PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent Investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

**Investigation into the death of a man at HMP Maidstone in January 2014**

## *Our Vision*

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

This is the investigation report into the death from an overdose of medication of a man at HMP Maidstone in January 2014. He was 36 years old. I offer my condolences to his family and friends.

A clinical review of the clinical care which the man received in prison was undertaken. Maidstone cooperated fully with the investigation.

In March 2013, the man was sentenced to prison for two years six months. He spent the first six months of his sentence at HMP Wormwood Scrubs. On two separate occasions, in March and September, he was admitted to hospital after he was found unresponsive. Healthcare staff suspected that he had taken an overdose, but the hospital did not provide a definite diagnosis in either case.

The man transferred to Maidstone in October. He was allowed to keep most of his medication in his possession, but the risk assessment to support this decision was inadequate. He reported losing consciousness twice during December, but no one reviewed his medication and whether he should be allowed to keep it in his cell.

In January, another prisoner found the man dead in his cell. There is no evidence that anyone saw him alive in the previous 20 hours. Prison officers did not seek a response from him as they were supposed to, either during roll counts or when they unlocked his cell. I have previously made a recommendation to Maidstone about this issue and it is unacceptable that officers do not check prisoners' welfare when they unlock cells. Although I have concerns about the amount of medication he was allowed to keep in his possession, and that the level of medication he received does not appear to have been based on a full clinical assessment of need, I am satisfied that there was little to indicate to staff at Maidstone that he had any intention of taking a deliberate overdose.

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 2014**

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## SUMMARY

1. On 27 March 2013, the man received a two and a half year prison sentence for benefit fraud. He had claimed to be partially sighted and permanently disabled, but he was discovered walking unaided, working on a market and driving a car. He was taken to HMP Wormwood Scrubs. He became unresponsive the same evening and was taken to hospital. The prison GP suspected that he had taken an overdose, but there was no definite diagnosis. He returned to the prison the next day.

2. He was prescribed a large amount of different medications and claimed to have a number of health problems, for some of which there was no medical evidence. He lived in the healthcare centre at Wormwood Scrubs. On 20 September, he again became unresponsive and healthcare staff suspected he had taken another overdose. He was taken to hospital but again there was no diagnosis. A hospital consultant suggested referring him to a neurologist to consider if epilepsy was a possible explanation.

3. On 17 October, the man transferred to HMP Maidstone. He was given a specially adapted cell for prisoners with disabilities and allowed to keep most of his medication in possession. The first GP he saw was reluctant to prescribe such a large quantity of medication without full evidence of his medical problems, but another GP did so and the issue was not raised again. After he reported losing consciousness twice during December, the GP referred him to a neurologist.

4. Another prisoner found the man dead in his cell one morning in January 2014. The last person to have spoken to him was his “buddy” (a prisoner who helped him with everyday tasks) at lunchtime the day before. There is no evidence that anyone else saw him alive for the next 20 hours. Staff did not seek a response from him as they were supposed to during roll counts and when they unlocked his cell in the morning. Nurses attempted cardiopulmonary resuscitation, although it was apparent that he had died.

5. The post-mortem examination found that the man had died of an overdose of tramadol (a pain killer) and amytriptyline (an antidepressant). Tramadol was prescribed to him, but prisoners are not allowed to keep it in their possession at Maidstone, so it not apparent how he accumulated a quantity of this drug. He was allowed to keep supplies of amytriptyline in his cell to administer as prescribed. There were also traces of another antidepressant, nortriptyline. No prisoners at Maidstone had been prescribed nortriptyline for the previous two months.

6. While we do not know whether the man’s overdose was deliberate, we are satisfied that there was little to indicate to staff that he was in distress or had any thoughts of harming himself. However, the investigation found that the risk of him keeping medication in his possession was not appropriately assessed. There was no clear clinical assessment to justify the amount of medication he received. One doctor at Maidstone queried this but this was not pursued.

7. Prison officers at Maidstone did not seek a response from prisoners as their instructions require during roll counts and when unlocking cells and we are

concerned that no one could evidence any contact with the man for some 20 hours. As in another recent case, resuscitation was attempted unnecessarily, when it was clear that he was dead. We make five recommendations.

## THE INVESTIGATION PROCESS

8. Notices were issued to staff and prisoners at HMP Maidstone about the investigation. Several prisoners wrote in response. As the cause of death was originally unknown, the investigation was suspended until the outcome of the post-mortem examination. Once the cause of death was established as an overdose of medication, the case was allocated to an investigator.

9. The investigator interviewed staff and prisoners at Maidstone on 1 and 2 May. He gave verbal and written feedback to the Governor about the initial findings of the investigation. He subsequently interviewed other members of staff by telephone. He was unable to interview one officer who was on long-term sick leave throughout the investigation.

10. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

11. We informed HM Coroner for Mid Kent and Medway of the investigation, who provided the results of the post-mortem report. We have sent the Coroner a copy of this investigation report.

12. One of our family liaison officers contacted the man's family to explain the investigation process. They asked us to consider the prison's contribution towards the cost of the funeral.

13. The man's family received a copy of the draft report. Their solicitor wrote to us raising a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

## HMP MAIDSTONE

14. HMP Maidstone holds up to 600 foreign national prisoners mostly in single cells. The prison's healthcare unit is open from 8.00am to 6.30pm Monday to Thursday. From Friday to Sunday and on bank holidays, the healthcare unit is staffed by a single member of staff from 8.00am to 5.30pm. Kent Healthcare Consortium (a joint venture between Oxleas NHS Foundation Trust and the Medical Centre, Maidstone) provides primary healthcare services at Maidstone. Oxleas provide the mental health services.

### Her Majesty's Inspectorate of Prisons

15. HM Inspectorate of Prisons (HMIP) last carried out an inspection of Maidstone in September 2011. Inspectors identified good support for prisoners with disabilities. Prisoners with long-term health problems were well managed. Inspectors found that most prisoners prescribed medication were allowed to keep it in possession without sufficiently rigorous risk assessment. They recommended a more robust risk assessment process, but our investigation found that this had still not been implemented.

### Independent Monitoring Board

16. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published report for the year to February 2014, the Board noted that there had been some changes in personnel within the healthcare unit, meaning the manager took multiple roles for a period during the year. Despite this, the timeliness of medical appointments and range of services compared well with those in the community.

### Previous deaths

17. Six prisoners died at Maidstone in 2012 and 2013. When we investigated the death of a prisoner in May 2012, we found, like HMIP, that the risk assessment completed before prisoners were issued with in possession medication needed improvement. The man's risk assessment was also inadequate. The death of the prisoner who died in May 2012 had not been discovered, as it should have been, during the morning roll count at 7.00am or when his cell was unlocked at 8.10am. Again we found that staff did not seek a response from the man during these checks. This led to another prisoner finding him dead.

18. When we investigated the death of a prisoner in December 2013, we found that a nurse attempted to resuscitate him despite there being clear signs of death. The same nurse made similar efforts with the man, who was also clearly dead.

### Assessment, Care in Custody and Teamwork (ACCT)

19. Assessment, Care in Custody and Teamwork (ACCT) is a Prison Service-wide process for supporting and monitoring prisoners thought to be at risk of harming themselves. The purpose of 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. Levels of supervision and interactions are set according to the perceived risk of harm. There should be regular multi-disciplinary review meetings involving the prisoner.

## HMP WORMWOOD SCRUBS

20. HMP Wormwood Scrubs is a large local prison in West London which can hold more than 1,200 men. In addition to the five main residential units, there is an induction unit, an inpatient healthcare centre and a dedicated drug stabilisation unit.

### Her Majesty's Inspectorate of Prisons

21. The most recently published report followed an inspection of HMP Wormwood Scrubs in June 2011. Inspectors noted that primary healthcare had improved as a result of effective leadership and there was less reliance on agency staff. Inspectors found that most prisoners were able to see a doctor reasonably quickly. All nurses held lead roles for more specialised clinics, such as diabetes or the older prisoner. Prisoners were consulted about the delivery of healthcare services.

22. We have received preliminary feedback on a recent inspection conducted in May 2014. Inspectors found that the quality of healthcare services was reasonable, but that there were too many missed appointments. Inspectors were concerned about safety at the prison and the fact that few recommendations from previous investigations into deaths at the prison had been implemented.

### Independent Monitoring Board

23. In its most recently published report for the year to May 2013, the IMB reported increasing concerns about the safety of both staff and prisoners. The IMB noted some positive improvements in healthcare, but were concerned about the number of missed healthcare appointments.

## KEY EVENTS

### HMP Wormwood Scrubs

24. On 27 March 2013, the man was sentenced to prison for two and a half years after being convicted of benefit fraud. He was taken to HMP Wormwood Scrubs. None of the documents accompanying him indicated that he was at risk of self-harm. However, reception staff began Assessment, Care in Custody and Teamwork (ACCT) suicide and self-harm monitoring after he refused to communicate with them. He was uncooperative and would not give a medical history.

25. The man was admitted to the healthcare centre and then became sleepy and unresponsive for a time. The prison GP suspected a drug overdose and gave him naloxone (an anti-opiate treatment). He was taken to hospital in an emergency ambulance, but was discharged back to Wormwood Scrubs without a diagnosis the next day. Staff continued to support him under ACCT procedures but, at a case review on 3 April attended by a GP and a senior mental health nurse, the document was closed. He remained living in the healthcare centre because of his complex physical health needs.

