



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in September
2013 at HMP Lowdham Grange**

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 man at HMP Lowdham Grange in September 2013. He was 27 years old and died from a subtoxic level of drug abuse and myocarditis (inflammation of the heart muscle). I offer my condolences to his family and friends.

A clinical review of the care the man received during his time in custody was undertaken. HMP Lowdham Grange cooperated fully with the investigation. I apologise for the delay in issuing this report.

For much of his time at Lowdham Grange, the man was on a methadone programme to treat opiate addiction and was regularly reviewed. The clinical reviewer concluded that he received a good level of care at the prison for his substance use problems.

An officer was concerned about the man's appearance one morning at the beginning of September and summoned help. When staff went into the cell they found him unresponsive. Although they believed he was dead, they attempted to resuscitate him until paramedics arrived and confirmed his death. It appears that his death was sudden and unexpected and there was little that prison staff could have done to prevent it. Nevertheless, there were some aspects of his care at Lowdham Grange which cause me some concern, particularly as it is possible that drug use was a contributory factor.

The man was prescribed antidepressants and painkillers, which he kept in his possession. There was also evidence that he used illicitly obtained drugs in addition to his prescribed medication. Other prisoners told us that drugs were easily available in the prison. The investigation found that this problem was not effectively addressed through appropriate information sharing and robust security measures. I am also concerned that a prisoner known to abuse and trade medication was allowed to retain medication in his cell. I consider there is a need for tighter measures to reduce the availability of illicit medication and other drugs in the prison and a need for more effective risk assessment before allowing prisoners to keep medication in their possession which reflects all relevant information known about them.

Although it would not have affected the outcome for the man, I am also concerned that emergency procedures at the prison were poorly coordinated and did not comply with current national guidance.

This version of my report, published on my website, has been amended to remove the names of the man who died and those of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

July 2014

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SUMMARY

1. The man was convicted of wounding with intent in July 2009 and sentenced to ten years imprisonment. He had been at HMP Lowdham Grange since March 2010.
2. The man had been addicted to heroin and said he wanted to be free of drugs when he left prison. He had completed a methadone detoxification programme when he first went to prison. When he transferred to Lowdham Grange in March 2010, he said he had no drug problems. However, in July 2010, he referred himself to a drug worker at Lowdham Grange and began another methadone programme. He actively participated in regular meetings.
3. Security reports suggested that the man continued to be involved with illicit drug taking at the prison and there was information indicating he was involved in obtaining and distributing illegal drugs and trading medication with other prisoners. The security department monitored his activities, but no formal action was taken. He told healthcare staff that he took illicit drugs to top up his prescribed medication. Because of medical confidentiality, this information and other information about his drug use was not disclosed to prison security staff. Although he admitted abusing prescribed medication and other drugs, he was allowed to keep his prescribed medication in his possession.
4. Early one morning at the beginning of September, a prison custody officer noticed that the man was slumped on his bed in an odd position. He was unable to get a response from him, so asked the duty manager to come to the wing. He did not indicate that it was an emergency. The manager arrived with a nurse and other staff. They looked through the cell observation hatch, but could not tell if he was breathing, so they unlocked the cell and went in.
5. The man felt very cold and showed no signs of life. The nurse called an emergency code blue and requested an ambulance and emergency equipment. She then started cardiopulmonary resuscitation, assisted by the duty manager. When paramedics arrived they confirmed that he had died. A post-mortem examination found that the cause of death was drug abuse and mild myocarditis. It added that on probability, drug abuse was the main cause of death knowing that the patient was taking a variety of illicitly obtained drugs.
6. While we conclude that little could have been done to predict or prevent the man's sudden death the investigation found that the procedures for assessing risk and reviewing the medication prisoners are allowed to keep in their possession need strengthening. Healthcare staff felt unable to report any incidents of drug abuse which came to their attention, but we consider that it should be possible to report security concerns without compromising individual patient confidentiality. Healthcare staff in different clinical teams were not able to access and share clinical records easily as they used different systems.

7. Although it would not have affected the outcome for the man, who appears to have been dead at the time he was found, we are concerned that the emergency response procedures at Lowdham Grange were not compliant with current national instructions. This meant that staff responding to the call for help were unaware of the urgency and nature of the incident and there was a delay in calling an ambulance and escorting the crew to his cell.
8. There were also deficiencies in family liaison arrangements. The prison's family liaison officer asked the police rather than prison staff from a nearby prison to notify the man's family of his death and no one from the prison offered to visit his family subsequently as they should have done.

