



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at
HMP Exeter in November 2012**

Our Vision

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

This is the report of the investigation into the death of a man at HMP Exeter in November 2012. A post-mortem report indicated that he died of methadone toxicity. He was 35 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a clinical review of the man's care. The prison cooperated fully with our enquiries.

The man was a remand prisoner, who had been at Exeter for just one week. He was a prolific drug user and had used drugs illicitly in prison during previous sentences. He had been on a methadone maintenance programme in the community and was prescribed methadone in prison. He reported that he had suffered from several seizures in the days before his death, but there was no medical information to support this.

Two days before he died, the man called a hospital helpline and said that he would take his own life. He was then monitored under suicide prevention procedures. On 21 November, he was moved from the vulnerable prisoners' wing to the first night centre after it was alleged he had been intimidating other prisoners. Later that afternoon, officers removed a homemade blade, a fermenting liquid and an unknown drug from his cell. The next morning, when cells were unlocked, he was found unresponsive by staff. Resuscitation was attempted but was unsuccessful.

While the investigation has not concluded that the man's death was foreseeable, it has nonetheless identified a number of significant concerns about his short time at Exeter. The clinical reviewer makes a number of criticisms, including of dispensing arrangements and of substance misuse staff. It is of particular concern that the substance misuse team lacked clinical leadership. The investigation also identifies weaknesses in suicide and self harm procedures, searching arrangements and the conduct of observations by night-time staff on someone on a methadone maintenance programme.

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

November 2013

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SUMMARY

1. The man had previously served a number of prison sentences in Wales and the South West. He had a long history of drug abuse and self-harm, and had received numerous interventions for drug addiction both in custody and in the community. He had been subject to Prison Service suicide prevention procedures (known as ACCT) before and, on one occasion during a previous sentence, he had been found with a ligature.
2. On 14 November, the man appeared at Magistrates' Court charged with theft and robbery and was remanded to HMP Exeter. In reception, he tested positive for methadone (a heroin substitute) and a number of other drugs. The prison doctor prescribed methadone and anti-seizure medication. He asked to be located on the vulnerable prisoners' wing for prisoners who feel at threat from others, usually because of the nature of their offence or because of potential intimidation.
3. A substance misuse nurse saw the man the next day. The nurse noted that he was experiencing mild withdrawal symptoms and was on a standard methadone maintenance programme. The nurse recorded no physical observations, such as blood pressure, and did not formally assess his withdrawal. A member of the prison's safer custody team saw him, but no issues were raised.
4. On 16 November, another nurse from the substance misuse team noted that the man had no withdrawal symptoms. The nurse discussed his drug use with him, but took no physical observations and did not formally assess his withdrawal. That evening, healthcare staff went to his cell several times, because he was reportedly having seizures. The nurse who attended noted that his physical observations were normal and not consistent with having had a seizure.
5. On 17 November, a different substance misuse nurse observed the man on the landing and recorded that he had no withdrawal symptoms. Later that day, he was seen by one of the prison's general nurses after he reported feeling drowsy. On 18 November, a nurse was called to his cell because he was again reportedly having a seizure. The nurse concluded that he had not had one.
6. In the early hours of 19 November, the man told officers he was suffering from abdominal cramps and vomiting. A nurse examined him and suggested that he might have a virus.
7. Later that evening, the man called his partner and said he was thinking about killing himself. They subsequently planned for her to visit him later that week. He then rang the NHS Patient Advice and Liaison Service (PALS)¹ to complaining about a prison nurse. He also expressed thoughts

¹ PALS offers confidential advice, support and information on health-related matters. They provide a point of contact for patients, their families and their carers.

of self-harm.

8. On 20 November, the man made another call to the PALS line and again talked about self-harm. PALS notified the prison and an ACCT was opened. That night, a nurse dressed a cut on the back of his hand.
9. At 2pm on 21 November, a senior officer stopped an ACCT assessment interview and said he was unable to assess the man's risk of self-harm or suicide as he considered that he was 'extremely intoxicated' either through drugs or alcohol. Another senior officer who chaired an ACCT review just half an hour later told the investigator that he had been lucid and coherent. At the review, the SO told him that he was suspected of intimidating other prisoners and he was moved from the vulnerable prisoners' wing to a single cell in the first night centre.
10. Shortly after he moved to the first night centre, officers found him cutting his mattress. They searched his cell and removed a homemade blade, two bottles of fermenting liquid and a tablet, for which he was placed on a disciplinary charge.
11. Under his ACCT plan officers were required to check the man once an hour throughout the night. There is some confusion about who carried out the checks, but the written ACCT entries record that during the night he was lying on his bed either watching the television or apparently asleep. Although one of the officers said she thought he did not look well, she did not try to get a response from him, even when at about 6.30am she thought he had been in the same position all night, with his right arm hanging out of the bed.
12. Just after 7.24am, the officer unlocking the cells in the first night centre could not rouse the man. The officer immediately raised the alarm and colleagues responded quickly. They went in to his cell but he was unresponsive and there was no sign of life. Paramedics took over resuscitation attempts from prison staff when they arrived at 7.33am, but pronounced him dead at 8.06am.
13. The post-mortem examination concluded that the man died from methadone toxicity, with twice the therapeutic dose in his blood.
14. We do not believe that staff at Exeter could have foreseen the man's death. However, there were a number of deficiencies in the delivery of substance misuse services at the prison. The clinical reviewer reports his particular concern about the lack of clinical leadership in the unit and the lack of formal observations by substance misuse nurses. We are also concerned about the operation of suicide prevention procedures and the adequacy of cell searches at Exeter.

