

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Long
Lartin in January 2013**

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 an investigation into the death of a man at HMP Long Lartin in January 2013. The cause of his death is inconclusive, however the post-mortem indicated a possibility of acute heart failure or a fatal asthmatic episode brought on by the use of illegal medication. He was 34 years old. I offer my condolences to his family and friends.

A clinical review of the medical care the man received was conducted. Long Lartin cooperated fully with the investigation.

The man had longstanding asthma for which he received treatment and medication. He was also known to misuse drugs. On 2 January 2013, he developed breathing difficulties, initially believed to be an asthma attack. His condition worsened and he failed to respond to extensive resuscitation attempts by healthcare staff and paramedics. After his death, illicitly obtained prescription drugs were found in his cell and the post-mortem examination found that he had taken a number of drugs which he had not been prescribed.

Although the investigation found some room for improvement in emergency procedures at Long Lartin, these do not seem to have significantly affected or delayed the emergency response such as to have impacted on the outcome for the man. The clinical reviewer was satisfied that he received an appropriate standard of clinical care at Long Lartin but pointed to the need for more awareness about the risks associated with the combination of some drugs he was prescribed. I am also concerned about the apparent extent of diversion of prescription drugs within Long Lartin and the associated health risks, but I recognise that the prison warns prisoners about the dangers of this practice. Without a clear cause of death it is not possible to know what might have contributed towards it, and therefore what might have helped prevent it.

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

February 2014

CONTENTS

Summary

The investigation process

HMP Long Lartin

Key events

Issues

Recommendations

SUMMARY

1. The man transferred to Long Lartin on 19 December 2012. He had a full health screen and a prison doctor prescribed medication, including inhalers for asthma, antidepressants and an antipsychotic drug. On 21 December, a nurse detected that he had an elevated pulse of 94 and referred him for a routine ECG test to measure the electrical activity of his heart. (He had not had the ECG test before he died.)
2. In January 2013, the man pressed his cell bell. He was struggling to breathe and told the officer who attended that he was having an asthma attack. The officer went to the wing office to contact the control room, which put out a code blue emergency call to indicate breathing problems. He pressed his bell again and the officer returned to his cell, where two senior officers and several nurses quickly joined him. One of the nurses asked for the prison doctor and an emergency ambulance to be called.
3. The man's breathing deteriorated and he lost consciousness. The nurses initially administered oxygen and a medication for acute asthma attacks. The doctor then injected an antidote for drug overdose and adrenaline. They found it difficult to establish an airway to resuscitate him as there appeared to be an obstruction in his throat which they were unable to find and remove. Healthcare and ambulance staff continued resuscitation attempts but these were unsuccessful and they declared him dead at 1.20 pm.
4. After the man's death, white powder and a white tablet were found in his cell. Other prisoners informed staff that he had recently taken illicit beta blockers¹. A toxicology screen detected a number of medications at therapeutic levels in his blood and urine that he had not been prescribed.
5. The post-mortem did not determine a definitive cause of death. The pathologist found indications of possible acute heart failure or a fatal asthmatic episode brought on by the use of illicit medication.
6. While there do not appear to have been significant delays in the emergency response which affected the outcome for the man, the investigation identified some aspects of the procedures at Long Lartin which need improvement. The officer who first responded to his request for help did not stay with him but went to wing office on the floor below to summon help, rather than using his radio. The control room did not call an ambulance immediately when the code blue was activated. The procedures at Long Lartin at the time required control staff to consult healthcare staff before calling an ambulance and an ambulance was not called until a nurse examined him, which was contrary to national guidance. Healthcare staff had to return to the healthcare department several times to collect relevant equipment.

¹ beta blockers – used to treat various heart conditions

7. We make recommendations on the matters highlighted above as well as the payment of funeral expenses, and raising staff awareness of the combination and doses of medication.

