belmarsh the man was seen in reception by an officer who recorded that the man had told him that he suffered from depression for which he needed medication. During his first reception health screening interview (which identifies any immediate mental or physical health problems requiring referral to the doctor or other specialist service) a nurse recorded that the man abused drugs and alcohol.

25. At a second health screen[2] on the same day, another nurse recorded that the man had started using heroin and crack cocaine by injection within the past five months and that he drank five to six cans of strong lager a day. The man said that he had injected heroin and crack cocaine immediately before he had handed himself into the police. The nurse recorded that the man's blood pressure was 147/80 and his pulse was 84 beats per minute (bpm) – both within normal limits. A urine test which was positive for buprenorphine (an opioid drug used to treat opiate addiction in higher dosages and occasionally to control moderate acute pain at lower dosages), opiates and amphetamine. The nurse referred the man to a prison doctor who saw him that same evening.

26. The prison doctor recorded that the man appeared "unwell, nasal sniffles, yawning, gooseflesh, pupils dilated" which are clear signs of opiate withdrawal. He recorded that the man had used illicit substances for the previous 15 years including cannabis, heroin and crack cocaine. The man began a standard five day methadone opiate withdrawal. The prison doctor also prescribed diazepam for alcohol withdrawal. All medication was to be administered under supervision.

27. An officer completed a cell sharing risk assessment (CSRA) and recorded that the man was a standard risk and able to share a cell. The healthcare assessment of the CSRA recorded that there was no increased risk in relation to his health. The man was located on the First Night Centre in Houseblock 3.

[2] The secondary health screening is a general health assessment equivalent to a primary care assessment when registering with a doctor in the community. It provides an opportunity for gathering further health information, health education and promotion and, importantly, checking how a prisoner is settling in.

28. On the morning of 9 November, a healthcare assistant assessed the man and recorded his blood pressure and pulse within normal limits. At around 2.00pm, a nurse assessed the man and again recorded his blood pressure and pulse within normal limits.

29. At 9.00am on 10 November, a nurse assessed the man and noted that his blood pressure and pulse were normal. That afternoon another prison doctor prescribed citalopram, sodium valproate and tramadol. There is nothing in the records to indicate why the medication was prescribed. The prison doctor did not see the man and, when interviewed as part of this investigation, he was unable to explain why he had prescribed the medication.

30. At around 10.00am on 11 November, a nurse assessed the man when his pulse rate and blood pressure were within normal limits. That afternoon, another nurse saw the man and recorded that he was "orientated, cheerful, communicative and cooperative". His medical observations were again normal.

31. At around 9.00am on 12 November, a nurse recorded that the man's pulse rate was 73 bpm and his blood pressure was 134/113, which was slightly high. That afternoon his blood pressure was normal again.

32. When interviewed as part of the investigation, the man's cellmate on Houseblock 3 said that they had known each other in the community. He said after they met again at Belmarsh, the man was at first his normal self and was "lively, having a laugh and a giggle". However, the man's cellmate said his condition appeared to deteriorate over the days they shared a cell. He said he was concerned that the man appeared to very drowsy and was spilling his drinks. The man told him that his medication was wrong. The man's cellmates raised his concerns with healthcare staff as he was worried about how the man appeared.

33. A healthcare assistant told the investigator that on 12 November the man's cellmate told her he had concerns about the man's condition. She said she informed her nurse colleagues who told her that she should monitor his blood pressure and keep them informed of any further developments. The healthcare assistant did not record the details of the concerns raised by the man's cellmate or her discussions with colleagues on the SystmOne (the healthcare computer system) records for the man.

13 November 2012

34. During the morning of 13 November, the man's cellmate told the healthcare assistant that the man was still not himself and he had had to assist him to the toilet. The healthcare assistant recorded that the man's pulse rate was 75 bpm and his blood pressure was 93/58, which was low. She recorded that he was a "bit drowsy". She reported this to the nurses at the medication hatch who advised that the man should not receive his methadone that morning and that his blood pressure should continue to be monitored.