26. The man told healthcare staff that he had been injured in a road traffic accident in 1997 and suffered from:

- osteomyelitis (an infection of the bone)
- chronic neuropathic pain
- lower back and leg pain
- type 2 diabetes
- a history of mini-strokes
- obesity
- incontinence
- asthma
- high blood pressure
- high cholesterol
- some deafness
- limited sight

27. The healthcare team confirmed the man's prescriptions with his community GP. He was not allowed any of his medication in possession at Wormwood Scrubs because this is not permitted for any prisoners living in the healthcare centre. He was prescribed the following different medications:

- Paracetamol;
- Salbutamol inhaler for asthma;
- Amitriptyline (an antidepressant sometimes used for neuropathic pain);
- Cetirizine (to treat allergies);
- Clopidogrel (to prevent mini-strokes);
- Montelukast (to treat asthma);
- Pantoprazole (to control gastric acid);
- Pregabalin (to treat chronic neuropathic pain);
- Simvastatin (to control high levels of cholesterol);
- Sodium alginate / potassium bicarbonate (to settle stomach pain);

- Tramadol (a high strength pain killer);
- Oramorph (a high strength pain killer);
- Lactulose (to treat constipation);
- Flixotide (to treat asthma);
- Colecalciferol (for bone health).

28. The man maintained that he was in a lot of pain and had very limited mobility. However, his trial for benefit fraud had apparently demonstrated that he had been deceitful and had exaggerated his level of disability. He had claimed to be partially sighted and permanently disabled, but was discovered walking unaided, working in a market and driving a car. Doubts about the true extent of his lack of mobility therefore persisted throughout his time in prison. Staff said they sometimes observed him moving independently when he thought nobody was looking. Some of his medical conditions were self-declared. He consented to his GP releasing his community clinical record, but this did not provide evidence for all of the conditions he had told healthcare staff about. Healthcare staff wanted to contact hospital consultants who had treated him, but he refused to give consent to this. He also refused any further assessments. Over the summer, no further information was obtained to clarify the true extent of his health problems.

29. The man was initially given an acute medical bed, before moving to a dormitory, a single cell and then eventually a dormitory again. He was regarded as a low risk offender, and staff discussed his categorisation so he could move to a prison which better suited his needs. However, a transfer was difficult as long as he required accommodation on a healthcare unit, because lower category prisons do not usually have 24 hour healthcare provision and do not have inpatient units.

30. In April, one of the prison's GPs assessed the man and found no evidence of a mental illness, depression or an increased risk of self-harm. He appeared to be in pain, but the GP could not explain his medical condition.

31. There was initially some confusion about the man's nationality and immigration status but, in May, the Home Office confirmed that he was a British citizen.

32. In late May, healthcare staff discussed the man at a multidisciplinary meeting and planned more assessments to determine the exact nature of his health problems. The GP referred him to the neurology department at hospital, but cancelled the referral on 23 June, because he believed that he was transferring to another prison imminently. In the event, the transfer did not happen until later in the year.

33. On 1 August, nurses had difficulty rousing the man, but there was no significant concern about his health. During August, plans were made to move him to HMP The Mount. However, on 19 September it was decided that the transfer would not be possible because of his health requirements.

34. On 19 September, the man appeared at Crown Court in relation to further matters. The next day, 20 September, he was taken to hospital by emergency ambulance after he became drowsy and unresponsive with fixed pupils. The prison healthcare staff again suspected that he had taken an

overdose and gave him naloxone. Hospital tests did not find a definite reason for his collapse and a brain scan was normal. The hospital consultant suspected epilepsy and recommended a referral to a neurologist. He also diagnosed a urinary tract infection and prescribed a seven day course of antibiotics. He returned to prison on 22 September. He was not referred to a neurologist again while he was at Wormwood Scrubs.

35. On 9 October, the GP decided that the man could be discharged from the healthcare centre to a standard wing. However, he remained in the healthcare centre until he transferred eight days later because there was no suitable cell for him elsewhere in the prison.

**HMP Maidstone**

36. The man transferred to HMP Maidstone on 17 October. During his reception health screen, he told a nurse that he had no thoughts of suicide and self-harm. She completed an in-possession risk assessment which permitted him to keep all his medication in possession apart from opiate based high strength pain relief such as tramadol. The in-possession risk assessment was ticked 'yes' on the clinical record with no rationale given for the decision. He signed a copy of the offender medication policy with an undertaking that he would not hoard or sell medication, or be in possession of another prisoner's medication.

37. The man moved immediately into a specially-adapted single cell for prisoners with disabilities on the first floor of Weald Wing, the induction unit for the general prison population. He remained in this cell because it was the only one suitable for his needs in the prison. He was given an electric mobility scooter and a prisoner buddy to help him with everyday tasks. He made many complaints to the Head of Healthcare over the next few months about his facilities as he had also done at Wormwood Scrubs.