THE INVESTIGATION PROCESS

9. We issued notices about the investigation to staff and prisoners at Lowdham Grange. In response, three prisoners contacted the investigator. Two agreed to be interviewed.
10. The investigator visited Lowdham Grange on 13 November and 10 December 2013 and interviewed staff and prisoners.
11. A clinical reviewer assessed the man's medical care at Lowdham Grange on behalf of NHS Midlands. He joined the investigator for most of the interviews.
12. The investigation was suspended for a period until the post-mortem and toxicology report was available which delayed the clinical review. We regret the consequent delay in issuing this report.
13. The investigator notified HM Coroner for Nottinghamshire of the investigation and we have sent her a copy of this report.
14. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process and invite them to identify any relevant issues they wanted the investigation to consider. They had a number of questions and concerns, including:
 - Whether the fact that he had put on a significant amount of weight in prison had been identified and monitored.
 - Whether his medication had been properly monitored, especially in conjunction with his weight gain.
 - They wanted to know what medication he had been prescribed and whether he had remained on it too long, including the reasons for methadone treatment and the extended use of sleeping tablets.
 - They said that he seemed breathless when he spoke to his family and wanted to know whether this had been explored.
 - They said that a significant amount of money had left his prison account and wanted to know whether he had been bullied. The investigation found no evidence of this.
15. The family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP LOWDHAM GRANGE

16. HMP Lowdham Grange is a category B training prison, privately managed by Serco, which holds over 900 men. The accommodation consists of five houseblocks which typically hold 120-130 prisoners on two or four residential wings.
17. General healthcare services are provided by Serco Health while secondary mental health services are provided by Nottinghamshire Healthcare NHS Trust. Serco Health subcontracts GP services.

HM Inspectorate of Prisons

18. At an inspection of Lowdham Grange in March 2011, inspectors found that treatment for opiate-dependent prisoners was flexible and appropriate to their needs. Secondary detoxification was available for those who had relapsed in prison. Prisoners receiving drug treatment were located throughout the prison, which allowed them to attend work and education. They were fully involved in care plans and reviews.
19. The Inspectorate noted that cannabis and diverted medication were the main drugs used illicitly at the prison. Around 18% of prisoners the Inspectorate surveyed said that it was easy to obtain illegal drugs in the prison against a comparator of 31% in other similar category prisons. There were good links between the security department and the substance misuse team. However, inspectors were concerned that the quality of security information reports varied and that delays in processing intelligence information sometimes held up prompt testing of prisoners suspected of taking illicit drugs.

Independent Monitoring Board

20. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its annual report for the period to 31 January 2013, the IMB said they were satisfied that the prison had been well managed and that prison staff treated prisoners with respect and dignity. The healthcare unit had achieved significant reductions in waiting times for GP services but the IMB was concerned about the provision of secondary mental healthcare. The IMB noted that hooch (illicitly brewed alcohol) remained a problem at the prison and a number of targeted lockdowns and searches had been successful.

Previous deaths at Lowdham Grange

21. There have been two other deaths at Lowdham Grange since 2011. There were no similarities between the circumstances of those deaths and that of the man's.

KEY EVENTS

22. The man was remanded to prison at the beginning of January 2009 and sentenced to ten years imprisonment for wounding with intent in July 2009. He transferred to Lowdham Grange in March 2010, after serving time in custody at HMP Cardiff, HMP Swansea and HMP Parc.
23. When he arrived at Cardiff on 3 January 2009, the man's weight was recorded at 12 stones. He agreed to be referred to see a doctor for substance use problems. He had been addicted to heroin before he went to prison and sought help for his substance use problems. He said he wanted to be free of drugs when he left prison. On 20 January 2009, it was noted in the medical records that his detoxification programme had been completed. He transferred to HMP Parc on 15 July and told healthcare staff that he had previously had a drug problem and had used heroin and crack cocaine before his sentence, but no longer had a problem.
24. When he arrived at Lowdham Grange on 30 March 2010, it was noted in the man's medical records that he had no drug or detoxification issues.
25. On 5 July 2010, the man completed a self-referral form to see a drug worker saying he had a drug problem and needed to do something about it. During his assessment, he said he had relapsed due to boredom and being in the company of other drug users. He began a methadone programme taking 40 ml of methadone daily.
26. On 7 July, the man told a drugs worker at the prison that he wanted to be drug-free and that his family were questioning where his money was going. He said he was using three or four bags of heroin daily. She agreed to see him monthly. He said he was fine and attending the gym regularly, although by October 2010 he admitted he had been taking diazepam to cope with a reduction in his methadone. He said he felt 'stupid' as he had been spending a lot of money on diazepam. He said that he visited the gym to combat his feeling of restlessness.
27. At the beginning of 2011, the man's medication was reviewed because he was still using diazepam. He was prescribed 16ml of methadone, increasing to 20ml the next month and began a detoxification of diazepam. By February 2011, he was taking 10ml of methadone, but this increased again to 25ml in March and 30ml in May.
28. In May 2011, the man admitted to an IDTS nurse that he had taken opiates illicitly at Lowdham Grange. (This information was not reported to the security department.) In July 2011, he requested a rapid detoxification using subutex as he wanted to be drug-free. (Subutex is a brand name for buprenorphine, another synthetic opioid used to treat heroin addiction.) At that time, he was taking 15ml of methadone and was advised to stop taking additional illicit drugs. He had been prescribed nefopam for a painful knee but said it was ineffective and that he had taken dihydrocodeine (DHC, a painkiller) illicitly. The prison doctor prescribed him tramadol in place of the nefopam.

29. Between August and December 2011, security information reports suggested that the man had been in dealing in drugs and that he had threatened prisoners who were in debt to him. He had intimidated other prisoners while working at his job serving meals on the wing. As a result of this information, prison staff monitored him and subsequently removed him from this job.
30. On 3 August 2011, the man completed his detoxification programme. He said he did not want to have to use methadone again, or take any illicit drugs. On 9 November 2011 he said that he was still drug-free.

