Prisons & Probation
Ombudsman
Independent Investigations

Independent investigation into the death of a prisoner at HMP Thameside, in December 2014

A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141

Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

© Crown copyright 2015

This publication is licensed under the terms of the Open Government Licence v3.0 except where otherwise stated. To view this licence, visit nationalarchives.gov.uk/doc/open-government-licence/version/3 or write to the Information Policy Team, The National Archives, Kew, London TW9 4DU, or email: psi@nationalarchives.gsi.gov.uk.

Where we have identified any third party copyright information you will need to obtain permission from the copyright holders concerned.

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

The man died of acute methadone toxicity at HMP Thameside on 4 December 2014. I offer my condolences to his family and friends.

I have serious concerns about the care the man received on the evening of his death. A prison doctor asked for half-hourly clinical observations, but only two sets were done. Additional welfare checks were not carried out as frequently as they should have been or to the required standard and staff falsified the records. For over two hours, the man had been observed lying on the floor, with his head and chest under the bed yet no one went into the cell to check his welfare, even when he did not respond. When staff eventually opened the cell, it was apparent that he had been dead for some time. Although we cannot know whether earlier intervention would have changed the outcome, the failure to check him adequately meant that potential opportunities to save him were missed.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **January 2016**

Contents

Summary

The Investigation Process

Background Information

Key Events

Findings

Summary

Events

1. On 3 December 2014, the man was sentenced to ten weeks in prison and was sent to HMP Thameside. He had been in prison several times before. He had a long history of substance misuse and had been prescribed methadone (a heroin substitute) for some years. Immediately before he went to prison, he had been prescribed a 110ml daily dose of methadone, a high dose. On 2 December, the day before his sentence, he had been diagnosed with a deep vein thrombosis in his left leg and was prescribed medication to prevent blood clots.

2. When he arrived at Thameside, the man's pulse rate was below normal and the reception GP decided not to give him methadone until he had an ECG the next day, to help establish that it was safe to prescribe such a high dose. He admitted the man to the healthcare centre inpatient unit for observation.

3. After an ECG on the afternoon of 4 December, the duty GP prescribed a half-dose of methadone (55ml). As the man's blood pressure was high and his pulse rate was fluctuating, the GP asked healthcare staff to check these observations every half hour. However, a healthcare assistant took the observations just twice, the last time at 5.40pm. He said that he stopped because his observations had returned to normal levels the second time, but did not consult a doctor or nurse about this.

4. Healthcare assistants are expected to check the welfare of all prisoners in the inpatient unit every half hour. The healthcare assistant signed to say that he had completed welfare checks on the man at 6.00pm and 6.30pm, but CCTV footage shows that he did not. All the healthcare day staff had left the unit by 6.35pm, and it appears that there were no healthcare staff on duty in the unit for around half an hour until another healthcare assistant arrived at 7.05pm. There was therefore no staff handover.

5. The evening healthcare assistant signed for five welfare checks between 7.00pm and 9.00pm, when he had only completed three. At 7.18pm, the first time he checked the man, he was lying on the floor with his head and chest underneath the bed. When he checked again at 7.57pm, he man was in the same position. At 8.20pm, a night patrol officer found the man in this position and he did not respond when the officer shook the door. The healthcare assistant's final check was at 9.07pm and the man had not moved. Neither the healthcare assistant nor the night patrol officer took any further action.

6. At 9.30pm, another healthcare assistant arrived for the night shift and began welfare checks immediately. When she reached the man's cell, she found him in the same position and was concerned about him and sought help from the night patrol officer. The night patrol officer requested further help but no one opened the cell and went in, until other officers arrived around ten minutes later. When staff went into the cell and examined the man, it was apparent that he had been dead for some time, as rigor mortis had begun. Despite this, officers and nurses began resuscitation until paramedics arrived and pronounced him dead. A post-mortem report concluded that he had died from acute methadone toxicity.

Findings

7. We found that the man did not receive an adequate standard of care at Thameside. Although his initial treatment and methadone prescription were appropriate, clinical observations that should have been taken every half hour on the evening of his death were stopped without proper justification. Additional checks were not completed as required and did not ensure the man's welfare. No one considered that the man might be reacting badly to drugs or medication. There was no handover between shifts and there was a period of around half an hour when no healthcare staff were working in the inpatient unit. The healthcare provider at Thameside has changed since the man's death and the healthcare staff on duty on the evening of, the man's, death no longer work at the prison.