38. The next day, 18 October, one of the prison's GPs assessed the man. He noted the volume of medication the man was prescribed, apparently on the instructions of a pain specialist in Milton Keynes. There was no letter confirming this in the clinical record, so the GP telephoned the hospital and asked them to send documentation confirming exactly what treatment he was supposed to be given. In the meantime, the GP prescribed him most of his pain medication for seven days while he waited for more information. He was given weekly supplies of each in possession medication in a seven day dosette box. Prisoners can keep their dosette box in a lockable cupboard in their cell.

39. On 21 October, another prison GP prescribed the man the rest of the medication he had been taking at Wormwood Scrubs. The GP had not yet received any additional information after the previous GP's enquiries. No further information was ever received or added to his clinical record. The man told the GP that he had usually suffered from a degree of low mood because of his poor physical health, but did not require ACCT support or a mental health referral. He said that amitriptyline was enough to manage it. The GP had no significant concerns about his mental health.

40. Although Wormwood Scrubs had previously been informed that the man was a British citizen, Maidstone had mistakenly accepted him on the basis that he

was a foreign national. On 23 October, Maidstone learnt that he was in fact a British citizen. Maidstone was reorganising at the time to become a prison solely for foreign nationals and the main priority was removing the vulnerable prisoner population before gradually integrating groups of foreign national prisoners. Single transfers like him were not a priority, so he remained at Maidstone for the next few months.

41. On 30 October, the man applied for a transfer to a category D, open prison near his family. On 6 November, a nurse completed his secondary health screen. He reported low mood and a history of post-traumatic stress disorder from a car accident many years before, but did not voice any concerns which the nurse considered warranted a referral to the mental health team.

42. On 19 November, the Court of Appeal refused the man permission to appeal against his conviction or his sentence. The same day, the Head of Public Protection at Maidstone reviewed his categorisation and decided that he would remain a category C prisoner because previous disciplinary offences for poor behaviour (one at Wormwood Scrubs and one at Maidstone) were not indicative of the conduct expected of a category D prisoner in open conditions.

43. On 2 December, the man enquired about the possibility of release on temporary licence, but he did not meet the criteria. On 6 December, a member of the prison's offender management unit began gathering information for his potential release on home detention curfew (HDC, also known as electronic tagging), for which he would become eligible on 12 February 2014. She requested reports from his offender supervisor in the prison and his offender manager (probation officer) in the community. These reports were due by 10 January 2014.

44. The man reported bouts of unconsciousness on 11 and 13 December, although these were not witnessed by staff. A GP noted previous references to suspected epilepsy and blackouts. He could not explain exactly what had happened, so he referred him to a neurologist on 16 December.

45. Maidstone and Tunbridge Wells NHS Trust wrote to the man on 30 December, indicating that he was on the waiting list to see a consultant neurologist. On 31 December, another prison GP saw him to discuss his pain management and continued his tramadol prescription.

46. On 20 January, a member of the prison's offender management unit contacted the man's offender manager asking for the HDC report which had been due on 10 January. The man had also applied for a possible transfer to either HMP Stocken or The Mount (both category C prisons nearer his family). The member wrote to him explaining that The Mount and Stocken had both refused to accept his transfer (the reasons for their refusal were not clear). The HDC application still needed a report from his offender manager in the community to progress. He submitted written complaints about the lack of a transfer and the delay with his HDC application.

**Events leading to the incident**

47. It was the man's 36th birthday. At 11.30am, his buddy visited him in his cell, which officers left unlocked during association periods when prisoners are able to mix with each other. They spoke and his buddy brought him his lunch. His buddy went to see him again at 4.20pm. He said that the television was on with the volume up, but he looked like he was sleeping so he left without talking to him. He went back to the cell at 5.30pm when he was still lying on his side in the same position. He again assumed that he was sleeping and did not disturb him. He washed his lunch plates and brought his dinner which he left on the table. He shut the cell door as he still appeared to be asleep. He had not spoken to him since lunchtime.

48. There is no evidence of any further interaction with the man by either staff or prisoners. There is no CCTV coverage on the wing. An officer said that he usually slept a lot and spent most of his time in his cell, so it was usual for staff not to see him during association periods. His buddy always collected his meals, so he was not missed at the servery.

49. A Supervising Officer (SO) locked the cells on the man's side of the first landing on Weald Wing that night, about 30 prisoners in all. The SO said he locked his cell at about 7.45pm. As he did so, he checked he was present for the evening roll count, which had to be completed by 8.00pm. He told the investigator that he locked each cell door, opened the observation panel, counted the prisoner inside and then moved on to the next cell. He did not wait to get a response from him or other prisoners unless they were subject to ACCT monitoring.