THE INVESTIGATION PROCESS

15. The investigator issued notices to staff and prisoners at HMP Exeter to inform them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited the prison on 28 November. He met the Governor and the Head of Safeguarding. He also collected the man's relevant prison records.
17. HM Coroner for Exeter and Greater Devon District was informed of the investigation. The Coroner has been sent a copy of this report.
18. The local PCT appointed a clinical reviewer to review the clinical care that the man received in custody. He received copies of the man's relevant medical and prison documentation.
19. The investigator visited Exeter twice more to conduct interviews assisted by colleagues. He reviewed the man's prison records, CCTV footage and telephone calls.
20. The investigator liaised with Devon and Cornwall Police and shared information about the man's death.
21. One of the Ombudsman's family liaison officers contacted the man's mother and explained the purpose and scope of the investigation. She asked the investigation to consider the following questions:
 - Did he receive his anti-seizure medication when he attended court on 20 November?
 - Was CCTV footage available to the investigation team?
 - When and how was he found?
 - Why was he on suicide prevention measures and what were his levels of observations?
 - Did he fall down the stairs? If so, under what circumstances?
 - Was he heard snoring on the night of his death?
22. The man's mother received a copy of the draft report as part of the consultation period. She explained she had found it distressing reading the findings of the investigation, however welcomed the recommendations made. Furthermore she was concerned with a number of discrepancies between interviewees and explained these would be pursued further at inquest.

HMP EXETER

23. HMP Exeter is a local prison serving the courts of Cornwall, Devon and West Somerset. It holds just over 500 unconvicted and convicted adults and young adults.
24. At the time of the man's death, healthcare services at Exeter were commissioned by Devon Primary Care Trust and provided by Devon Partnership Trust. Devon Doctors provided GP services.
25. The prison's substance misuse service (SMS) delivers drug treatment services, with three full time substance misuse nurses and a drug support team, also known as CARATS (Counselling Assessment Referral Advice Throughcare Services). At the time of the man's death there was no clinical lead for the substance misuse service.

Her Majesty's Inspectorate of Prisons

26. The most recent inspection of Exeter by HM Inspectorate of Prisons (HMIP) was in July 2011. HMIP repeated a recommendation made in 2009 that Assessment, Care in Custody and Teamwork (ACCT) procedures should be improved with a focus on the involvement of other disciplines including healthcare professionals. The Inspectorate also noted that three recommendations about the substance misuse team, made during a previous inspection, had been accepted. These included forming a dedicated and supportive drug support unit and further integration between CARATS and other clinical drugs services.

Independent Monitoring Board

27. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In their 2012 annual report, the IMB said that they were impressed with the approach of staff and that the substance misuse service was functioning well.

Assessment Care in Custody and Teamwork

28. Assessment, Care in Custody and Teamwork (ACCT) is the Prison Service process for supporting and monitoring prisoners at risk of harming themselves. The purpose of the ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Checks should not be carried out at predictable intervals to prevent the prisoner anticipating when they will occur. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. The ACCT plan should not be closed until all the actions of the caremap have been completed.

Previous deaths

29. Since January 2010 there have been four deaths at Exeter, two from natural causes and two apparently self-inflicted. In our report into the death of a man at the prison in October 2012, we made a number of recommendations about the ACCT process and we make a similar recommendation about the operation of ACCT in this report.

KEY EVENTS

30. The man had served a number of prison sentences at HMP Swansea, HMP Cardiff and HMP Exeter and had a history of self-harm in prison. He had been using drugs since the age of 14. He received numerous interventions and treatments for drug and alcohol misuse in custody and the community. He had been subject to suicide and self harm prevention procedures (ACCT) during previous prison sentences and, in December 2011, he had been found with a ligature tied around his neck.

March 2011 to November 2012

31. On 2 March 2011, the man was remanded to HMP Exeter. He was treated for drug and alcohol withdrawal. On 5 March, he had an apparent seizure and paramedics were called. Paramedics assessed that he had not had a seizure, but he was taken to hospital for observation. He suffered more apparent seizures over the next few months. He was also recorded as taking illicit drugs while in prison.
32. On 28 April 2011, the man told a consultant neurologist that he thought his seizures were linked to his drug use. The consultant referred him for a scan, to establish whether he was actually experiencing seizures. The tests found no neurological or cardiovascular causes for the seizures. He was released from Exeter on 13 May 2011.
33. In April 2012, the man was in prison at HMP Exeter again when he stole and consumed 100ml of methadone. He apparently had another seizure a few hours later and was taken to hospital for treatment. On 18 May, officers noticed that he was extremely unsteady on his feet, and thought he had taken drugs. In June, he was accused of bullying. He claimed he had been injecting drugs that others on his wing had given him. He was released from Exeter on 6 July.

Wednesday 14 November 2012

34. On 14 November 2012, the man appeared at Magistrates' court charged with theft and burglary. He was remanded to HMP Exeter. When he arrived, he told staff he was dependent on drugs and alcohol but had no thoughts of harming himself. During the induction process, he was located on the vulnerable prisoners' wing at his own request, as he was worried about a particular prisoner and his associates in the prison.
35. At his initial health screen, the man told a nurse that he frequently took illicit drugs, including heroin, and drank 200 units of alcohol a week. He said that he had no thoughts of self-harm or concerns about his physical health. His urine tested positive for drugs, including methadone and cocaine, so he was referred to the prison doctor and the substance misuse team.

36. A locum prison doctor assessed the man and recorded that he was withdrawing from drugs. The doctor did not have access to his GP records at this time but he told him that he was prescribed 90ml methadone daily, took illicitly obtained diazepam (an antidepressant) and drank 40 units of alcohol a day. The doctor prescribed a standard course of methadone, starting at 10ml for the first twenty four hours, increasing to 20ml within 48 hours, and then to be maintained at 30ml daily. The doctor also prescribed sodium valproate, anti-seizure medication, used to prevent fits in those withdrawing from alcohol.

Thursday 15 November 2012

37. On 15 November, a mental health nurse working in the prison's substance misuse team saw the man and noted that he was experiencing mild withdrawal symptoms and was on a standard methadone maintenance programme. He also told the nurse that he used illicit methadone in the community but the nurse did not make a note of this. Despite his efforts, the nurse was unable to establish his drug treatment history, through prescribers and pharmacists in his home town. The nurse did not take his blood pressure or any other observations. An officer from the prison's safer custody team saw him, who raised no concerns with the officer.