2012

31. On 3 January 2012, the man told the drugs worker that he had taken heroin over Christmas. He estimated he had used between £50 and £100 worth a day and could not explain why he had relapsed. He was given an appointment to see a doctor the next day.
32. The next day, the man told a doctor that he had relapsed and had been using heroin over the past four weeks as he had felt stressed. He asked to be referred to the prison's Integrated Drug Treatment System (IDTS) programme for detoxification. He made a written application in which he said that he considered himself to be at high risk of taking drugs. He felt he had detoxified too quickly previously at the end of 2011. He began a new drug treatment programme the same day and was prescribed 20ml of methadone daily. Records show that healthcare staff reviewed and assessed him throughout 2012.
33. On 4 March, the man told a doctor that he had been using illicitly obtained diazepam (valium) as he had been feeling stressed. As a result, his dosage of diazepam was increased to 40ml daily. It was reduced to 30ml later that month. On 27 June, he admitted to 'topping up' the methadone dosage and taking as much as he could buy from other prisoners. To help avoid this, a prison doctor increased his methadone dose to 50ml. The same day, he told a nurse that he was still using additional methadone on top of the prescribed 50ml. The doctor then increased his dosage to 60ml. There is no evidence that healthcare staff took any action to report that methadone was being misused on the wing.
34. Wing staff submitted a security information report (SIR) on 23 April, indicating that the man and his cell mate had a 'drink issue' which seemed to be getting worse. The prisoners were then moved to different parts of the prison. On 14 May, a search of his cell found two white tablets, which were removed. There is no record of what these were or whether any action was taken.
35. On 13 September, an IDTS drug worker reviewed the man's drug treatment care plan with him. He said that he wanted to continue to be maintained on 60ml methadone daily until he was released from prison in 2014. In addition to his methadone and prescription of dihydrocodeine for knee pain he admitted that he had been taking between 30 and 40mls of illicitly bought

diazepam daily. He said he felt he would struggle to come off of diazepam and agreed to see a doctor. During this meeting, his weight was recorded as 101kg - 15 stones and 9 pounds. (There is no record of his weight when he first arrived at Lowdham Grange in March 2010.)

36. A security information report submitted in November noted that the man was involved in the drugs culture at the prison. The security manager ordered a mandatory drug test on grounds of suspicion and a cell search, but there is no record that this was done.
37. On 23 November, it is recorded in the man's medical records that a nurse called an emergency at 7.45pm, as he appeared disorientated and had a reduced level of responsiveness. He admitted that he had taken seven zopiclone (sleeping tablets). His pupils seemed small which indicated that he might also have taken opiates. Healthcare staff monitored him at five minute intervals for half an hour, which was then reduced to every ten minutes. By 8.40pm, his observations appeared normal. This was not followed up by healthcare staff, the IDTS team, or the security department to investigate where the drugs had come from. During her interview the lead GP at the prison said that the Medical Protection Society advised that healthcare staff should be careful about reporting such incidents because of patient confidentiality and the likelihood that prisoners would stop confiding in them.
38. A prisoner at Lowdham Grange told the investigator that one evening (he could not be specific about time) the man had told him that he had taken ten zopiclone tablets as well as amitriptyline (an antidepressant) and seroquel (an antipsychotic drug).

2013

39. On 11 January 2013, the man told his drug worker that he felt stable on 60mls of methadone. A week later, she told him about a new drug recovery unit that was due to open in the prison and suggested that he might find it helpful and should apply for a place. He said that he was settled on G wing, enjoyed his work and did not want to move. He said that he wanted to stop taking methadone at some stage, but that he did not feel that the new unit would be right for him at that time. At a further meeting with her on 4 February, he said he felt he might be able to reduce his methadone dose soon, but would not commit to a timescale.
40. On 28 January, the man complained of difficulty sleeping and breathing due to a broken nose he had sustained eight years earlier. He was referred to the doctor. On 6 February, he told a doctor that he had trouble sleeping. The doctor prescribed a five night course of zopiclone 3.75mg, to be kept in his possession. He continued to report problems with sleeping and he was given a further five zopiclone tablets on 13 February, 20 February, 27 February and 4 March. He continued to be prescribed zopiclone from March to August. A prescription of five tablets was issued at a time (3.75mg) one to be taken each night for five nights.