50. The next morning, an officer completed the roll count for both sides of the first landing of Weald Wing. Like the SO, she told the investigator that although she said good morning as she went along, she did not seek a response unless the prisoner was subject to ACCT monitoring. She said she had looked through the observation panel in the man's cell door at about 7.15am, when has lying on his side wearing his clothes, but she could not see his face. The television was on with the volume up. She did not seek a verbal response or look for any movement. She assumed that he was asleep because he was not lying in an awkward position.

51. The officer said that there was nothing that caused her concern as prisoners on the first landing of Weald Wing (the induction wing) do not work and it was usual for them to be sleeping at this time of the morning. The man had previously repeatedly complained about being woken up in the morning and had asked to be left alone to wake up in his own time, as he did not have a job.

52. At about 8.15am, a SO unlocked the man's cell. The investigator was unable to interview the SO because he was on long term sick leave during the investigation. However, he cannot have waited to obtain a response from him otherwise he would have discovered that he had died.

53. The man's buddy was unlocked at around the same time and went to help him with his breakfast. He found him lying fully clothed on his right hand side in exactly the same position as he had left him at 5.30pm the day before. His

dinner was still on the table, untouched. The television was on the same channel, with the volume up, as the previous day. His face was blue and he was not breathing. The buddy called his name and shook him but was unable to get a response. He then ran to alert staff.

54. The buddy initially went to the centre office on the first landing to speak to an officer. He went in without knocking and waiting as prisoners are expected to do. The officer said he was briefing two other officers at the time. Before the buddy had a chance to explain the seriousness of the situation, the officer cut him off and told him to wait outside the office.

55. The buddy then saw two officers nearby and asked them to check the man. They went to his cell but could get no response. They found his body was cold and stiff and he was not breathing. His pupils were fixed and he had no pulse. The officers both believed that he had already died. At 8.16am, an officer radioed a code blue emergency and asked for the emergency response nurse. (Code blue is the correct emergency code for staff to use to indicate that a prisoner is not breathing and that an ambulance is required.) The control room called an ambulance at 8.18am.

56. The emergency response nurse was in the healthcare centre when he heard the request on his radio. He collected the emergency response bag containing oxygen and went to Weald Wing.

57. As they were certain that the man had died, an officer went to fetch the wing manager and the other officer looked after the buddy, who was in shock. Other prisoners on the wing were locked in their cells. The nurse went to the man's cell and shook him and looked for a pulse. His body was rigid and cold. The nurse knew that he had died but felt it was his duty to resuscitate him, although he knew it would be futile.

58. The nurse asked the prison officers to request an ambulance (one had been called), bring other healthcare staff to the scene and collect the wing defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest). Once officers brought the defibrillator, an officer helped the nurse to attach it to the man, but the defibrillator found no shockable rhythm. The nurse began cardiopulmonary resuscitation (CPR) instead and another nurse arrived and assisted him.

59. A first response emergency vehicle reached the prison gate at 8.26am. The paramedics reached the cell quickly and advised the healthcare staff to stop CPR. They pronounced the man dead at 8.30am. The paramedics estimated that he had probably been dead for about six hours.

60. The man had nominated his mother as his next of kin. The family liaison officer (FLO) at Maidstone asked family liaison staff at HMP Bedford, near the man's mother's home, to inform her of her son's death. They went to her home but she would not open the door despite repeated attempts between 12.20pm and 2.00pm. The FLO then asked the local police to go and they were able to inform her of his death. The FLO subsequently spoke to his family and visited them two days later.

61. The buddy was already being monitored under ACCT procedures and staff held a case review with him immediately after the man died. They also offered support to the other men on the wing. Managers held a debrief meeting at 2.00pm to check on the welfare of the staff involved in the emergency.

62. Police took away the following items from the man's cell:

- Four boxes of Gaviscon tablets (three apparently unopened)
- One box of Aldara 5% cream
- Two blister packs of paracetamol 500mg unopened
- A prisoner ID card and medicine charts
- A seven day dosette box containing his prescription medication – medication for Tuesday dinner and bedtime and all of Wednesday was still in the box – the compartments for the other days of the week were all empty
- A bag containing two blue Ventolin inhalers, a sealed vial of sodium chloride solution, wristbands, emery boards and a bandage

63. The post-mortem examination and toxicology tests found that the man died as a result of amitriptyline and tramadol poisoning. The tests also found traces of another antidepressant, nortriptyline, but not in an amount sufficient to have contributed to his death.

64. The funeral was held on 19 February. The prison contributed towards the cost. A critical incident debrief was held for staff at the prison on the same day.