35. On the afternoon of 13 November, a nurse reviewed the man's medication and noted his blood pressure was 112/58. At around 3.30pm, the healthcare assistant also recorded the man's pulse rate and blood pressure was normal. A nurse arranged for the man to be reviewed by a doctor because of the earlier concerns about his blood pressure.

36. The man's cellmate told the investigator that the man was drowsy all that day and told him that he was being given more medication than he should have been getting

37. A prison doctor saw the man during the late afternoon of 13 November and recorded the following:

> "Observed to be unusually drowsy, claims he is well in himself and that he had not slept for one week and presently feels drowsy. Also wonders why is on citalopram has never taken citalopram claiming his lack of sleep and present drowsiness stems from taking citalopram."

38. After his examination, the prison doctor recorded: "Communicative, alert but then eye lids begin to close when he is not engaged. No apparent sadness no thoughts of self harm no suicidal thoughts". The prison doctor recorded that he planned to stop citalopram and the man should be monitored for symptoms and signs of overdose. He also noted "may rqr [require] to do urine test before further methadone". There is no indication that any arrangements were made for a urine test and prison doctor did not amend the prescription for citalopram on the SystmOne medical record.

39. Along with his other prescribed medication, the man received 20mls methadone at approximately 6.00pm that evening (his normal prescribed amount).

14 November 2012

40. As the prison doctor had not amended the prescription, the man was given citalopram in the morning of 14 November. Later that morning, an officer recorded that the man was unable to participate in the group induction process as he was unable to keep his eyes open. Observations were not taken at any time on 14 November to monitor the man's symptoms or for any signs of overdose. He was given 40mls of methadone at midday as one dose (whereas he had previously been receiving two doses of 20mls, one in the morning and one in the evening).

41. At around 5.00pm on 14 November, the man and four other prisoners moved from Houseblock 3 to Houseblock 4. A Senior Officer (SO) and an officer met the prisoners in a holding room and explained what was expected of them on the houseblock and what was available to them.

42. In a statement to the Governor after the man's death, the SO recorded that he had noticed the man leaning against the wall apparently asleep. He said he

called him twice to come over but got no response and asked the officer to wake him up. The SO said that the man then came across the room to him but he was still very drowsy. The man told him he was okay but also said that he had been given the wrong medication. The SO said that he did not appear "too distressed by this" and appeared happy to move onto the houseblock. The SO took no further action and did not refer the man to healthcare staff to discuss his concerns about his medication. The man was allocated a triple cell with two other prisoners. The SO also recorded that during the evening association[3] period the man spoke to officers about his medication being wrong and they had told him to speak to the nurse on duty that evening.

43. In his statement to the Governor, an officer recorded that at around 6.00pm the man got his medication from the nurse. He wrote that during the evening the man appeared "confused which was not unusual as it was a new environment for him as he just arrived in the houseblock during the afternoon". At around 7.00pm, the officer went into the man's cell. He recorded that he was sitting upright on his bed and awake. He had asked the man if he was all right and he had said he was but "he seemed a bit sleepy but no concern".

44. The officer told the investigator that the man was able to answer questions but "wasn't too stable on his feet. He was a little shaky and a bit confused". The officer said that he was not concerned by how the man presented. The man's cellmates came to see him later and told him they were worried about him. The officer told them he would ensure that the man was seen by healthcare staff. However, when interviewed he told the investigator that he did not speak to the nurse dispensing medication that evening. Instead he only told the man to see a member of healthcare staff to collect his medication. The officer did not record in the houseblock observation book or in the man's computerised case notes any information about the man's behaviour and presentation or the concerns that his cellmates had raised about him.