41. At a review with the drugs worker on 1 March, the man said he would like to reduce his methadone dose and they agreed it would be reduced by 2mls a week. By 27 March, he was on 52mls of methadone.
42. The man had a healthcare assessment on 29 April, at which a nurse noted that a family member had a history of heart problems and hypertension. He said that he smoked and the nurse gave him advice about giving up smoking. During this assessment, his weight was recorded at 16 stones and five pounds.
43. On 5 May, the man told a nurse that since his methadone dose had reduced to 40mls daily on 1 March, he had had trouble sleeping, in spite of a regular zopiclone prescription. He asked to remain on 40mls of methadone and the nurse made an appointment for him to see the doctor on 8 May. A doctor reviewed his methadone prescription on 8 May. He told her that he was finding it difficult to cope with the 2ml a week reduction, so she prescribed a further week on 40mls, to be followed by a 1ml reduction each week. On 10 May, he was prescribed another five zopiclone tablets.
44. On 14 May, staff carried out an in-possession audit to review the man's risk in keeping his medication in his cell. No concerns were noted.
45. A doctor reviewed the man's methadone prescription on 29 May. She noted that his methadone was being reduced by 1ml every week and that he was due to be released the following March (2014). He was unsure whether he wanted to be drug-free when he was released, or be prescribed subutex. The doctor noted that if he wanted to be drug-free they would have to review the reduction plan.
46. The same day, a prisoner alleged that he had been threatened by a number of prisoners, including the man, because he had refused to be involved in getting drugs into the prison. Staff monitored the situation, but no outcome was recorded.
47. The man had a review with a new drug worker on 29 May. He enquired about changing his medication to subutex once the methadone had reduced to 20mls. She told him that this could not be done until a week before his release and that a doctor had advised that changing medication could prove very disruptive.
48. The man was prescribed a further 56 dihydrocodiene 90mg tablets on 11 June. In June and July, he was prescribed amitriptyline for nerve pain. He had requested gabapentin (for neuropathic pain), but the doctor would not prescribe this. He continued to be prescribed zopiclone throughout July and August and received five tablets at a time as well as dihydrocodeine tablets to keep in his possession.
49. At a methadone medication review on 28 August, the man told a doctor that he was happy to continue with the 1ml weekly reduction. He said he wanted to be prescribed subutex when he was released in March. The doctor said

this was possible, but they would decide options nearer to his release date.

50. On 2 September, the man said he felt unwell and received a sick certificate to allow him to miss work for one day. That afternoon, a doctor reviewed him, although she did not see him in person. She prescribed a month's supply (28 tablets) of 50mg amitriptyline daily, to be kept in-possession. When interviewed, she said she did not regard this as a high dose, but she had some general concerns about the prison's in-possession policy, notably that the records were poor and there was no review system.
51. During the investigation Lowdham Grange clarified that, on 24 July, a doctor had prescribed the man a month's supply of 25mg amitriptyline to be held in-possession. The doctor did not record the reason for this, but the next day another doctor prescribed him a month's supply of amitriptyline 50g for pain in his right hand. However, this doctor had not stopped his repeat prescription for amitriptyline 25mg, so he began to receive both, making a total of 75g. A doctor stopped the repeat prescription of 25g on 2 September and prescribed the 50mg amitriptyline, in-possession.
52. The next day, 3 September, the man was prescribed dihydrocodeine 90mg tablets, also in-possession and, on the evening of 4 September, a nurse gave him a pack of 28 amitriptyline tablets.
53. A prison custody officer recalled seeing the man on the evening of 4 September when he was delivering prisoners' letters to them. He said that the man tried to take the mail from him and became confrontational. The officer noticed nothing else unusual.

Day of the Incident

54. At approximately 2.00am, an officer was carrying out routine rounds on G and H wing to check that prisoners were safe and well. He had previously checked G wing at about 11.40pm and said he had noticed nothing to concern him about the man at that time (although individual checks were not recorded). When he looked into his cell, he saw that the cell light and television were on and that he appeared to be asleep in a strange position. His legs were off the bed and his torso turned as if he had fallen asleep and slumped to the side of the bed. The officer told the investigator that this was not unusual, especially if the prisoner was on medication. He continued his check, but said that something about him and his position on the bed played on his mind. He decided to go back to his cell to try to wake him and asked another officer to accompany him for a second opinion.
55. When they reached the cell, the officer shouted to the man, but got no response. He banged on the cell door, but was still unable to rouse him. He shone his torch to see more clearly whether he could determine a rise and fall of his chest, but could not fully satisfy himself of this. At 2.10am, he telephoned to ask the night duty manager to attend the cell as he could not get a response from him. At interview, he explained that he had called for the night manager as there was a requirement for three staff to be present before

opening a cell at night unless it was an emergency (in which case he could use his sealed key pouch) and he did not think this was an emergency at that stage.

56. The duty manager arrived a few minutes later with a nurse, who had been with her when she received the telephone call and decided to accompany her. The nurse said that they had put on their coats and walked to the houseblock with no urgency as they were unaware it was an emergency, although they had been told that the man had not responded when officers knocked on his door. When they arrived at the houseblock, they did not initially know which wing to go to as the officer had not given the cell location. The nurse said that she had a small medical bag with her which she carried routinely during night duty.
57. The duty manager looked at the man through the observation panel and asked the nurse and the officers whether he was breathing. The nurse could not be sure so advised her to open the cell door. They went into cell, but were unable to rouse him. He was lying face down on the bed and the officer said that when he put his hand on his back he felt very cold. The officer and the duty manager turned him onto his side and noticed that his face was dark purple. They could not detect a pulse and thought it looked as if he might have been dead for a couple of hours.
58. The nurse radioed an emergency code blue (to indicate a prisoner who is unconscious or not breathing) at 2.18am. She requested an emergency ambulance be called and asked that a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest) and an emergency response bag should be brought to the cell. At interview, the nurse said that at the time of the man's death, ambulances were not called automatically for code blue emergencies; the person calling the emergency had to request one and indicate whether a defibrillator was required. She said that it was unusual for anyone other than a member of healthcare staff to call an ambulance. The control room log shows that an ambulance was requested at 2.23am, five minutes after the code blue. No reason was noted for this delay.
59. The officers laid the man onto the floor of the cell and, although they thought that resuscitation was unlikely to be possible, the nurse and duty manager took it in turns to administer chest compressions. The officer brought a defibrillator from the wing control room. When he returned to the cell he said the duty manager was administering rescue breaths. The nurse applied the defibrillator pads to the man's chest but no heart rhythm was detected and they continued to attempt resuscitation. The officer noticed that his leg seemed to be in a fixed position.
60. Two more officers arrived at the cell and one took over giving breaths. Another nurse had heard the emergency call over the radio and brought another emergency bag from the healthcare centre with airway devices and other equipment, shortly after 2.18am. The first nurse was unable to insert an airway into the man's mouth as his jaw was clenched shut, so she inserted it