THE INVESTIGATION PROCESS

8. Notices announcing the investigation were issued to staff and prisoners at Long Lartin, inviting anyone with relevant information to contact the investigator. No one came forward.
9. The investigator visited Long Lartin on 8 January 2013, where she met the deputy governor, the deputy Head of Healthcare and a member of the Independent Monitoring Board. She obtained copies of the man's prison and medical records and visited various parts of the prison, including the healthcare centre and his cell. She returned to Long Lartin on 8 and 11 March, to interview members of prison staff.
10. Worcestershire Primary Care Trust (PCT) commissioned a clinical reviewer to conduct a clinical review of the care the man received at Long Lartin.
11. The investigator informed Her Majesty's Coroner of the investigation and requested a copy of the post-mortem and toxicology reports. The investigation was suspended for some time until we received the outcome of the toxicology tests and the post-mortem report to indicate the cause of the man's death. A copy of this report has been sent to the Coroner.
12. One of the Ombudsman's family liaison officers spoke to the man's sister about the investigation process and his family raised the following matters:
 - They were told that all funeral expenses would be covered but later discovered the prison had not contributed the amount expected which caused them difficulties and distress.
 - They had been informed that the man's cell had been left as it was immediately after his death, but when they visited nothing appeared to be out of place. Christmas cards from three years earlier were displayed but not recent ones and his inhaler was empty. They believed the cell might have been 'staged' for their visit.
 - They were concerned about the emergency response, including the sequence and timings of events from the initial cell bell call until the arrival of healthcare staff, whether any of the emergency equipment was missing and the protocol for emergency response when prisoners are locked in their cells.
 - They noted from comments in the toxicology report that a prisoner was seen on CCTV footage passing something under his cell door and wanted to know when this happened.
13. The man's family received a copy of the draft report. They raised a number of concerns that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.
14. The report was also issued to the Prison Service and their responses have been reflected in the action plan attached to the end of the report.

HMP LONG LARTIN

15. HMP Long Lartin in Worcestershire is a high security prison. It holds up to 622 men who have been sentenced to at least four years in prison. It has six main residential units containing single occupancy cells. The man was a category B prisoner.
16. NHS Worcestershire provides primary healthcare services at Long Lartin, which operate in a similar way to a community general practice. There is a small acute admissions unit for prisoners needing more intensive short-term healthcare.

HM Inspectorate of Prisons

17. HM Inspectorate of Prisons (HMIP) conducted an unannounced inspection of Long Lartin between 17 and 26 August 2011. The inspection report highlighted concerns about the diversion of medication, with prisoners reporting that prescription drugs, particularly tramadol (an opioid painkiller) and gabapentin (to relieve pain or treat epilepsy) were widely available throughout the prison. In spite of this, HMIP noted that suspicion testing and mandatory drug testing rates were very low.

Independent Monitoring Board

18. Each prison has an independent monitoring board (IMB) of volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recent annual report for the period to 31 January 2013, the IMB also commented on the problem of diversion of prescribed drugs in the prison.

Previous deaths

19. The man was the fourth of six men to die at Long Lartin since 2011. There are no similarities between his and previous deaths.