## ISSUES

### Clinical care

65. The man was prescribed a large quantity of different medications, even though there was not evidence in the clinical record to support all of the different conditions he claimed to suffer from. He refused to give consent to healthcare staff to check with hospital consultants who had previously treated him. The circumstances of his offence might have suggested that accepting his account at face value was inadvisable. Although doubts were expressed by staff at Wormwood Scrubs about the true extent of his mobility and ill health, no further evidence was obtained and he continued to be prescribed the same medication. At Maidstone, a GP initially questioned the volume of medication, but his attempt to get clinical verification, particularly in relation to the amount of pain relief prescribed, was not pursued, and the prescriptions continued. The clinical reviewer thinks that the amount of medication he was prescribed required supporting evidence (or further investigation at hospital if none was available) and a medication review with the GP. We make the following recommendation:

    **The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that only medication that is essential and evidence-based is prescribed.**

66. The man became unresponsive at Wormwood Scrubs twice and had to be taken to hospital. Prison healthcare staff suspected that he had taken an overdose on both occasions. However, on the first occasion, hospital staff provided no diagnosis and, on the second, they suspected epilepsy or a urinary tract infection. As there was no evidence that he had taken an overdose at Wormwood Scrubs and he was not allowed medication in possession the prison saw no need to investigate whether he had been hoarding medication. He also said that he had lost consciousness twice at Maidstone in December, but nobody else witnessed these episodes and doctors suspected epilepsy.

67. In May 2013, a GP referred the man to a neurologist to investigate his unexplained collapses and suspected epilepsy, but later cancelled the referral when it seemed that he would move prison. He did not transfer at that time and, after his second collapse in September, the hospital suggested a referral to a neurologist, but one was not arranged before he transferred on 17 October. In December, the Maidstone GP made a neurology referral, but he had not seen a neurologist by the time he died. Although he ultimately died from an overdose of medication, we are concerned that the need to be seen by a neurologist had first been identified in May 2013, yet he had still not seen one more than eight months later. We make the following recommendation:

    **The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that prisoners are promptly and appropriately referred for specialist hospital treatment as necessary and that referrals are not cancelled unless a prisoner has transferred and can no longer attend.**

68. The clinical reviewer noted that epilepsy was thought to have been a possible cause of the man's collapses. She questioned why he continued to receive

opiate-based pain relief when this is known to reduce resistance to seizures in patients with epilepsy, especially those with previous head injuries. We make the following recommendations:

**The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that a prisoner suspected of having epilepsy has an urgent medication review.**

**In-possession medication risk assessment**

69. The man died as a result of tramadol and amitriptyline poisoning. There was no evidence at the time to suggest that he was feeling suicidal or that this was a deliberate act to take his own life. We are satisfied that there was no reason for staff to have identified him as at risk of suicide or self-harm.

70. There were never any security reports at either prison about him trading or hoarding medication. At Maidstone, he was allowed all of his medication in his possession apart from high-strength opiate based pain killers. He received his other medication (including amytriptyline) in weekly supplies and collected other pain relief medication daily from the medication hatch, where he had to take it in front of a nurse.

71. It is possible that the man hoarded his amytriptyline in the weeks before he died. However, it is unclear how he accumulated enough tramadol to kill himself. The concentration found in his urine was high (207mg per litre) suggesting that he had taken a quantity far in excess of his prescribed dose. This drug was not issued to him or any other prisoners at Maidstone to keep in possession. One possibility is that he or other prisoners were not appropriately supervised when they were given their daily dose of tramamdol. Traces of nortriptyline (a less commonly prescribed antidepressant) were also found in his system. Maidstone's prescribing records show that no prisoners were prescribed nortriptyline in December 2013 and January 2014, so again it is not known how and from whom he obtained this drug.

72. An accurate medication in-possession risk assessment was particularly crucial at Maidstone because the man had not previously been allowed to keep his medication in possession when he was living in the healthcare centre at Wormwood Scrubs. This was his first time living on a standard wing. Ideally prisoners should be responsible for managing their own medication and have the autonomy they would have in the community. There are a number of benefits to this approach, but prisons also have a duty of care to ensure security and the safety of prisoners. Allowing prisoners to keep stocks of medication in their possession can lead to bullying and intimidation or trading in medication and other misuse. The risks and benefits therefore need to be carefully assessed. We consider that his risk assessment was inadequate. The assessment on the SystmOne electronic patient record consisted of a yes or no tick box and a free text dialogue box. A nurse ticked yes, but there was no evidence to support the decision in the dialogue box. There was no previous risk assessment from Wormwood Scrubs for her to consult.