into his nasal passage. The other nurse then took over from the officer, using an ambu-bag (a bag valve mask used to provide ventilation.) Throughout this time the defibrillator detected no shockable heart rhythm.

61. At approximately 2.34am, two paramedics arrived at the prison and reached the cell five minutes later at 2.39am. (Records indicated that two members of staff escorted the ambulance, unlocking and locking the prison gates along the way.) Another paramedic arrived shortly after and all three assessed the man. At 2.46 they formally confirmed his death. Before the staff left the cell, an officer found an empty strip of ten amitriptyline tablets in the cell toilet. The first nurse checked his medical record and discovered that he had been prescribed 28 amitriptyline 50mg tablets, to be held in-possession, the day before. No other tablets or empty strips were found in his cell.

Informing the man's family

62. The man's family lived in Wales and a senior manager asked South Wales Police to break the news of his death to them. She spoke to a Sergeant at 6.20am, who agreed to speak to the family and then notify the prison when this had happened. The time the police spoke to his family is not recorded in the family liaison log, but at 9.41am the senior manager returned a call to the man's aunt to give her further information. That afternoon, the details were passed to the prison's family liaison officer, who telephoned again at 1.30pm. The funeral was held on 24 September and the prison contributed to the costs, in line with national guidance.

Post-mortem

63. The post-mortem report concluded that the cause of death was a subtoxic level of drug abuse and mild myocarditis. There were no external signs of violence or injury. The toxicology report noted the following:

"There is no clear evidence of a toxicological cause of death. The level of amitriptyline is higher than usually seen in therapeutic dosing, but has not reached the level generally associated with acute fatal toxicity. The levels of all other drugs are consistent with recent therapeutic dosing. Zopiclone was not detected. The level of methadone is consistent with recent intake that could be potentially fatal due to its CNS depressant effects. However, the levels of methadone and EDDP are at the lower end of those expected to be found during regular dosing for opioid maintenance therapy. In an individual with little or no previous exposure to methadone such levels would be associated with significant toxicity, but in an individual taking methadone/opiates regularly such a level would be expected to be tolerated without experiencing toxic effects."

64. The clinical reviewer noted that, while the toxicology report concluded that none of the drugs found during the toxicology examination were at toxic level, it is well documented that a combination of drugs in these classes can lead to cardiac problems.

65. When he died, the man weighed 110kg (17 stones and four pounds). He was 197 centimetres tall (six feet and five inches) and his body mass index (BMI) was calculated at 28.35, which was considered overweight. He had gained 23 pounds since September 2012 and over five stone since 2009, but he had not raised this with healthcare staff or seemed concerned about it. Neither had he reported any breathlessness. There is no record that healthcare staff specifically advised him about his weight.

ISSUES

Clinical care and drug treatment

66. The clinical reviewer examined the standard of care the man received at Lowdham Grange. He noted some deficiencies which might have impacted on his general clinical care and made several recommendations which the healthcare manager will need to consider. We repeat those directly relevant to the circumstances of his death.
67. The clinical reviewer noted that the integrated drug treatment system team (IDTS) and primary health team are located in different parts of the prison. The IDTS team primarily treat prisoners with opiate dependency needing methadone treatment, while the primary care team deals with prisoners addicted to prescription drugs. The teams use different formats to record clinical information, both of which the clinical reviewer found lacked detail and were not comprehensive. There were no regular meetings between the two teams and communication was poor. This meant that the two services worked in isolation, with the risk that vital information about treatment and medication could be overlooked. It was difficult to establish the reasons for consultations, diagnosis and changes of medication. While there is no indication that this was a factor in the man's death, the absence of cooperative working was particularly pertinent in his case as he was on a methadone treatment programme while apparently misusing other drugs at the same time. We make the following recommendation:

The Healthcare Manager should ensure that there is effective communication between the primary care and IDTS team and that all clinicians have access to and are able to share electronic clinical information.

68. Although the clinical reviewer had some concerns about information sharing between the two teams, he was satisfied that both the IDTS team and the primary healthcare team prescribed appropriate medication for the man's medical conditions and that the doses were commensurate with those found in the guidance for these medications (British National Formulary, December 2013) including the prescription of zopiclone for his problems with sleeping. The entries in the IDTS records show that the drug treatment team reviewed him regularly and took account of his wishes about the rate of his detoxification. The clinical reviewer comments that if he had been in the community, it is unlikely that he would have received the enhanced level of care provided at Lowdham Grange.