Friday 16 November 2012

38. On 16 November, a nurse from the substance misuse team noted that the man had been a patient with the team before. She recorded that he currently had no withdrawal symptoms. She told the investigators that she had known him for several years. She said she discussed with him his drug and alcohol abuse in the community and described him as cheerful and said he had no thoughts of self-harm. The nurse took no formal medical observations.
39. At approximately 4.30pm, a nurse was called to the man's cell and recorded that he had had a few episodes of fainting and shaking but no black outs. His blood pressure was low, he appeared very pale and the nurse described him as having a "bad detox", so she planned to discuss her concerns with the prison doctor when he arrived. She told the investigators that, later, she did not believe that he was suffering from withdrawal as badly as she first thought. She said she relayed her concerns to her colleague, but did not speak to the doctor.
40. At 6.17pm, a nurse was called to the man's cell after his cell mate said he had had a seizure. She recorded that he claimed to be fine, but then retched into a bucket. She sought advice from the prison doctor. A doctor noted that his physical observations were okay and he had no injuries, so he advised that he should continue with his methadone maintenance regime. The doctor said that he was not aware that he had experienced any withdrawal symptoms.

41. At 10.30pm, a nurse went to the man's cell after he had had another apparent seizure. The nurse found him lying on the floor in the recovery position, fully conscious and articulate. She noted that his observations were normal, that his symptoms were not consistent with a seizure and that he showed no signs of withdrawal.

Saturday 17 November 2012

42. At around midday on 17 November, another member of the prison's substance misuse team observed the man on the wing interacting with other prisoners. The nurse noted that he had no withdrawal symptoms, but that his presentation changed when interacting with healthcare staff. The nurse concluded that his drug regime was sufficient, but he did not speak to him at the time, or take any medical observations. The nurse told the investigators that he had asked him for an increase in his methadone later in the day, but he did not agree because there was no evidence that he was suffering from withdrawal symptoms. The nurse summarised his involvement with him that day as "no withdrawal symptoms" in his medical record.
43. At 5.50pm, a nurse assessed the man because he had told officers that he was feeling drowsy. He slurred his words and appeared to drift in and out of consciousness. The nurse took his observations, which were normal, and noted that, when challenged, he was "... perfectly lucid in conversation and rather argumentative".
44. The man made three written complaints that day. One complaint about a faulty flask was answered on 21 November. The two other complaints were about healthcare, one about the treatment he had received for his seizures and another against a nurse², were not answered before his death. The allegations made against the nurse were investigated by the prison after his death and were found unproven.

Sunday 18 November 2012

45. On 18 November, during a secondary health assessment, the man told a nurse that he had no thoughts of self-harm. They discussed his misuse of alcohol and drugs. At 3.30pm a nurse treated him in his cell after he had accidentally scalded himself with boiling water from his flask.
46. At 8.00pm, a nurse went to the man's cell because he was apparently having a seizure. The nurse noted that he appeared to be alert, but then appeared to have another seizure. The nurse tested his eyelid response during the seizure and concluded that the seizure was not genuine. The nurse said that when he told him this, he instantly challenged him and asked him to leave his cell. He told the nurse that he would report him for

² It appears that the man may have dated one of the complaints incorrectly as he did not have contact with the nurse until the following day, Sunday 18 November. The complaints were stamped as having been received by the prison's complaints clerk on 19 November.

incompetence. The nurse told the investigators that he took his observations, but he did not record them in the medical record. Later that evening he and was given use of the prison's cordless Samaritans telephone.

Monday 19 November 2012

47. At 1.30am on 19 November, a nurse was called to the man's cell because he had abdominal cramps, a nose bleed and had been vomiting for hours. The nurse noticed phlegm in the toilet and told him that it was likely he had a virus. Later that day, she asked another nurse to review him the next afternoon (20 November) to see if he needed an urgent doctor's appointment.
48. That day, in an untimed entry in the wing observation book, an officer recorded that the man had rung his cell bell and asked to make a telephone call to the prisoner's advice service (PAS), an independent charity that provides legal advice and information to prisoners. He was told that he could not and asked him to wait until unlock. The officer noted that a minute later he had said that he wanted to speak to the Samaritans. There is no record to show whether this request was granted. The officer noted that when he was later let out of his cell he used the telephone but did not ring either PAS or the Samaritans.
49. At around 7.00pm that evening, the man rang PALS, the NHS patient advice line and left a message saying that he was being abused by a nurse and wanted to kill himself. The person who picked the message up on 20 November reported it to the Patient Liaison Specialist Nurse for Devon Partnership NHS Trust.
50. At 8.30pm, a nurse was called to the man cell and found him curled up on the floor. The nurse noted in his medical record that he was fully alert. He said he had had a seizure which he thought was caused by not having his prescribed injections. The nurse explained that the injections were vitamins, and that not taking them would not result in a seizure. He got back into bed. The nurse told the investigators that she had taken his medical observations, but she did not enter them in his medical record. The nurse said he displayed no withdrawal symptoms.

Tuesday 20 November 2012

51. At 9.50am on 20 November, the man called PALS again to ask how the investigations into his complaints were progressing. He said that he had had another fit and that the nurse attending him had said he was okay, despite blood "coming out of his head".
52. Charges of theft against the man were dropped at Magistrates' Court in his absence, but different charges were substituted. His solicitor wrote to him to advise him that he was now facing more serious charges of burglary and robbery and that he was due to appear before Crown Court

on 27 November. It is not clear whether he received this letter before he died.