KEY EVENTS

20. The man was remanded to HMP Birmingham on 25 June 2008. He was convicted of serious sexual offences on 18 December 2008 and sentenced to a discretionary life sentence with a minimum term to serve of eight years before he could be considered for release. He remained at Birmingham prison until 19 December 2012.
21. The man was a smoker and had been diagnosed with asthma, for which he had been prescribed a salbutamol² inhaler. He self-harmed in prison on a number of occasions by cutting his forearms and explained it was because he had felt low and was in debt through buying illicit subutex³. He was prescribed citalopram and mirtazapine (both antidepressants), as well as propranolol (a beta blocker) and nefopam (a non-opioid painkiller). His medication was reviewed between May and December 2012 and his prescription for propranolol and nefopam was stopped. Owing to his misuse of drugs at Birmingham, he was referred for drug treatment.
22. The man transferred to HMP Long Lartin on 19 December 2012, where he had a comprehensive reception health screen. Both his physical and mental health conditions were assessed and noted. One of the prison GPs prescribed fluticasone⁴, salbutamol, lansoprazole (for acid reflux) amitriptyline (an antidepressant) and olanzapine (an antipsychotic).
23. During a further health check on 21 December, a nurse recorded that the man had an elevated pulse of 94. (The normal range is 60 – 100.) After discussing this with another of the prison GPs, a referral was made for a routine electrocardiogram (ECG) to measure the electrical activity of the heart) for tachycardia - an abnormally fast heart rate. (He died before the ECG took place.) On 29 December, he was given a ventolin inhaler for his asthma and the pharmacist completed a medication review on 31 December.
24. The man lived in a single cell (2-26) on A wing. On 1 January 2013, at about 4.15pm, the prisoner in the cell next door to his (2-25) collected a week's supply of medication to be kept in his cell. CCTV footage indicates that he showed other prisoners his box of medication. That evening the man, together with other prisoners, went into cell 2-25 several times. At about 7.30pm, CCTV footage shows the prisoner from cell 2-25 pass something under the door of the man's cell. We have been unable to identify what this was. The man left his cell at 9.02pm and went to the landing toilet area alone, where he remained for eight minutes. He then filled his flask with hot water and returned to his cell at 9.12 pm. (As the cells on A wing do not have integral sanitation there is an electronic unlocking system which allows prisoners out of their cells one at a time to use the toilet.)

² An asthma inhaler used to provide immediate relief of asthma.

³ Subutex – an opioid drug similar to heroin.

⁴ An asthma inhaler containing two drugs – to be taken twice daily.

25. At the beginning of January 2013 the man collected his lunch and was then locked in his cell. Officer A, was in the wing office on the ground floor, and said he heard a cell bell at 12.26pm and responded immediately. This is confirmed by CCTV evidence. He went to landing 2 and saw that the light indicated outside the man's cell. He opened the cell door observation hatch and saw him bent over, leaning on his knees. He said he was having an asthma attack.
26. The officer went back downstairs to the wing office and telephoned the control room. At interview, he explained that although the man was breathing heavily, he did not consider his condition to be life-threatening. He asked the control room to get healthcare staff to telephone him but after a brief discussion with the staff member in the control room, he designated it as a code blue (to indicate a medical emergency in which the individual has breathing difficulties). He then pressed his cell bell again. The officer responded immediately and went back to his cell at 12.28 pm.
27. Officer B and an operational manager arrived at the man's cell at 12.29 pm, closely followed by two nurses. After hearing the code blue call, two nurses went to the healthcare centre to get the emergency bag and joined the first two nurses shortly afterwards. At times when all prisoners are locked in their cells the electronic locking system means that cells cannot be opened by officers independently but have to be unlocked by the control room. Nurse A said that officers were standing outside the locked cell as she approached. As soon as the nurses and other staff arrived, Officer A radioed to ask the control room to unlock the cell.
28. The nurses found the man on his knees, short of breath, with a ventolin inhaler on the floor by his side. Nurse A took charge. He was unable to speak but indicated that he had used the inhaler. She asked for a doctor and an emergency ambulance to be called urgently. She then set up oxygen and wanted to give him a salbutamol nebuliser (a drug to treat acute asthma attacks which is administered in the form of a mist inhaled into the lungs) but the appropriate emergency bag had not been brought to the cell. Two nurses went to get it and returned with it quickly. The officers then moved him onto the bed and Nurse A gave him oxygen and salbutamol through a nebuliser. His breathing continued to deteriorate and he lost consciousness. According to accounts of members of the healthcare team, after obtaining the nebuliser, nurses returned to the healthcare centre several times to get a further emergency bag, airways, a defibrillator and more oxygen. (A defibrillator administers a shock to restore the rhythm of the heart in a cardiac arrest.)
29. A doctor and the deputy Head of Healthcare arrived at 12.35. The doctor examined the man and administered a dose of Narcan (a drug used to counter the effects of an opiate overdose) as it appeared from his presentation that this could have been a cause of his attack. He was still breathing but the pattern was abnormal. Efforts were made to administer oxygen but his airway appeared to be blocked. The doctor attempted to find and remove an obstruction in order to insert an airway but could not do so. She continued to monitor his pulse, heart and breathing and as his pulse