Security and drugs

69. Prison security staff believed that the man was involved in the drug culture in the prison and they monitored him when incidents were reported. The investigation found that, although there was awareness of the use of illicit drugs throughout the prison, there was little evidence that this led to effective action to reduce drug supply and availability. Few reports were submitted to

the prison's security department by healthcare staff and many of them were unclear about the policy for reporting illicit drug use.

70. Prison and healthcare staff knew that the man used illicit drugs to supplement his prescribed medication. On one occasion, he appeared to overdose on several zopiclone tablets and possibly opiates. This does not appear to have been an intentional overdose and there is no suggestion from the records that he felt suicidal. There were other occasions when he disclosed to healthcare staff that he had obtained and used illegal drugs and illicitly traded in prescribed medication. The lead GP at the prison told the investigator during her interview that healthcare staff had been advised that they should be careful about reporting such incidents because of patient confidentiality and that it might deter a prisoner from sharing vital information about their health or medication. She said that healthcare staff would put in security information reports, for example when they had heard there were particular problems on a specific houseblock, but would not name or report individual prisoners. Other healthcare staff were not so clear about this.
71. We acknowledge that healthcare staff are placed in a difficult position when prisoners make disclosures about drug use and there can be a conflict in prisons between confidentiality and privacy and the needs of security and safety. Doctors in the community would not be expected to report a patient to the police who disclosed illegal activity such as dealing in drugs. The primary task of prison doctors and other healthcare workers is, rightly, the health and wellbeing of their patients and it is important that prisoners understand that they can speak to clinicians openly and confidentially about matters such as drug use, otherwise decisions could be made which might compromise their safety. Healthcare workers need to know what substances their patients have taken to make appropriate decisions about their care.
72. Information can be shared when it would help protect the individual or anyone else from the risk of death or potential serious harm. This is a high threshold, but there are occasions when illicit drug use can be very harmful and endanger life. Decisions about whether or when to disclose information must always be down to the professional judgement of the individual clinician. However, we consider that healthcare staff should provide more general and anonymous security information about potentially dangerous situations, such as when they become aware that there is a particular problem of medication being traded on a wing, without compromising individual medical confidentiality. There is of course also a need for the prison to act on security information and take effective action to help reduce the dangers of illegal drug taking and illicit trading in medication. Prisoners told the investigator that drugs were rife at the prison and could be bought to order. We note that HM Inspectorate of Prisons found that the quality of security information reports varied and there were delays in taking effective action. We make the following recommendation:

The Director should ensure that that there is an effective response to security information about illicit drug use in the prison and, together with the Healthcare Manager, ensure that healthcare staff understand

the circumstances in which they can contribute security information about illicit substance use without compromising individual patient confidentiality.

In-possession medication

73. The in-possession medication policy at the time of the man's death had been issued in June 2013. A revised version was issued in August 2013. Both policies say that all prisoners should be given responsibility for their medication unless there are clear reasons why this should not be the case. The prescribing doctor is responsible for the decision to allow a prisoner to hold their own medication, taking into account a risk assessment of the prisoner and the drug to be prescribed. The lead GP at the prison said that usually prisoners kept their medication in- possession unless they were high value or addictive such as opiates and antipsychotics. She had concerns about in-possession risk assessments, such as the absence of a standard format or a systematic system of review.
74. The newly-appointed clinical lead at the prison said at interview that the previous in-possession policy lacked clarity about which medication prisoners were allowed to hold. It said that the aim was for all prisoners to be responsible for holding and using their own medication and this should be the normal position unless there were clear reasons why this should not be the case. It also stated that prisoners could regard prescription medication as currency and this should be a consideration. The new policy sets out clear criteria to be considered when completing a prisoner's risk assessment, such as a history of self-harm, history of previous selling, trading or trafficking medication, other abuse of in-possession medication and high risk of non-compliance. The policy also specifies the drugs that can and cannot be held in-possession, as well as assessment and review mechanisms.
75. In line with the principle that prisoners should have access to healthcare services of equivalent scope and quality as are available to the wider population, we broadly agree that prisoners should have autonomy for storing and administering their own medication where it is safe and practical to do so, but prisons are not equivalent to a community setting. There is often misuse and trading in prescribed medication in prison and decisions to allow prisoners to keep supplies of their own medication have to be made in that context and be subject to appropriate risk assessments.
76. As there were well documented suspicions about the man's involvement in illicit trading in medication and he himself had disclosed such behaviour to healthcare staff we are concerned that the staff did not follow the policy then in place and questioned and reviewed his suitability to have in-possession medication. We also note that some of the drugs detected in his body after this death had not been prescribed to him, indicating that he was able to acquire medication, most likely from other prisoners who had been prescribed them to keep in their possession. We make the following recommendation:

The Director and Healthcare Manager should ensure that all staff follow clear procedures to assess the risk of a prisoner holding medication in possession, that there is effective information sharing to inform decisions and that decisions are fully reviewed in the light of security information or disclosures to healthcare staff which indicate increased risk.