53. At 2.45pm, an officer recorded that the man had tripped down some stairs. A nurse noted that there was no obvious bruising or swelling on his back, head or leg, but that there was a slight abrasion to his left shin. The nurse advised him to contact healthcare staff if he had any problems. The officer later noted that, although he had claimed that he was unable to use his left leg, he "... came walking out of the cell toilet without a trace of a hobble. But as soon as he saw me he pretended he could not use his left leg".
54. As requested the previous day, a nurse reviewed the man at 3.30pm. The nurse noted that he had continued to ask to see a doctor, but there had not been an IDTS doctor available since he had arrived at the prison. However, he had been seen by the substance misuse team and was undergoing detoxification. The nurse noted that he had vomited on the landing before lunch and had been observed to be drowsy. In a further telephone call to PALS at 3.30pm, he said that he was not allowed to speak to healthcare staff.
55. Later that afternoon, a CARATS worker noted that he seemed sleepy when he saw him, but became more alert when requesting an increase in his medication. The worker explained that he would not ask for an increase in his medication on his behalf, so the man stopped the conversation.
56. At 4.00pm, the man made a further telephone call to PALS. During the call he was upset and talked about killing himself. He said that healthcare staff were not helping him and he had been told just to lie on his bed. The content of the telephone calls was reported to the prison's Safer Custody team at 6.45pm.
57. In response to his threats to harm himself in the telephone calls to PALS, a Health Care Assistant (HCA) opened an ACCT. The unit manager agreed an immediate action plan for the man to be located in a shared cell, and to be observed hourly. He was reminded about the availability of the Samaritans and Listeners³.
58. At about 6.00pm, the man called his partner and told her she would be better off without him. He said he was thinking about killing himself and sought reassurance from his partner that she would not leave him. At the end of the call the couple talked about their future together and discussed arrangements for her visit at the end of that week.
59. At around 7.30pm, shortly before being locked up, the man told an officer that he had argued with another prisoner who was trying to sell him drugs.

³ Listeners are prisoners trained by the Samaritans to offer confidential support for prisoners in distress.

He handed four packets of white substance to the officer. At 8.43pm, it was noted that he had “accidentally” cut his hand while trying to make a curtain. A nurse was called to attend and treat the injury. The nurse cleaned and dressed the cut and noted that it was not being treated as an act of self-harm. The nurse described him as very chirpy during their exchange.

Wednesday 21 November 2012

60. On 21 November, during the morning briefing a Senior Officer (SO) told staff that there was possible tension between the man and other prisoners due to drugs. As expected, tensions increased at breakfast time between he and the prisoner with whom he had argued the previous evening. After breakfast, the SO attended a daily operational briefing where it was agreed that he should be tested for drugs. The result of the drug test, received by the prison two weeks later, tested positive for cannabis, benzodiazepines (tranquilisers) and methadone. The SO reported that prisoners on the wing had complained about his intimidation. The SO considered that his vulnerable prisoner status should be reviewed, so he could be moved, but he was nervous about taking any action without consultation because of his history of self-harm.
61. An officer noted in the wing observation book, “I have been informed that the man is “plugged” [drugs hidden internally in the body] with a substantial amount of drugs”. In a later entry, he described other prisoners being threatened by him and suggested that he be unlocked at different times to prevent him associating with others on the wing.
62. At around 11.00am, the man’s previous cell mate told an officer that he felt threatened by him. A SO agreed that it was safe for the man to remain in a cell on his own and asked an officer to complete his ACCT assessment interview.
63. To prevent conflict with other prisoners, the man was unlocked to collect his lunch on his own before the other prisoners on the wing. He first collected his medication and filled his hot water flask. He then declined to collect his lunch. He asked to speak to a doctor.
64. At 2.00pm, an officer collected the man from his cell to complete the ACCT assessment interview. The officer said that when he told him that he needed to speak to him, he first asked for some time to get ready and went into the toilet area of the cell for ten minutes. He called twice to check he was all right, but could not see what he was doing.
65. During the ACCT assessment interview, the man told the officer that he had been “stitched up” by officers but did not elaborate. The SO noted several scratches to the right side of his neck, but did not ask about them. The officer said that he repeatedly fell asleep and that his speech was slurred to the point of being incoherent. The officer believed that he was under the influence of drugs or alcohol. He warned him three times that if

he was unable to stay awake he would be forced to stop the interview, which he eventually did. The SO submitted a security information report describing him as “extremely intoxicated”. The officer said told a nurse in passing that he looked intoxicated, but he did not ask a member of the healthcare team to assess him.

66. The officer spoke to the SO about the man’s behaviour and asked two officers to attend his ACCT review at 2.30pm. The SO told the investigators that during the ACCT review he was lucid and coherent. The senior officer asked why he had been obstructive during his ACCT assessment interview with the officer. He said it was because he had been woken up and was tired. He told the SO that he had no thoughts of self-harm. The SO told him that his vulnerable prisoner status had been reviewed. He was told that he would be moving from the wing and monitored under anti-bullying procedures. He denied the allegations of bullying. The SO concluded the review early because he considered that he was not cooperating. The SO said he was not concerned that he was being moved to the first night centre.
67. The SO considered that the man was at a low risk of self-harm and was low in risk behaviours. He was still to be checked at least once an hour, but the ACCT caremap (support plan) was not completed. The SO explained to the investigators that this was because he had no information from the ACCT assessment and he wanted to discuss the caremap with the manager of the first night centre.
68. The SO told the investigators that when he reviewed the man’s vulnerable prisoner status he did not complete any documentation as he could not immediately find the relevant paperwork. He said that the decision was discussed and agreed with his line manager and other members of staff. The SO said that he did not complete anti-bullying documents as he felt further investigation was necessary.
69. The man was moved to the first night centre at about 3.00pm and was placed in one of the wing’s camera cells. (The CCTV footage can be monitored in the wing office, but the footage is not recorded.) Officer A noticed on CCTV that he was unsteady on his feet when he was talking to another prisoner through his cell door. He described his walking as “jelly like”.
70. Officer B told police that when the man arrived on the wing, his pupils were large and he was slurring his words. He said that he was assessed by a nurse and a senior officer before being placed in his cell. However, there is no record of these assessments.
71. A short time later, Officer A said he saw the man cutting the protective cover of his mattress, and peeling it away from the foam underneath. He and a SO and another officer then went to his cell and searched it. The officers removed a plastic knife with a blade melted into it, two bottles containing fermenting fruit liquid, believed to be hooch and a small tablet.

The officers reported the matter to the prison's security department and he was charged with a disciplinary offence under Prison Rules for unauthorised possession of the items. The officer said he was neither upset nor angry. His speech did not appear slurred, but that he was a little unsteady on his feet. This incident was not recorded in the ACCT document.