weakened, the deputy Head of Healthcare began cardiopulmonary resuscitation (CPR), assisted by two nurses. They continued giving oxygen and connected the defibrillator to him at around 12.45pm. This advised there was no shockable rhythm, so they continued CPR in rotation and the doctor administered adrenaline.

30. Paramedics arrived at the cell at 12.55pm. Together with the doctor they continued to administer emergency aid and attempted to pass a tube into his throat. The resuscitation attempts were unsuccessful and at 1.20pm, he was pronounced dead.
31. After the man's death, the Governor immediately spoke to the healthcare staff involved. The Head of Security held a debrief for all the staff involved in the incident and the Head of Healthcare held an additional separate debrief for healthcare staff. At the main debrief, Officer A acknowledged that he might have made a mistake by leaving the man's cell and going to the wing office to speak to the control room rather than radioing a code blue immediately. The staff involved agreed that there had been too many people in the cell and the healthcare staff considered that a learning point was to review the kits used for emergency incidents.
32. All prisoners subject to suicide and self-harm monitoring were reviewed in case they had been adversely affected by the man's death. Management visited the wing and spoke to the prisoners about what had happened.
33. The prison's family liaison officer and a colleague went to the man's mother's home at 4.00pm. As there was no response, they went to see his aunt and informed her of her nephew's death. She then broke the news to his mother who was in Australia. The prison offered financial assistance towards the funeral costs. Subsequently they agreed to contribute more to match the maximum amount recommended in Prison Service guidelines. However, as the funeral director's invoice had already been settled, the prison's financial management systems would not allow a further payment so the additional sum was not paid.
34. During a search of the man's cell, staff found some white powder in the plastic casing of a pen, as well as a white tablet, later identified as nefopam, a painkiller which had not been prescribed to him. Some other prisoners gave prison staff information later that day suggesting his death was as a result of an overdose and he had recently received drugs from another prisoner, which he had taken by snorting on the day of his death. They also said that he had taken illicitly obtained beta blockers (used to treat various conditions, including angina, migraines, high blood pressure and anxiety).
35. Prison staff questioned the prisoner in cell A 2-25, who appeared to have passed something under the man's door. He said that he had panicked and disposed of seven days of medication that he had kept in his cell after the man's death. (We were unable to question the prisoner about this as the matter was originally part of a police investigation. The prisoner moved to a secure mental health unit and was deemed not fit to provide a statement.)

36. Toxicology screening of the man's blood and urine detected that he had taken benzodiazepines before his death but it was not possible to identify which specific drugs he had taken. Propranolol (a beta blocker), nefopam and tramadol (an opioid painkiller) were also found, all at therapeutic levels. He had also taken zuclopenthixol (an antipsychotic) some time before his death. None of these drugs had been prescribed to him.
37. The post-mortem did not establish a definitive cause of death and the man was found to have no obstructions to his airway. The pathologist indicated there were signs of possible acute heart failure due to an arrhythmia⁵ or a fatal asthmatic episode brought on by propranolol.

⁵ Arrhythmia – a problem with the rate or rhythm of heartbeat, either too fast or slow

ISSUES

Clinical care

38. The clinical reviewer commented that the man's reception medical screen and assessment on 19 December when he arrived at Long Lartin was comprehensive and was recorded appropriately in his notes. At a health check on 21 December, the nurse noted that he had an elevated pulse rate of 94. Although this is within the normal range of 60 to 100, she appropriately sought the doctor's advice and they decided to refer him for a routine ECG. He died before the referral was made so it was not possible to establish whether there might have been any potential health risks arising from the elevated pulse. The clinical reviewer considers that the healthcare received by him before his death was in line with that he could have expected from a primary care provider in the community.