45. In a statement written for the investigator, the nurse said that he had given the man his prescribed night time doses of diazepam, tramadol and sodium valproate. The nurse said that the man appeared to be "coherent, responsive and mobile" and that at "no time did he appear to be having any difficulty". The nurse also said that "at no time had anybody raised any issue regarding the man health and safety".

46. One of the man's cellmates told the investigator that when he first met the man he was incoherent, leaning forward and his eyes were rolling back. He thought he was under the influence of drugs. When he returned to the cell later he found the man sitting on the edge of the bed with his plate in his lap and all of the food in the sink. The man was swaying backwards and forwards but he agreed to lie down on the bed and promptly fell sleep. The man woke up to get his medication and when he came back to the cell he said: "I am on the wrong stuff, they have given me too much". He fell asleep soon after but as he was in an upright position leaning against the wall his cellmates moved

[3] Association is the period of time when prisoners are unlocked from their cells and are able to mix with their fellow prisoners.

him down the bed so the he was flat. The man did not wake up again after this but his cellmates said they could hear him snoring periodically.

47. The man was not assessed by healthcare staff at anytime on 14 November. His blood pressure and pulse observations were not carried out as this was no longer required after five days. However, healthcare staff did not monitor him for the effects of his medication as the prison doctor had requested.

15 November 2012

48. At about 7.00am on 15 November, one of the cellmates got up and asked the other cellmate whether the man was breathing as he was concerned he could not hear him snoring. The other cellmate said he was breathing shallowly. One of the cellmates felt the side of the man's face which was cold but he was not alarmed by this as it had been a cold night and he could feel hot breath coming out of his mouth. At around 7.50am, as they could hear doors being unlocked they tried to rouse the man but was unable to do so. An officer unlocked the cell, at around 7.55am, and one of the cellmates called out to her as he was concerned about the man.

49. In her statement after the man death, the officer states that, after she unlocked their cell, the two cellmates told her they were concerned about the man. When the officer tried to rouse the man she was also unable to get a response. His skin was grey and cold to touch. The officer called for assistance from her colleagues one of whom was the first aid at work instructor for Belmarsh. The officers asked the two cellmates to move out of the cell and radioed for medical assistance. The officers then moved the man onto the floor and started cardio-pulmonary resuscitation (CPR).[4] They were joined by a Principal Officer who assisted with the CPR attempt. One of the officers then asked for a defibrillator[5] to be brought. A member of the medical emergency team then assisted by removing the man's clothing and attaching the defibrillator to his chest. The defibrillator advised not to shock, so CPR was continued. Healthcare staff arrived and assisted with the resuscitation attempts.

50. An ambulance was requested at 8.00am. Prison records show that three ambulances arrived at the gate of the prison at 8.06am. They arrived at Houseblock 4 at 8.14am and paramedics arrived at the cell at 8.18am and took over the man's care. They continued to try and resuscitate him but stopped at 8.45am and pronounced the man dead.

[4] Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.
[5] An automatic external defibrillator measures electrical activity in the heart and issues audible instructions about treating the patient including, when appropriate, delivery of an electric shock to allow the heart to re-establish an effective rhythm.

Events after the man's death

51. After the man's death, the prison put in place its death in custody contingency plan. The police visited the prison (as they are required to do for all deaths in custody) interviewed staff and prisoners and found no suspicious circumstances.

52. The man's cellmates were moved to another cell and offered appropriate support, including the opportunity to speak to a Listener (prisoners who are selected and trained by the Samaritans to offer confidential emotional support to fellow prisoners in distress).

53. Officers told the other prisoners on Houseblock 4 later that morning that the man had died and asked whether they required any support or wanted to speak to a Listener Prisoners being monitored as a risk of suicide and self-harm were reviewed in case they had been adversely affected by the man's death.

54. Later that afternoon, prison managers held a hot debrief for the staff involved in the emergency incident. No specific issues were identified and the staff were offered support from the prison's care team.