73. An in-possession medication risk assessment should be rigorous, consider the likelihood of suicide and self-harm and refer to any security information

relating to hoarding or trading of medication. Although we were told that Maidstone's in-possession medication risk assessment process is currently under review, Her Majesty's Inspectorate of Prisons made a recommendation about this issue in 2011. We made a recommendation about this issue after our investigation into the death of a prisoner in May 2012. The National Offender Management Service (NOMS) informed us that the primary healthcare provider would review the system. We are concerned that this has not yet been satisfactorily concluded. We repeat our previous recommendation:

**The Head of Healthcare at Maidstone should ensure that there is an appropriate process to assess the risk of allowing prisoners to hold medicines in their possession.**

**Roll counts and unlock procedures**

74. The man's buddy appears to have been the last person to speak to him, at lunchtime on 28 January. Although he visited the cell again during the afternoon and early evening, he did not speak to him because he thought that he was asleep. No officers appear to have checked on him that day and he remained in the same position on the bed throughout. Nobody has been able to confirm that he was alive after lunchtime because no one went to see him and none of the prison staff sought a response from him during the teatime, evening and morning roll counts, or when he was unlocked the next morning. It would have been possible for him to have died up to 20 hours before he was found. It is very concerning that staff had no meaningful contact with a prisoner, particularly one regarded as having limited mobility and needing extra support, for this length of time.

75. The local security strategy at Maidstone requires staff to note movement when they check each prisoner during a roll count. However, the SO and an officer (who were responsible for the evening and morning roll counts respectively) both said that they only look for movement or wait for a response if a prisoner is subject to ACCT monitoring. We were told much the same thing when we investigated a death at Maidstone in May 2012.

76. The SO who unlocked the man at about 8.10am on 29 January, was unavailable for interview during the investigation. However, we can be certain that he did not obtain a response because it is clear that he had been dead for many hours at that time. The Prison Officer Entry Level Training (POELT) manual states:

> 'Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.'

77. Furthermore, Prison Service Instruction 10/2011 states that:

> "Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight … but

staff unlocking them have not noticed that the prisoner had died. This is not acceptable...

"[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process."

78. In spite of this guidance and a recommendation we made following the death of a prisoner in May 2012, the SO did not ensure that he got a response from the man when he unlocked his cell door. We make the following recommendation:

**The Governor of Maidstone should ensure that staff follow the guidance in the local security strategy and that, when conducting roll counts or unlocking a cell door, they check the safety of the prisoner and that there are no immediate issues that need attention.**

## Emergency response

79. The emergency response nurse attempted to resuscitate the man because he felt that he had a duty of care to protect life, even though he knew from his clinical observations that he had certainly died. The same nurse also attempted to resuscitate another prisoner in December 2013 when signs of death were also evident. There is no expectation to attempt cardiopulmonary resuscitation in such circumstances and it can be futile and distressing for those involved. We have made a recommendation about the need for guidance about this in the other recent case, so do not repeat it here.

## Family liaison

80. The man's family asked us to consider whether the prison's contribution to funeral cost was appropriate. The family liaison officer told the investigator that the prison agreed to pay £2,925 towards the cost of the cremation. Then, two days before the cremation, the family informed her that they had arranged an additional church service. They asked the prison to pay the cost of the additional service, a further £875. The prison declined. Prison Service Instruction 64/2011 which covers these matters states:

> 'Prisons must offer to pay a contribution towards reasonable funeral expenses of up to £3,000.'

81. Reasonable expenses are expected to include things like a simple coffin, a cremation, minister's fees and the funeral director's fees. While Prison Service Instruction 64/2011 does not specifically discuss an additional service, to pay for this, other costs would have had to be adjusted. The prison had already agreed to pay almost the maximum it had the discretion to pay and we are satisfied that this was reasonable.

## RECOMMENDATIONS

1. The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that only medication that is essential and evidence-based is prescribed.

2. The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that prisoners are promptly and appropriately referred for specialist hospital treatment as necessary and that referrals are not cancelled unless a prisoner has transferred and can no longer attend.

3. The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that a prisoner suspected of having epilepsy has an urgent medication review.

4. The Head of Healthcare at Maidstone should ensure that there is an appropriate process to assess the risk of allowing prisoners to hold medicines in their possession.

5. The Governor of Maidstone should ensure that staff follow the guidance in the local security strategy and that, when conducting roll counts or unlocking a cell door, they check the safety of the prisoner and that there are no immediate issues that need attention.

| Action Plan | | | | | |
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| **No** | **Recommendation** | **Accepted/Not Accepted** | **Response** | **Target date for completion and function responsible** | **Progress (to be updated after 6 months)** |
| 1 | The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that only medication that is essential and evidence-based is prescribed. | Accepted | **HMP Wormwood Scrubs:**<br>In line with Standard National Health Guidelines, medical staff are expected to prescribe only essential and evidence-based medication. Every effort is made to obtain supporting information from a prisoner's GP (with the prisoner's consent). Where this is not possible the doctor seeing the patient (in conjunction with the pharmacist) will make a clinical decision as to which medication should be prescribed.<br><br>A proposal for new pain management and analgesic review clinics will also be presented to the Central London Community Health (CLCH) Drugs and Therapeutic Committee in October 2014. Once this has been signed off, the clinics will be set up in January 2015. They will be regularly monitored via the Drugs and Therapeutic Committee and the Clinical | Target date for completion, January 2015<br><br>Lead GP<br><br>Target date for completion: January 2015 | |