Emergency response

Entering a cell at night

77. The prison's local security strategy, (instruction 2-53), informs staff of the correct procedure for opening prisoners' cells at night. It was last updated in March 2012. It says that, except in an emergency, a cell will only be opened at night with the authority of the duty manager, after the control room has been informed and when there are three officers (including the duty manager) present.
78. The instruction says that in the case of an emergency, for example danger to life, a cell may be unlocked without the authority of the duty manager and with only one officer present. (An example given is if a prisoner is seen hanging from a ligature.) The officer must make a judgement whether a delay entering the cell could be life-threatening and, after informing the control room, may enter the cell.
79. Prison Service Instruction (PSI) 24/2011, which gives guidance about security procedures at night, advises staff that they have a duty of care to prisoners, to themselves and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there appears to be immediate danger to life, staff can unlock and enter a cell on their own, without the authority of the night orderly officer. Staff are not expected to take action that they assess would put themselves or others in unnecessary danger and should first make every effort to gain a verbal response.
80. The officer said when he first saw the man he believed he was asleep, although he appeared to be lying at an odd angle. He went back shortly afterwards with another officer to check, but as they failed to get a response, he decided to call the duty manager for assistance. He waited for assistance before he, the duty manager and the nurse went into the cell. It was not until they went into the cell that they were able to tell that the man was not breathing. The officer followed the procedures set out in the instruction as he did not assess an immediate danger. However, we note that the man was alone in a single cell and the officer had another officer with him and was sufficiently concerned enough to call the duty manager for help. Hanging is not the only circumstance in which a prisoner's life could be at risk and staff need to be alert to this and act quickly when a prisoner's condition appears to be life-threatening. We consider the security instruction should be revised to include other examples of concern, rather than just the obvious one when a prisoner who appears to be hanging. There is nothing to suggest that earlier entry into the cell would have changed the outcome in the man's case who

appears to have been dead for some time, but in another similar incident this could be crucial. We therefore make the following recommendation:

The Director should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that local policies and instructions reflect this prominently.

Emergency medical codes

81. A nurse called a code blue emergency at 2.18am, several minutes after the man was found not to be breathing. There was then a further delay of five minutes before the control room called an ambulance. We are concerned that it then took longer than necessary for the ambulance crew to get to his cell.
82. PSI 03/2013, *Medical Emergency Response Codes*, issued in February 2013, sets out the actions staff should take in a medical emergency. It contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It stipulates that if an emergency code is called over the radio, an ambulance must be called automatically and immediately; it should not be a requirement for a member of the healthcare team or a manager to attend the scene before an ambulance is called; and measures should be in place to prevent any unnecessary delay in escorting ambulances and paramedics to cells. It also explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.
83. We are concerned that, by September 2013, Lowdham Grange had not yet complied with the requirement to have a local protocol in place by 28 February 2013, reflecting the guidance in the PSI. While this did not affect the outcome for the man, it is apparent from the response to this incident that emergency procedures need attention. We make the following recommendations:

The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Lowdham Grange has a medical emergency response code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of an emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Informing the man's next of kin

84. Prison Service Instruction 64/2011 which covers safer custody and procedures after a death, states that wherever possible, the prison's family liaison officer should visit the prisoner's family or next of kin to break the news of the death face-to-face. However, they should try to ensure that the family do not find out about the death from another source and if the family live a long distance away, consideration must be given to asking a family liaison officer from the nearest prison to assist. If it is not possible to notify the family personally or if another prison's family liaison officer or the police have visited the family, the prison must arrange a follow-up visit as soon as practicable.
85. The prison asked the police to break the news of the man's death to his family, rather than a member of staff at a prison closer to them. Although there was frequent telephone contact with his family there is no evidence in the family liaison log that a member of staff from Lowdham Grange ever visited his family in person or offered such a visit. We make the following recommendation:

The Director should ensure, in line with PSI 64/2011, that wherever possible, a Prison Service representative visits the next of kin to break the news of a prisoner's death. Where it has not been possible for someone from the prison to inform the family a visit should be arranged as soon as possible afterwards.

RECOMMENDATIONS

To the Healthcare manager:

1. The Healthcare Manager should ensure that there is effective communication between the primary care and IDTS team and that all clinicians have access to and are able to share electronic clinical information.

To the Director and Healthcare manager:

2. The Director and Healthcare Manager should ensure that all staff follow clear procedures to assess the risk of a prisoner holding medication in possession, that there is effective information sharing to inform decisions and that decisions are fully reviewed in the light of security information or disclosures to healthcare staff which indicate increased risk.