72. At 4.45pm, Officer A noted in the ACCT that the man had been demonstrating odd behaviour since he had arrived on the wing and had cut his hand. An officer discussed the cut with him, who claimed it was an accident. (Despite being on hourly observations this was the first recorded ACCT observation that had taken place since 2.30pm. Earlier in the day there had been no recorded observation between 8.15am and 10.05am.)
73. The man's injury was treated by two nurses. One nurse said that he did not think that he had self-harmed or was at risk of doing so, but an officer removed other sharp objects, such as razors, from the cell. The nurse told police that he was asked to treat a cut to his hand, which he had made on the window the previous day. The nurse said he did not disbelieve what he said as, "... it wasn't a classic self-harm injury". The nurse said in his dealings with him over the previous week he had no concern about his state of mind or was aware of any suicidal or mental health issues.
74. A SO said that the man showed no signs of crisis that evening, and he did not need any medical intervention. Another SO said he observed him a few more times that evening and, at 7.20pm, when he checked him for the final time, he said he was in bed with the light off.

Events leading to the incident

75. At 7.30pm, an officer noted in the ACCT on going record, that the man appeared to be asleep. This was the first entry in the ACCT record since 4.45pm. Not long after, another officer issued him with the formal written details of his disciplinary charge for possessing illicit items. The officer said he was lying in bed watching television. The officer said he was wearing a T-shirt and had his arms behind his head. He said that he was polite. He thanked him as he left the cell. The officer said he spent around 30 seconds in his cell and said he did not slur his speech or appear intoxicated.
76. Operational Support Grade (OSG) 1 started work at 8.45pm and it was only the second time that she had worked nights. She recorded in the ACCT document that she had checked the man at 9.00pm and he was watching television. When interviewed, she could not specifically recall the check or whether she had spoken to him at the time. The CCTV footage appears to show that the check was completed by her colleague rather than her.

77. The OSG told police that she checked the man again at 10.05, although CCTV footage again shows that it appears to have been another OSG who completed the check. She said that at the time he was lying on his back with his head furthest from the door, tilted back a little and his right arm was hanging out of the bed. There was a cup on the floor near his right hand, as if he had fallen asleep and dropped it. She said she could see the whites of his eye and this initially shocked her. She said, "He was just lying back and his eyes weren't fully, fully closed, so they were just slightly open". She said she found this, "quite unnerving", adding that he didn't look very healthy. The OSG said that she observed him for about ten seconds when he gave a loud snore which reassured her that he was breathing.
78. The OSG returned to the staff office and said she commented to her colleague that she had been unnerved by what she saw, and had thought that the man was dead until she heard him snore. The other OSG said he could not recall her speaking to him about the man that evening. The OSG recorded in the ACCT document that she checked him every hour until 2.30am. She told the police that each time she had observed him long enough either to hear him snore or see him breathe and said that he did not move position throughout the night. When asked about these checks, she told our investigator that she could not really recall them.
79. OSG 2 checked the man at 3.15am, 4.10am and 5.00am. The ACCT documents record that OSG 1 made the 11.15pm check but OSG 2 told police that he checked his cell at that time. CCTV footage appears to confirm this, although this is not what OSG 1 told the investigators when interviewed. OSG 2 said that when he did the checks the man either had his television on, or a night light, as he could see him clearly, despite the main cell lights being off. He said he also used a torch so he could see him more clearly. The OSG said that he was lying on his back with his eyes closed, but could not say if he was sleeping or not.
80. When OSG 2 checked the man at 4.10am he said he kicked the cell door to make a noise as he was still lying in the same position. He said he heard him grunt and his body moved slightly. He said he observed him for a few more seconds before continuing with his rounds. At 5.00am, the OSG recorded that he still remained in the same position, on his back with his eyes closed, so concluded that he was asleep. He did not consider there was any cause for concern, so he did not feel the need to disturb him.
81. OSG 1 said she started her final checks of the wing at 6.00am, starting on the top landing and working her way down. (CCTV footage shows she started the check at 5.30am.) She told police that when she reached the man's cell he was in the same position that he had been in all night. She still thought he was asleep. She told the investigators that had his eyes been open she would have been concerned. She could not recall if the television was on or off during the night.

82. The CCTV footage shows OSG 1 going down to the first night centre at 5.44am and coming back a minute later, at 5.45am. Although the man was required to be observed at least once an hour, the CCTV footage indicates that no one else went to his landing until an officer began a roll check at 7.21am.

Discovery of the man

83. At 7.15am Officer C started the C wing's morning roll check, and got to the man's landing just after 7.24am, when she went straight to his cell. She told police that the television in his cell was on, as well as a light. She said she could clearly see him lying on his back, eyes slightly open and arm outstretched with the bed covers across his chest. She said she thought he was watching television so she proceeded to count the other prisoners. However, she was surprised, that he had not spoken to her, so she went back to check him again. The officer said he was still in the same position.
84. Officer C said she went back to the wing office to put the main landing lights on to wake the man and then went back to his cell for a third time. She said that she could not see any rise or fall in his chest and noticed that his eyes were not focussed and appeared glassy. She kicked the cell door and called his name, but got no response. The officer said her initial reaction was to go into the cell to check him, but thought it against prison protocol. She telephoned from the wing office, next door to his cell, to alert the senior officer in charge of the prison at that time. She said the time between her first and third check was about a minute and that it took another 30 seconds for assistance to arrive.
85. A SO and an officer went straight to the first night centre. The SO looked into the cell and said he saw the man lying on his back, mouth open and eyes rolled back, with his arm hanging towards the floor. The officers opened the door, and moved the television and cabinet away before they could get in. The SO tried to rouse him by banging his chest. He said that when he pulled back the bed clothes he could see that he had urinated and that his skin was mottled and cold. He called an emergency code blue (a life threatening situation).
86. The SO Ford asked the officer to take Officer C away from the scene because she was in shock. The SO, left alone in the cell, continued to try and rouse the man. He said he could not lift him safely off the bed and onto the floor on his own to start resuscitation. He continued trying to get a response and, at 7.26 am, asked for an ambulance to attend.
87. A nurse arrived at the cell about 30 seconds after the responding officers and lifted the man onto the cell floor. The nurse removed his shirt and checked his vital signs but found none. The nurse started cardiopulmonary resuscitation (CPR). A SO was asked to collect a defibrillator from the prison's central office. One nurse radioed for an ambulance (although one had already been called) and another went to

the central office to collect oxygen. He returned to the cell with a nurse who had brought the emergency resuscitation bag. The nurses assisted the first nurse with resuscitation attempts. The defibrillator was attached but detected no shockable rhythm.