55. Belmarsh appointed one of the chaplains and the deputy governor as the prison's family liaison officers. Around noon on 15 November, they saw the man's partner to inform her of his death as he had nominated her as his emergency contact and his next of kin. His partner informed the rest of the man's family. After his death, the prison found it increasingly difficult to contact the man's partner and his daughter became the main point of contact. In line with national guidance, Belmarsh offered financial assistance with the costs of the man's funeral, which took place on 6 December 2012. The chaplain arranged for the man's belongings to be returned to his family after his funeral.

Post-mortem report

56. The post-mortem examination recorded the man's death as being due to methadone, tramadol and diazepam intoxication. The results of the toxicology were the concentration of methadone detected in the blood was 'typical' of those normally encountered in individuals on methadone maintenance therapy, the concentration of tramadol detected in the blood was 'slightly higher' than might be expected following a recent therapeutic dose; the concentration of diazepam detected in the blood was 'entirely consistent' with the use of therapeutic amounts of diazepam and the concentration of citalopram detected in the blood is 'within the range' that might be expected following regular therapeutic use of the drug.

57. The post-mortem report states that the lung findings show widespread pulmonary oedema which represents respiratory failure, in addition "the recording of snoring prior to [the man] death would be compatible with central nervous system depression and low oxygenation".

58. The clinical reviewer states that methadone, tramadol and diazepam are all sedative and respiratory depressants that in combination would cause excessive drowsiness and could compromise a person's ability to breathe.

ISSUES

Clinical care

59. An independent doctor reviewed the man's clinical care. From the medical records, it was clear that the man was seen regularly by healthcare staff until he moved to Houseblock 4 on 14 November.

60. The man had a history of substance misuse and alcohol dependence. He had also received psychiatric support after acts of self-harm and attempted suicide in the community. After the man's reception screening, he started a five day opiate withdrawal programme. In the man's case, as it was unclear how much heroin he had been using, his dose of methadone was low and was to be gradually increased until a safe dosage was achieved. The man also started a five-day alcohol withdrawal programme.

61. On 10 November 2012, a prison doctor, prescribed citalopram, tramadol and sodium valproate without seeing the man. The SystmOne record noted only the three drugs and their dosage with no indication of why they were prescribed. When interviewed, the prison doctor was unable to offer any reason for this clinical decision. The Head of Healthcare at Belmarsh told the investigator that it was probable that the three drugs had been prescribed based on records of medication when the man had previously been in Belmarsh. However, at that time he was not also prescribed diazepam and methadone. Community GP medical records were not requested so healthcare staff did not establish that the man's antidepressant medication had been changed from when he was previously in custody, or that the sodium valproate was used as a mood stabiliser and that the tramadol (a strong analgesic) had been prescribed on only a few occasions during 2012 and was not a regular medication.

62. The clinical reviewer draws attention to the British National Formulary (BNF), which states that there is an increased risk of central nervous system toxicity (leading to seizures) if tramadol and citalopram are prescribed together. In addition, both of these drugs cause an increase in serotonin[6]. If prescribed concurrently there is the potential risk of moderate to severe toxicity leading to the so-called 'serotonin syndrome'. This can lead to tremor and muscle rigidity, sweating and raised pulse rate, and agitation and confusion. The BNF is available to all GPs and information on drug interactions and side effects is also on SystmOne. There is also a potential drug interaction between methadone and citalopram that alters the electrical activity of the heart. Methadone, diazepam and tramadol are all sedatives and respiratory depressants that in combination would cause excessive drowsiness and could compromise a person's ability to breathe.

63. The clinical reviewer is concerned that the prison doctor did not see the man on 10 November when he prescribed medication. There was no clinical assessment conducted for depression or to establish the need for tramadol, a

[6] Serotonin is a type of neurotransmitter (the brain chemicals that communicates information throughout the brain and body)

strong analgesic. There is no evidence that either the BNF or SystmOne information on drug interactions were consulted and taken into account.