8. It seems likely that the man had been dead for at least two hours, possibly longer, when staff eventually opened the cell and actively checked him. We cannot say with certainty that it would have made a difference to the outcome, but the failure to intervene earlier meant that there were potential missed opportunities to prevent the man's death. Even after the final healthcare assistant raised concerns, it took too long to go into the cell and check him. Staff unnecessarily tried to resuscitate him, when it was clearly too late. We make six recommendations.

Recommendations

- The Head of Healthcare should ensure that healthcare staff take clinical observations as instructed, understand why they have been ordered and how long they should continue.
- The Director and Head of Healthcare should ensure that staff complete and record welfare and roll checks in line with local policy, and satisfy themselves at each check that the prisoner is breathing and does not need immediate medical assistance.
- The Director and Head of Healthcare should ensure that all staff working with prisoners receiving drug treatment are trained to recognise the commons symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.
- The Head of Healthcare should ensure that there is always a member of healthcare staff working in the inpatient unit, and that there are recorded comprehensive handovers to ensure continuity of care.
- The Director and Head of Healthcare should ensure that staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life. If they assess the risk to themselves as too great, they should request urgent and immediate help
- The Director and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

The Investigation Process

9. The investigator issued notices to staff and prisoners at HMP Thameside informing them of the investigation and asking anyone with relevant information to contact him. No one responded.

10. The investigator visited Thameside on 12 December 2014. He obtained copies of relevant extracts from the man's prison and medical records.

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

12. The investigator and the clinical reviewer interviewed 12 members of staff at Thameside in January and February 2015.

13. We informed HM Coroner for Inner South London of the investigation, which was suspended until the results of the post-mortem examination and toxicology tests were received. We regret the delay this has caused to the publication of this report. The suspension was lifted on 13 August when we received the final post-mortem report from the coroner. The coroner has a copy of this report.

14. One of the Ombudsman's family liaison officers spoke to the man's sister and her partner to explain the investigation and to ask if they had any matters they wanted the investigation to consider. They wanted to know why the man had been admitted to the prison's healthcare inpatient unit and what was wrong with him. They asked whether staff had monitored him appropriately and responded properly to how he appeared.

15. The man's family received a copy of the initial report. The solicitor representing them 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.

Background Information

HMP Thameside

16. HMP Thameside is a local prison in south east London that holds up to 900 men. It is privately run by Serco. Health Services were contracted to Care UK until 31 March 2015, when the contract passed to Oxleas NHS Foundation Trust. There is 24 hour nursing provision and an 18 bed inpatient unit.

HM Inspectorate of Prisons

17. The most recent inspection of HMP Thameside was in September 2014. Inspectors reported that drug-dependent prisoners received consistent first night treatment and that the supervision of controlled drug administration had improved. Prisoners were very positive about drug and alcohol interventions and most surveyed said they received helpful support. Inspectors found there were comprehensive care plans for inpatients with good joint working between nurses and custody staff in the inpatient unit.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to June 2015, the IMB reported that Thameside was a good prison and had improved rapidly during the year. The IMB noted there was good communication between healthcare and custody staff in the inpatient unit and that there were effective substance misuse services.

Previous deaths at HMP Thameside

19. The man was the fourth prisoner to die at Thameside since it opened in March 2012. Two of the three previous deaths were due to natural causes and the third was an apparent suicide. In two of these investigations we made recommendations about responding to medical emergencies.

Key Events

20. The man had been in prison several times since the late 1980s. He had a history of drug use and had been on methadone maintenance programmes (as a substitute for heroin) in prison, including most recently from March to June 2014. In the community, he was prescribed a 110ml dose of methadone each day, which he received at his local pharmacy. This is a high dose and he had taken methadone on or around this level for at least a year. Pharmacy records show that he last took methadone there on 2 December 2014.

21. Later on 2 December, the man was arrested on suspicion of theft and for failing to appear at court for a previous hearing. The police were concerned about his health and took him to Lewisham Hospital, where doctors diagnosed a deep vein thrombosis (DVT, a blood clot) in his left leg. A hospital doctor prescribed Clexane, a medication used to stop blood clots.

22. On 3 December, the man appeared at Camberwell Green Magistrates' Court and was sentenced to a total of 10 weeks imprisonment. He arrived at HMP Thameside at around 5.30pm.