88. Paramedics arrived at 7.33am and took over resuscitation, but were unsuccessful. At 8.05am, paramedics decided to stop resuscitation and the man was pronounced dead at 8.06am.
89. After the man's death, police recovered a number of items from his cell and took photographs. These included what appears to have been about a metre of toilet roll, compressed and rolled into a paper rope, and the blanket on his bed, which appears to have been cut down the middle.

Family Liaison

90. An operational manager travelled to the man's mother's house in South Wales that morning and broke the news of his death. The prison's family liaison officer arranged for the family to visit the prison on 27 November. The prison offered to contribute to the funeral in line with national guidance.

Post-mortem examination

91. A post-mortem report reported that:

"The man had a high level of methadone in his bloodstream. The concentration present was within the range reported to have resulted in deaths in previously published cases. Whilst he was being prescribed methadone in prison, the concentration was higher than one might expect as a result of his prescribed dose. This is highly suggestive of him having gained access to additional methadone and supplemented his prescribed dose."

92. The post-mortem report concluded that the man's death was as a consequence of methadone intoxication with acute bronchopneumonia, (inflammation of the lungs). The pathologist explains that toxic concentrations of methadone reduces consciousness, which leads to breathing difficulties. The symptoms of methadone intoxication are almost indistinguishable from normal sleep. The post-mortem notes there was no specific feature to suggest that he had had a seizure before he died.

ISSUES

Possible seizures

93. The clinical reviewer reports that the man repeatedly collapsed in custody, which was often recorded as seizures by healthcare staff. However, he notes that there is no documented evidence in his medical record that he suffered from any convincing tonic-clonic seizure. (A tonic-clonic seizure is one where there is loss of consciousness, repeated spasms of the limbs and temporary absence of respiration.) He saw a consultant neurologist as an outpatient in hospital in 2011 and any significant neurological illness or cardiovascular reasons for the seizures were excluded.
94. The clinical reviewer reports that healthcare staff, including those in the community, suspected that the man's seizures were pseudo-seizures and attention seeking behaviour. He notes that there was sufficient evidence in his medical record to support this. However, nurses repeatedly failed to record his basic observations, such as pulse rate, respiration and blood pressure. He notes that these would have provided an opportunity to monitor his condition. We make the following recommendation:

The Head of Healthcare should ensure that all healthcare staff take and record prisoners' basic observations after a reported seizure.

Drug maintenance programme

95. When the man arrived at the prison on 14 November, he tested positive for opiates, he started a methadone maintenance programme and an alcohol detoxification programme to minimise the risks associated with withdrawal. The clinical reviewer notes that he was prescribed methadone in accordance with locally agreed treatment protocols, in line with national procedures and was entirely appropriate. The doctor notes that he had no other significant illnesses.
96. When he began his methadone maintenance programme and alcohol detoxification, the man was seen only once a day, each time by a different member of the prison's substance misuse team on, 15, 16 and 17 November. Clinical observations were not recorded then or subsequently and there was no further recorded contact with the substance misuse nurses.
97. None of the substance misuse nurses took or recorded the man's heart rate or blood pressure and they did not use the appropriate opiate withdrawal scale in their assessments. Two nurses told the investigators that prisoners undergoing drug maintenance were generally seen once a day and basic observations were only taken if there was a concern or need and observations were not a routine requirement.
98. Prison Service Order (PSI) 45/2010, Integrated Drug Treatment System, section 5.17 says:

“There is a requirement for those who are undergoing [opiate] stabilisation to have clinical observations recorded twice a day for a minimum period of five days...”

The prison’s own integrated drug treatment protocol, Devon Prisons Healthcare Partnership Integrated Drug Treatment System (IDTS) Protocol Clinical Management Opiate Dependency, clarifies this national guidance. Section 5.2 of the protocol, follow up and subsequent prescribing of methadone says:

“Any new patient with opiate dependency who is being induced on methadone on arrival in reception is to be followed up during the next day, including Saturday and Sunday, and will receive enhanced observation over five days. The patient will be seen by a substance misuse nurse who will take a short opiate withdrawal focused history and assess the patient with the aid of a validated opiate withdrawal scale.”

99. Section 3.1, Clinical Safety, says that adult fatalities from methadone have been reported at doses as low as 20ml and that death from the drug tends to occur on the second or third day as a result of cumulative toxicity. To avoid an overdose, the guidance requires that nurses get a prisoner’s history, and monitor them regularly for drowsiness. If a prisoner is drowsy, the advice is to withhold methadone until he can be reassessed.
100. The clinical reviewer concludes that the prison’s protocols for the clinical management for opiate dependency were not followed and that none of the records made on the man demonstrated a formal structured follow up or evidence of any enhanced observation. He suggests an urgent audit, followed by necessary remedial measures to ensure that substance misuse treatment is delivered safely and follow protocols. We agree with his conclusions and make the following recommendation:

The Head of Healthcare should ensure that opiate dependent prisoners are treated and monitored safely, within clinical guidelines and to the standards set out in PSI 45/2010.

Substance misuse clinical lead

101. The clinical reviewer notes that there had been no medical lead for the substance misuse team since the retirement of the previous substance misuse doctor in October 2012. He is concerned that there was little evidence of multidisciplinary team meetings, training or education.
102. The locum doctor in reception told the investigator that he thought he was only authorising the initial dose for the man’s first night to ensure his safety until he could be reviewed by a specialist substance misuse doctor the next day. As there was no substance misuse doctor in post at Exeter at that time, he was never reviewed by a doctor. A nurse told

investigators that substance misuse nurses would recommend changes in methadone prescriptions to the prison GP, who would generally alter the prescription according to the nurse's advice.

103. The clinical reviewer is concerned that it was common practice at Exeter for doctors to issue prescriptions for controlled drugs at the request of a substance misuse nurse, without seeing the patient and that doctors were not adequately trained in substance misuse to challenge the nurses' recommendations. He says:

“The legal liability for harm arising from any drug prescription lies with the prescriber. Recommendation from a nurse would not carry the same weight as from a specialist doctor, unless there is a clearly agreed governance framework in place.”