| Action Plan | | | | | |
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| | | | Governance Forums.<br><br>Analgesic prescribing guidelines have been written and will be presented to the CLCH Drugs and Therapeutic Committee in October 2014<br><br>**HMP Maidstone**<br>A full medical screening is carried out on reception. Where needed mental health assessments and investigations into medical history and medications are instigated as a result of this.<br>Staff are reminded through team meetings and supervision about the importance of this.<br>Assurance checks are now carried out quarterly to ensure that the screening is robust and supported by investigation where appropriate | Healthcare Manager<br><br>Complete<br><br>Healthcare Manager | |
| 2 | The Heads of Healthcare at | Accepted | **HMP Wormwood Scrubs:** There have been | | |

| Action Plan | | | | | |
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| No | Recommendation | Accepted/Not Accepted | Response | Target date for completion and function responsible | Progress (to be updated after 6 months) |
| | Wormwood Scrubs and Maidstone should ensure that prisoners are promptly and appropriately referred for specialist hospital treatment as necessary and that referrals are not cancelled unless a prisoner has transferred and can no longer attend. | | significant changes made to the external appointments system at HMP Wormwood Scrubs to ensure the referral process is closely monitored and that patients are seen by specialists in a timely manner. This includes the introduction of a RAG (red, amber green) system to ensure that urgent external Healthcare appointments are prioritised with the security department and not cancelled due to staffing issues. Upcoming external appointments are discussed weekly at the 'virtual ward round' where the priority rating is agreed. This is also communicated to the Security Department who are requested to contact Healthcare staff if an appointment needs to be cancelled so Healthcare staff can liaise with the Hospital to rearrange the appointment. | Complete<br><br>Clinical Business Unit (CBU) Manager | |

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| **No** | **Recommendation** | **Accepted/Not Accepted** | **Response** | **Target date for completion and function responsible** | **Progress (to be updated after 6 months)** |
| | | | **HMP Maidstone**<br><br>A full medical screening is carried out on reception. Where needed, secondary screening, mental health assessments and investigations into medical history and medications are instigated as a result of this.<br>Assurance checks are now carried out quarterly to ensure that the screening is robust and supported by investigation where appropriate.<br>If patients are identified as having outstanding referrals from the sending establishment they are reviewed by the GP in view of a local referral<br><br>Referrals are only cancelled at the request of the prisoner after consultation with nursing or medical staff | Complete<br><br>Healthcare Manager | |

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| **No** | **Recommendation** | **Accepted/Not Accepted** | **Response** | **Target date for completion and function responsible** | **Progress (to be updated after 6 months)** |
| 3 | The Heads of Healthcare at Wormwood Scrubs and Maidstone should ensure that a prisoner suspected of having epilepsy has an urgent medication review. | Accepted | **HMP Wormwood Scrubs:** Any prisoner suspected of having epilepsy will routinely undergo a full and urgent medical review by a General Practitioner, including a medication review. If appropriate, the prisoner would also be referred on for specialist help as per national guidance issued by the National Institute of Clinical Excellence. – "The epilepsies: the diagnosis and management of the epilepsies in adults and children in primary and secondary care".<br><br>**HMP Maidstone**<br><br>A full medical screening is carried out on reception, this prompts a GP appointment for review where appropriate, including where a diagnosis of epilepsy is suspected or reported by the prisoner. This medication or diagnosis is subsequently reviewed on a monthly basis and | Complete<br><br>CBU Manager<br><br>Complete<br><br>Head of Healthcare | |

| Action Plan | | | | | |
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| | | | following medical assessment appropriate follow-ups are put in place. This information was communicated to staff in August, so all staff were aware, as part of the team meetings. | | |
| 4 | The Head of Healthcare at Maidstone should ensure that there is an appropriate process to assess the risk of allowing prisoners to hold medicines in their possession. | Accepted | **HMP Maidstone**<br><br>A full review of in-possession medication policy has been carried out resulting in the development of a new risk assessment supported by a secondary screening, to ensure the risk is appropriately managed. The risk assessment was implemented August 2014 and staff were reminded at this time through staff meetings and clinical supervision. | Complete<br><br>Head of Healthcare | |
| 5 | The Governor of Maidstone should ensure that staff follow the guidance in the local security strategy and that, when conducting roll counts or unlocking a cell door, they check the | Accepted | An annual reminder of the prison's security strategy forms part of the SPDR review of operational staff. A Notice to Staff about the security policy is also published annually. Assurance checks are regularly conducted by | Complete<br><br>Head of | |

| Action Plan | | | | | |
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| | safety of the prisoner and that there are no immediate issues that need attention. | | wing managers and supervising officers. | Security | |