Management of the man's medication

38. The clinical reviewer considers that the man was prescribed the appropriate treatment for his asthma in the form of inhalers. He does not appear to have suffered any recent asthma attacks, as there are no recorded entries in his medical notes.
39. The post-mortem results were inconclusive but could not rule out the possibility of cardiac failure due to an arrhythmia. The man's prescribed medication at the time of his death included olanzapine, amitriptyline and citalopram. The clinical reviewer reported that the Medicines and Healthcare products Regulatory Agency (MHRA) issued an alert in December 2011 citing that "citalopram could cause prolongation of the QT interval⁶, thereby inducing an arrhythmia and increase risk of sudden death". The guidance placed a restriction on the dose to a maximum of 40mg, which he was taking. The advice given by the MHRA was that citalopram should not be used in combination with other drugs with a potential to extend the QT interval.
40. The clinical reviewer explained that olanzapine and amitriptyline also have the potential to extend the QT interval and that it is possible a combination of the two drugs (one at the maximum recommended dose - citalopram) could have extended the QT interval and induced an arrhythmia as described by the pathologist. However, she considers that the man's small prescription dose of amitriptyline was unlikely to have had much of an impact. Nevertheless, we believe it would be beneficial for staff to be reminded of the MHRA guidance. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff receive current MHRA guidance and advice relating to the combination and doses of drugs which might affect the heart.

⁶ QT interval – measure of time between the heart's electrical cycle

Trading of prescription medication

41. The toxicology results show that the man had taken prescription medication that had not been prescribed to him, including propranolol, nefopam and tramadol. The clinical reviewer reported that propranolol and tramadol could induce bronchospasm⁷ but the severity of this would be dependent on the dose. Both drugs were taken illicitly, so it is not possible to identify the quantity he had taken. Neither were we able to discover how or when he had obtained these substances but it is likely that this must have been the result of some form of trading with other prisoners who were legitimately prescribed them.
39. We do not know whether the man was aware of the possible risks associated with taking medication prescribed for others. As the cause of death is not definitive, we are unable to establish if his consumption of the medication contributed to his death. We are concerned about the illicit trading of prescription drugs between prisoners, which was also highlighted by the HM Inspectorate of Prisons and the Independent Monitoring Board but we recognise that it is difficult for prisons to eradicate such practices completely. The prison says that it provides information to prisoners about the dangers of combining illicit medication.

Emergency response

40. Officer A did not radio for help when he responded to the man's cell bell, but went to the wing office to contact the control room. Although he was breathing heavily, the officer did not believe his condition was life-threatening. When he returned to the cell, by which time he had pressed his bell again, he asked the control room to open the cell as two other staff and then a nurse had arrived.
38. The Chief Executive Officer of the National Offender Management Service and the former Director of Offender Health jointly wrote to prison governors about emergency access to establishments on 17 February 2011 to reinforce earlier guidance. (This was later formalised in Prison Service Instruction (PSI) 03/2013.) The letter emphasised the need for "rapid access" to emergency services in clinical crises. Prisons were instructed that an ambulance should be called in all cases where there are grave concerns about the immediate health of a prisoner and that it should not be a requirement for a member of the healthcare team to attend before an ambulance is called.
39. Long Lartin's local policy at that time of the man's death was that staff should contact the control room to request an ambulance after consulting healthcare staff. This was contrary to guidance in the 2011 letter. An ambulance was not called until after Nurse A had gone to the cell and requested one.