104. He suggests the appointment of an expert in substance misuse to oversee the safe delivery of clinical substance misuse treatment and adequate training. We agree with his findings and make the following recommendation:

The Governor and Head of Healthcare should ensure that a clinical lead doctor in substance misuse is appointed urgently.

Methadone dispensing

105. The responsibility for dispensing methadone to prisoners had passed from the substance misuse team to general nurses, employed by a different healthcare provider. One of the prison's general nurses told the investigators that it was very confusing for prisoners to understand the difference between substance misuse nurses and the primary care team and that this confusion was added to by the fact that primary care team nurses dispensed methadone. Substance misuse nurses explained that they relied on general nurses to identify concerns about prisoners from the brief interaction when dispensing methadone.
106. In his clinical review the clinical reviewer reports that:

“Dispensing is an intensive process due to the numbers involved and leaves little time for patient interaction and general health assessment. The training for this is one to one education from more senior and experienced nurses. Having trained general nurses dispensing methadone seems inappropriate, unless their skill in general nursing care can be utilised at the same time. The time pressure and the numbers involved mitigate against this.”

We agree with him that, where possible, it is important to have trained substance misuse nurses administering methadone and other controlled drugs as specialist staff are better able to spot the signs of drug intoxication or withdrawal symptoms that need treatment. We make the

following recommendation:

The Governor and Head of Healthcare should ensure that appropriately trained nurses are used to dispense controlled drugs.

Resuscitation

107. When the man was found unresponsive in his bed, none of the responding nurses brought emergency equipment with them despite a code blue being called. Some staff left the scene to collect emergency equipment from elsewhere. Although it does not appear that this would have had any bearing on the outcome in the man's case, it could make a difference in a similar situation. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff take appropriate life saving equipment to incidents when responding to an emergency code indicating a life-threatening situation.

Searching

108. On 21 November, an officer submitted a security information report reporting the man's "intoxication" during his ACCT assessment interview. Despite this intelligence and his previous behaviour on B wing, we are surprised that no search of his possessions was conducted before he transferred to C Wing. Shortly after he arrived on C Wing, a cell search a homemade blade, fermenting liquid and a tablet were removed from his cell. (We make the assumption that the cell had been cleared before he moved in.)
109. After the man's death, the police found a rope made of compressed, rolled toiled paper under his bed. Photographs showed that the blanket on his bed had been cut down the middle. We are surprised that when his cell was searched these additional items were not noticed. If he cut the blanket and made the paper rope, after the search, that would suggest he had an additional bladed instrument which was not found.
110. Staff told the investigators that prisoners moving wings would not usually have their belongings searched unless there were grounds for suspicion. However, another officer said that when moving a prisoner from one wing to another their belongings should be searched.
111. We consider that the man's behaviour and demeanour before his transfer to C1 should have indicated a need for his possessions to be searched. He had been described as intoxicated and suspected of intimidating other prisoners. It is also appears that the cell search on C wing shortly after he arrived there was not as thorough as it should have been. As he had been identified as a risk of suicide and self-harm and there were indications that he has access to drugs or alcohol this is a matter of concern.

The Governor should ensure that appropriate searches are conducted to help support prisoners' safety when they move cells.

The ACCT process

112. An ACCT was opened on 20 November when the man said that he felt like taking his own life. While it is unlikely to have affected the outcome in this case, we have identified a number of deficiencies in the ACCT process which meant that his risk was not effectively managed.
113. The man's first ACCT review took place shortly after his abortive assessment interview. Although he had been described as extremely intoxicated minutes before, the SO conducting the review described him as being normal and lucid. Little useful information was recorded in the review and no caremap to support him was completed. The list of attendees was inaccurate. There was no multi-disciplinary attendance and no one from the substance use team was present despite his acknowledged problems. As he had not had an ACCT assessment at that stage we consider an ACCT review should have been scheduled sooner than the planned seven days.
114. Although subject to hourly observations on the morning of 21 November, there was no record of observations between 8.15am and 10.05am. Observations after that were too regular on the hour and then he was checked only once between 2.30pm and 7.30pm, although an entry in the ACCT notes that he was seen at 4.45pm after he had rung his cell bell to seek treatment for a cut hand. Despite a number of illicit and potentially dangerous articles being removed from his cell during a search, no mention of this was made in the ACCT record.
115. On 21 November, we are concerned that the man had a cut to his hand which at least some staff had considered was a potential act of self-harm. It is possible that this was an accidental injury but, as he was on an open ACCT, an ACCT review should at least have been considered.

The Governor should ensure that ACCTS are managed in accordance with Prison Service Instruction 64/2011 and that observations and documentation are completed appropriately.

ACCT observations during the night leading up to the incident

116. OSG 1 said she checked the man at 9.00pm and noted the check in the ACCT ongoing record. When interviewed she could not recall the details of her observations or whether she spoke to him at the time. CCTV footage⁴ suggests that it was OSG 2 who completed the 9.00pm observation check. Similarly, she said she checked the cell at 10.05am and 11.15pm, however, the CCTV footage appears to show that OSG 2

⁴ CCTV footage reviewed is from the camera on C2 viewing the stairwell leading to C1. There was no CCTV footage covering the landing of C1.

made the observations.

117. Although it does not appear from the CCTV footage that OSG 1 conducted the 10.05 check, she told the investigators that at that time she found the man's appearance "quite unnerving". It may be that she confused the time of this with another check. She said she had been concerned enough to mention it to her colleague, but he could not recall the conversation. OSG 2 was also unable to recall much of what happened that night.
118. The vagueness and discrepancies in these accounts is concerning, but whoever made the check we are satisfied that they were carried out. However, we note from the CCTV footage that some of the ACCT checks took little more than 30 seconds to complete including walking along the wing to his cell.

The Governor should ensure that ACCT checks are recorded accurately and that staff responsible for conducting observations do so thoroughly and are alert to any concerns.