To the Director:

3. The Director should ensure that there is an effective response to security information about illicit drug use in the prison and, together with the Healthcare Manager, ensure that healthcare staff understand the circumstances in which they can contribute security information about illicit substance use without compromising individual patient confidentiality.
4. The Director should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that local policies and instructions reflect this prominently.
5. The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Lowdham Grange has a medical emergency response code protocol which:
 - Provides guidance to staff on efficiently communicating the nature of an emergency;
 - Ensures staff called to the scene bring the relevant equipment; and
 - Ensures there are no delays in calling, directing or discharging ambulances.
6. The Director should ensure, in line with PSI 64/2011, that wherever possible, a Prison Service representative visits the next of kin to break the news of a prisoner's death. Where it has not been possible for someone from the prison to inform the family a visit should be arranged as soon as possible afterwards.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress to be updated after month
1	The Healthcare Manager should ensure that there is effective communication between the primary care and IDTS team and that all clinicians have access to and are able to share electronic clinical information.	Accepted	<p>Communication between the healthcare department and IDTS team has been improved. The IDTS manager and other IDTS personnel now regularly attend the monthly clinical governance meeting chaired by the healthcare manager and Serco's head of clinical governance / lead nurse. A new informal monthly clinical meeting has been introduced. This is attended by nurses from IDTS and healthcare, and occasionally the Interim Medical Director of Serco Custodial Health.</p> <p>In addition, there is now greater awareness by both teams of each other's prescribing arrangements and the need for clarity around prescribing. The IDTS team now record their methadone dosing regimes more consistently on SystemOne and healthcare staff are more aware of the need to check SystemOne for this information.</p>	<p>Healthcare Manager</p> <p>Completed and ongoing.</p> <p>(After the end of September 2014, IDTS and Healthcare will be in a single contract with a new provider)</p>	
2	The Director and Healthcare Manager should ensure that all staff follow clear procedures to assess the risk of a prisoner holding medication in possession, that there is effective information sharing to inform decisions and that decisions are fully reviewed in the light of security information or disclosures to healthcare staff which indicate increased risk.	Accepted	<p>Risk assessments for in-possession medication are carried out by either a nurse or the pharmacy technician. The risk assessment pro-forma, which is standardised on SystemOne, sets out the same criteria as outlined in the latest in-possession medication policy. The GP will review the risk assessment taking into account the prisoner's current and previous history including self-harm, overdose and depression. Based on the risks identified in the assessment the GP will make a decision on whether the prisoner can be given in-possession medication.</p> <p>Staff are made aware of the policy and the procedure for risk assessments during their initial induction (new starters), as well as at team briefings and discussions surrounding monthly audit findings.</p>	<p>Healthcare Manager & Assistant Director Security & Operations</p> <p>Completed and ongoing</p>	

			<p>Since the man's death, the process of auditing in-possession medication has been considered and reviewed. HMP Lowdham Grange has introduced a new 'medication compliance audit', with a regular programme of audits undertaken by the pharmacy technician, alongside a prison custody officer. The results are reported to the monthly clinical governance meeting and the senior management team meeting.</p> <p>When the security team receive intelligence this is disseminated to the Healthcare department to initiate action and/or medication reviews.</p>		
3	The Director should ensure that there is an effective response to security information about illicit drug use in the prison and, together with the Healthcare Manager, ensure that healthcare staff understand the circumstances in which they can contribute security information about illicit substance use without compromising individual patient confidentiality.	Accepted	<p>All information received into the security department is analysed and acted upon as appropriate (resource dependant). Reports of bullying are communicated via the appropriate channels and any reports relating specifically to unauthorised possession of illicit substances will result in a cell search by the dedicated search team.</p> <p>Healthcare staff have been made aware (both individually and in governance meetings) of the need to report illicit drug use where this relates to potentially dangerous situations, and reassured that providing anonymised information does not breach medical confidentiality. The healthcare manager attends the monthly security meetings to raise any concerns.</p>	Healthcare Manager & Assistant Director Security & Operations	Completed and ongoing
4	The Director should ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that local policies and instructions reflect this prominently.	Accepted	The local security strategy (opening cells at night) will be amended to reflect that subject to a personal risk assessment, staff should enter a cell at night when there is potentially a risk to life. A notice to all colleagues will be published to enforce such matters.	Assistant Director Security & Operations	30 June 2014
5	The Director should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical	Accepted	Healthcare staff have been made aware of the code blue procedure and must attend with the relevant medical equipment. If the nurse/operational staff on scene recognise serious issues which appear to be life-threatening, an ambulance will be called	Assistant Director Security & Operations	

	<p>emergencies and that Lowdham Grange has a medical emergency response code protocol which:</p> <ul style="list-style-type: none"> • Provides guidance to staff on efficiently communicating the nature of an emergency; • Ensures staff called to the scene bring the relevant equipment; and • Ensures there are no delays in calling, directing or discharging ambulances. 		<p>immediately via the control room in the prison.</p> <p>A local security strategy will be written and the emergency response plan updated to ensure compliance against PS1 03/2013. A notice to all staff will be published to enforce such matters.</p>	30 June 2014	
6	<p>The Director should ensure, in line with PSI 64/2011, that wherever possible, a Prison Service representative visits the next of kin to break the news of a prisoner's death. Where it has not been possible for someone from the prison to inform the family a visit should be arranged as soon as possible afterwards.</p>	Accepted	<p>Where possible a representative from the prison will visit the next of kin to break the news of a prisoner's death. However, where it is not possible for someone from the prison to inform the family, a visit will be arranged as soon as possible afterwards.</p> <p>(The Assistant Director visited the man's family on 15 October 2013).</p>	<p>Safer Custody Manager</p> <p>Completed and ongoing</p>	