⁷ Bronchospasm – sudden tightening of passageways by which air passes to the lungs

40. PSI 03/2013, which was issued after the man's death now 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 explicitly states that in the event of difficulty in breathing, the control room must call an ambulance immediately.
41. While it might have been better to have radioed for help rather than telephone from the wing office, we are satisfied that this did not cause an unreasonable delay as the control room immediately issued a code blue indicating a prisoner with breathing difficulties. A nurse attended quickly and the staff then went into the man's cell. In these circumstances, we do not consider it was unreasonable to wait until the nurse arrived before the cell door was opened. There was little that the officer could have done on his own and, at that stage, he did not recognise the situation as life-threatening.
42. During the resuscitation attempts, nurses made several trips to the healthcare centre to get additional bags and equipment, such as a defibrillator. Although the items were brought quickly, ensuring the appropriate emergency equipment is taken in the first instance minimises delays. During the investigation, the prison provided documents to show that the bags were fully stocked and audited, so it is unclear why it was necessary for nurses to collect additional equipment.
43. The clinical reviewer comments that all staff responded promptly and appropriately to the emergency. The response to the emergency call when the man was found to have breathing difficulties was timely and appropriate. All reasonable efforts were made to save him and medicines and equipment was available and used appropriately.
44. We agree that the staff worked skilfully and cooperatively in their attempts to save the man. There is no indication that the slight delay directly affected his chances of survival but a quick response is vital in increasing the chances of successful resuscitation. Since his death Long Lartin has issued a new order to staff, on 22 July 2013, requiring an ambulance to be called automatically when a code blue emergency is called so we make no further recommendation.

Family issues

Funeral expenses

45. Prison Service Instruction (PSI) 64/2011 advises that reasonable financial assistance up to £3000 should be offered towards funeral expenses. After a meeting with the prison's family liaison officer, the man's family believed that the prison would provide sufficient financial assistance to cover all funeral costs up to that amount. However, only £2500 was paid. The deputy governor later agreed that it would be appropriate, and within the parameters of what is regarded as reasonable costs in PSI 64/2011, to pay expenses up to £3,000. Regrettably the prison has not so far been able to identify a way

within its prison financial management processes to pay this as the original invoice was dealt with. This has caused difficulties and distress for the family and we consider the prison needs to honour its commitment. We make the following recommendation:

The Governor should ensure that the prison offers to pay a contribution towards reasonable funeral expenses of up to £3,000 in line with national guidance. The family should be reimbursed the outstanding sum the prison agreed to pay.

Condition of the man's cell

46. The man's family visited his cell and were concerned that it had been set up and not left untouched after his death, as they had been told. The police were satisfied that nothing untoward had occurred and only emergency medical equipment was removed before their visit. His ventolin inhaler was empty as he had used it during what he thought was an asthma attack. Prison staff assured the investigator that nothing in the cell had been touched.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff receive current MHRA guidance and advice relating to the combination and doses of drugs which might affect the heart.
2. The Governor should ensure that the prison offers to pay a contribution towards reasonable funeral expenses of up to £3000 in line with national guidance. The family should be reimbursed the outstanding sum the prison agreed to pay.

ACTION PLAN

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 healthcare staff receive current MHRA guidance and advice relating to the combination and doses of drugs which might affect the heart.	Accept	All medication in HMP Long Lartin is initiated by a GP. All prescriptions are clinically checked by a pharmacist, either within the establishment or by a pharmacy contracted by Worcestershire Health and Care Trust to dispense in possession medication. All GP's and Pharmacists in the course of their profession are knowledgeable of MHRA guidance and advice relating to the combination and doses of drugs which might affect the heart. The Pharmacist will share the MHRA guidance appropriately with members of the healthcare team.	Immediate effect	

2	<p>The Governor should ensure that the prison offers to pay a contribution towards reasonable funeral expenses of up to £3000 in line with national guidance. The family should be reimbursed the outstanding sum the prison agreed to pay.</p>	Accepted	<p>A cheque for £500 was posted to the funeral directors on 7th November 2013 to take the total amount paid up to the £3000 required.</p>	Completed	
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