The Head of Healthcare should ensure that prescribers consider the effect of drug interactions and side effects and follow protocols for managing drug withdrawal which comply with best practice.

64. The healthcare assistant did not record on SystmOne her interactions with the man's cellmate or his concerns about the man or her subsequent discussion with her colleagues on 12 November. When the prison doctor saw the man on 13 November he decided to stop the prescription of citalopram but he did not take the required action, so the man was given it again the next day. The man's methadone was not stopped until a urine test was done and there was no consideration given to admitting the man to the healthcare centre for observation. After he moved to Houseblock 4, the man was not clinically assessed and he received 60ml of methadone within 18 hours.

65. The clinical reviewer considers that the medical assessment conducted by the prison doctor on 13 November was of an unacceptable standard. He has identified significant concerns about the prison doctor's clinical performance in relation to the man and makes recommendations in the clinical review in relation to this. Following an internal investigation, the Head of Healthcare also highlighted concerns about the prison doctor's clinical practices and advised that this should be investigated by the clinical director. We have been informed that the prison doctor has been excluded from the prison pending the outcome of the Ombudsman's investigation, the clinical review and the Care UK medical peer review. Another doctor continues to provide GP services at Belmarsh under supervision. This is a serious matter and we make the following recommendation:

The commissioner of healthcare at Belmarsh should ensure that the clinical performance of the prison doctor is thoroughly investigated in relation to the man's treatment, including referral to the General Medical Council if appropriate.

66. Prison Service Instruction (PSI) 45/2010 Integrated Drug Treatment System (IDTS), states that "Healthcare managers should ensure that practitioners are able to attend IDTS clinical training to enable them to achieve the level of competence required by their role. This training comprises resuscitation and naloxone training, Royal College of General Practitioners (RCGP) certificate level 1 and 2 clinical substance misuse training". Neither of the prison doctors who saw the man possessed the RCGP level 2 clinical substance misuse training. We note that Her Majesty's Inspectorate of Prisons drew attention to this deficiency at an inspection in April 2011 and made a recommendation about this. It is a serious concern that at the time of the man's death over 18 months later the GPs had still not been trained. The prison has told us that rather belatedly arrangements for training are being made and in the meantime specialist medical advice is available when required. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all GPs and nurses responsible for the clinical management of substance-dependent prisoners undertake the Royal College of General Practitioners (RCGP) level 2 clinical substance misuse training.

67. The post-mortem report states death was caused by: "Methadone, tramadol and diazepam intoxication". As the clinical reviewer has noted, all three of the drugs were sedative and respiratory depressants that in combination would cause excessive drowsiness and hinder the person's ability to breathe. Heart damage can be associated with cocaine abuse and this increases the chances of sudden death. The man was a known crack cocaine user and was supported for his dependency on opiates. Methadone was prescribed for the man's heroin addiction to stabilise his condition and clinical reviewer states that the process of assessment and prescribing methadone followed the set guidelines. The man's withdrawal from alcohol was supported by a prescription of diazepam. The clinical reviewer states that this also followed the set guidelines. He notes that the man had similar programmes in the past without any problems. He confirms that both drugs (methadone and diazepam) were prescribed within the therapeutic range.

68. Prison Service Instruction (PSI) 45 2010 requires prisoners with substance use problems who are undergoing clinical stabilisation, to have clinical observations recorded twice a day for a minimum period of five days. During his five day stay in Houseblock 3 at Belmarsh, the man was seen by staff from the substance misuse team at least twice each day and his clinical observations were recorded each time as required. After his move to Houseblock 4, on 14 November, no further observations were recorded and the man's methadone was administered as a single (40 mls) dose whereas previously it had been given in two divided doses (20 mls). The clinical reviewer was uncertain as to the rationale for this prescription authorisation. We are concerned that the actions requested by the prison doctor were not followed up.

The Head of Healthcare should ensure that actions identified at GP consultations are clearly recorded and followed up by an identified member of the healthcare team.