Symptoms of methadone withdrawal

119. We consider that more thorough observations by night staff might have identified concerns about the man which needed further investigation, particularly as he was on a methadone maintenance programme and had been noted by some staff earlier in the day as appearing intoxicated. We consider it is important that staff in prisons are trained to be vigilant for signs of methadone toxicity. It is possible that had the OSG interpreted his deep sleep and loud snore as a sign of methadone toxicity it may have alerted her to seek medical assistance.

The Governor should ensure that staff are trained to recognise the common symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.

Access to methadone

120. In his clinical review, the clinical reviewer concludes that the man's prescription of methadone was in line with prison and national prescribing practice. The doctor notes that he had been prescribed higher doses during previous custodial sentences and claimed to have taken higher doses in the community. There was no previous evidence of overdose, but on one occasion his methadone prescription had been withdrawn in because of illicit drug use and the risk of overdose.
121. The man's post-mortem examination indicates that he died of methadone intoxication, with nearly twice the expected therapeutic dose in his blood. This suggests that in addition to his prescribed medication he had also obtained some illicitly. The clinical reviewer concludes that if this was the case this would have made any steady withdrawal of opiates difficult. He

reports that, had the man been a community patient, serious consideration would have been given to the wisdom of continuing methadone prescription if there was evidence of illicit drug use, of which he had a history. He says a senior clinical lead would have made that decision.

122. It is likely that the man obtained methadone illicitly but we cannot know the source. It is possible that he obtained it in the prison but there was also some intelligence which indicated that he might have brought the methadone with him into prison. Although not common, methadone is also available in tablet form. As no tests were completed on the tablet removed from his cell on the day before his death, there is a possibility that this could have been methadone.
123. The man had a known history of methadone abuse, had previously stolen a quantity of the drug from the dispensing hatch and appears to have feigned seizures to obtain drugs. He was noted to have behaved strangely and intimidated other prisoners on the vulnerable prisoner wing. It is therefore a concern that he was not more closely monitored by specialist substance misuse nurses and by wing officers to assess the possibility of him obtaining methadone illicitly in prison.

The Governor and the Head of Healthcare should ensure that there are adequate security measures including when dispensing methadone to prevent its illicit use in the prison.

RECOMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff take and record prisoners' basic observations after a reported seizure.
2. The Head of Healthcare should ensure that opiate dependent prisoners are treated and monitored safely, within clinical guidelines and to the standards set out in PSI 45/2010.
3. The Governor and Head of Healthcare should ensure that a clinical lead doctor in substance misuse is appointed urgently.
4. The Governor and Head of Healthcare should ensure that appropriately trained nurses are used to dispense controlled drugs.
5. The Head of Healthcare should ensure that healthcare staff take appropriate life saving equipment to incidents when responding to an emergency code indicating a life-threatening situation.
6. The Governor should ensure that appropriate searches are conducted to help support prisoners' safety when they move cells.
7. The Governor should ensure that ACCTS are managed in accordance with Prison Service Instruction 64/2011 and that observations and documentation are completed appropriately.
8. The Governor should ensure that ACCT checks are recorded accurately and that staff responsible for conducting observations do so thoroughly and are alert to any concerns.
9. The Governor should ensure that staff are trained to recognise the common symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.
10. The Governor and the Head of Healthcare should ensure that there are adequate security measures including when dispensing methadone to prevent its illicit use in the prison.

ACTION PLAN: The Man – HMP Exeter

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that all healthcare staff take and record prisoners' basic observations after a reported seizure.	Accepted	All trained nursing staff have been instructed that they will record physical observations on System One post seizure	30 th Sept 2013	
2	The Head of Healthcare should ensure that opiate dependent prisoners are treated and monitored safely, within clinical guidelines and to the standards set out in PSI 45/2010.	Accepted	Health services now monitor all prisoners with opiate dependence for a five day period and are seen daily by a member of the Substance Misuse Service. Night time observations for prisoners working with the SMS team have been introduced.	30 th Sept 2013	
3	The Head of Healthcare should ensure that a clinical lead doctor in	Accepted	Clinical lead for substance misuse has been in post since April 2013.	Completed	

	substance misuse is appointed urgently.				
4	The Head of Healthcare should ensure that appropriately trained nurses are used to dispense controlled drugs.	Accepted	All trained nurses are qualified to dispense controlled drugs – further training has been arranged in addition to this.	30 th Sept 2013	
5	The Head of Healthcare should ensure that healthcare staff take appropriate life saving equipment to incidents when responding to an emergency code indicating a life-threatening situation.	Accepted	All healthcare staff have been instructed that they must collect the emergency treatment response bag when called to any life threatening situation.	30 th Sept 2013	
6	The Governor should ensure that appropriate searches are conducted to help support prisoners' safety when they move cells.	Accepted	Any prisoners identified as requiring help and support to ensure that they move cells safely will be subject to an appropriate level of search with HMP Policy.	30 th Nov2013	

7	The Governor should ensure that ACCTS are managed in accordance with Prison Service Instruction 64/2011 and that observations and documentation are completed appropriately.	Accepted	All staff are allocated to attend ongoing Safer Custody Awareness training, which incorporates completion of ACCT documents, and a revised management check and audit procedure have been implemented to monitor compliance	31 st Jan 2014	
8	The Governor should ensure that ACCT checks are recorded accurately and that staff responsible for conducting observations do so thoroughly and are alert to any concerns.	Accepted	All staff are allocated to attend ongoing Safer Custody Awareness training, which incorporates completion of ACCT documents, and a revised management check and audit procedure have been implemented to monitor compliance	31 st Jan 2014	
9	The Governor should ensure that staff are trained to recognise the common symptoms of drug-induced unconsciousness and	Accepted	Key identified staff will undergo training by the Substance Misuse Service to increase awareness around symptoms of drug-induced unconsciousness and methadone toxicity.	30 th Nov 2014	

	methadone toxicity and know how to respond.				
10	The Governor and the Head of Healthcare should ensure that there are adequate security measures including when dispensing methadone to prevent its illicit use in the prison.	Accepted	HMP Exeter utilises Methasoft dispensing software, all prisoners are supervised during the dispensing and all prisoners are required to drink a cup of water to ensure that any dispensed medication is swallowed	30 th Sept 2013	