Actions taken by prison officers

69. The man was seen by a number of officers when he arrived at Houseblock 4, which has a specialist function as a second stage for prisoners receiving clinical treatment for substance misuse. Although the man expressed concern to a Senior Officer that he had been given the wrong medication, the SO took no specific action. His cellmates raised their concerns with an officer about the man's behaviour, but he did not ensure the man was seen by healthcare staff. Neither member of staff recorded what they had witnessed and been told in the houseblock observations book or in the man's prison record. This meant that other staff on the houseblock were not alerted to the concerns raised by his cellmates, the possible issue about the wrong medication and how the man was presenting in relation to his prescribing regime.

70. The houseblock observation book and individual prisoner computer records are important methods for effectively passing key information about a prisoner's wellbeing and behaviour from shift to shift and it is important that these are used effectively to alert staff to any concerns.

The Governor should ensure that all officers effectively use the houseblock observation books and individual prisoner records to alert other staff when there are identified concerns about a prisoner.

71. We accept that it is not possible for prison staff to be trained in the signs and symptoms of a wide range of complex medical conditions. However, we are concerned that the staff on Houseblock 4 which has a specialist function for prisoners undergoing drug treatment did not seem to be aware or alert for the signs of drug intoxication, despite several of them noting at the time that the man was extremely drowsy, shaky and confused. Only his cellmates appeared to identify that there were reasons to be concerned about the man's presentation. Despite raising their concerns with prison staff, these concerns were not effectively acted on and none of the officers spoke to specialist healthcare staff to alert them to the concerns, instead preferring to leave it to the man himself to consult them. This is a particular concern in the light of the Inspectorate's observations about staff having a poor attitude towards drug dependent prisoners. It is also a concern that the man's cellmates and some staff had identified the man as notably drowsy throughout the day, the nurse administering medication on the evening of 14 November later described him as "coherent and responsive". In the light of the other evidence about the man's condition that day, we think that is unlikely to be the case. We make the following recommendation:

The Governor and Head of Healthcare should ensure that prisoners on methadone maintenance and detoxification regimes who appear unwell are checked regularly and that staff who work with prisoners undergoing drug treatment are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.

The emergency response

72. An officer discovered the man unresponsive when unlocking cells at around 7.55am on 15 November after being alerted by his cellmates. Within minutes the officer had radioed for and received assistance, an ambulance had been called, and attempts were being made to resuscitate the man. The paramedics arrived at the prison quickly and took over the man's care at 8.18am; they pronounced death at 8.45am. From both the records and the investigator's interviews with staff it appears that, after the man was discovered, all those involved acted quickly and in a professional manner. The clinical reviewer states: "The transfer of the ambulance from the prison gates to the cell was timely".

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendations. All of the recommendations were accepted.

1. The Head of Healthcare should ensure that prescribers consider the effect of drug interactions and side effects and follow protocols for managing drug withdrawal which comply with best practice.

2. The commissioner of healthcare at Belmarsh should ensure that the clinical performance of the prison doctor is thoroughly investigated in relation to the man's treatment, including referral to the General Medical Council if appropriate.

3. The Governor and Head of Healthcare should ensure that all GPs and nurses responsible for the clinical management of substance-dependent prisoners undertake the Royal College of General Practitioners (RCGP) level 2 clinical substance misuse training.

4. The Head of Healthcare should ensure that actions identified at GP consultations are clearly recorded and followed up by an identified member of the healthcare team.

5. The Governor should ensure that all officers effectively use the houseblock observation books and individual prisoner records to alert other staff when there are identified concerns about a prisoner.

6. The Governor and Head of Healthcare should ensure that prisoners on methadone maintenance and detoxification regimes who appear unwell are checked regularly and that staff who work with prisoners undergoing drug treatment are made aware of the common symptoms of drug-induced unconsciousness and drug intoxication and know how to respond.