23. At an initial health screen, the man told Nurse A that he took a 110ml daily dose of methadone in the community and that doctors had diagnosed a DVT the previous day. The nurse told us that the man seemed very withdrawn and looked unwell, although she did not record this at the time. She referred him to Dr A, the reception GP.

24. Dr A noted that the man's routine urine test confirmed he used methadone as well as other drugs. He took the man's blood pressure which, at 141/87, was slightly higher than the normal range. His pulse rate was low at 50 beats a minute. He concluded that the man's pulse rate was too low to give him the high dose of methadone safely. Instead, Dr A, prescribed medication to help with withdrawal symptoms, as and when the man needed it. He arranged for the man to be admitted to the healthcare inpatient unit for observation. He asked for an electrocardiogram (ECG) - which measures the rhythm and electrical activity of the heart - to be carried out the next day to help determine whether it was safe to prescribe methadone.

25. The local policy at Thameside is that a healthcare assistant checks inpatients every half an hour from 7.30am to 9.30pm and every hour overnight. This is a basic welfare check and involves looking through the observation panel in the cell door to check each patient. The healthcare assistant signs a form to say they have completed each check.

26. At around 11.30pm, Healthcare Assistant A checked the man, who appeared to be in pain. When she asked him what was wrong, the man asked her to switch the light off. She told the man to call her if he had any further problems.

27. At around 3.30am on 4 December, the man told Healthcare Assistant A that his hands felt numb. The healthcare assistant asked the duty Nurse B to see the man. The nurse recorded that the man was "very agitated and in a lot of discomfort". The man said he had not yet taken any of the symptomatic relief

medication prescribed earlier, and Nurse B gave him the medication. The man fell asleep at around 5.00am.

28. Dr B, a prison doctor, reviewed the man on the morning of 4 December. He recorded that the man did not appear to be withdrawing from methadone. The man's blood pressure and pulse, at 122/88 and 74 beats per minute respectively, were both within the normal range. He asked healthcare staff to take an ECG and check the man's prescription with his community GP before he was given methadone. The doctor examined the man's leg and noted that it was swollen and red.

29. The man's medication was confirmed a few hours later, and Dr B wrote a prescription for methadone at around 1.20pm. Healthcare staff did not give the man methadone at this stage as he had not yet had the ECG.

30. Around 2.00pm, Nurse C completed an initial assessment for the prison's integrated drug treatment service (IDTS). She recorded that the man appeared very angry about issues from his past, such as his dislike for his school teachers. He said that he was cold in his cell. The nurse recorded that the man did not have any symptoms of withdrawal, but when she asked how he was, he repeatedly said "I am fucked". He told her that he had been to hospital after the police arrested him and said that nurses there had told him he needed to go back for a review in ten days. The nurse recorded that she would ask administration staff to follow this up with the hospital.

31. Between 4.00pm to 4.30pm, Nurse D completed the ECG. She took the man's pulse which, at 46 beats per minute, was low. His blood pressure, at 148/81, was above the normal range.

32. Shortly afterwards, Dr B examined the results of the ECG and took his own reading of the man's pulse, which was now 68 beats per minute. His blood pressure was 149/84. The doctor decided that the man should have a half dose of methadone (55 ml) that afternoon. He asked healthcare staff to check the man's pulse and blood pressure every 30 minutes. The doctor told us that he gave this instruction to Nurse D and Healthcare Assistant B. He also recorded it in SystmOne, the electronic medical record. The doctor did not say how long the observations should continue, but told us that his expectation was that they should continue until a doctor had reviewed it. Nurse D gave the man his methadone and Clexane shortly afterwards.

33. Healthcare Assistant B took the man's clinical observations at around 5.00pm. The man's blood pressure was 174/105, which is high, and his pulse rate was 64 beats per minute. The healthcare assistant recorded that he discussed these observations with Dr B, who told him that the pulse rate was the main concern and it was improving.

34. At 5.40pm, Healthcare Assistant B took the man's observations again. His blood pressure was now 149/81, above the normal range, and his pulse rate was 73 beats per minute, within the normal range. This was the last time Healthcare Assistant B took clinical observations.

35. Healthcare Assistant B signed to say that he had completed welfare checks at 6.00pm and 6.30pm and that the man was awake at the time. However, closed circuit television (CCTV) shows that he did not go to the cell after 5.40pm. The healthcare assistant told us that he stopped taking clinical observations because he thought they had returned to normal levels. He said that he had guessed when he wrote that the man was awake at the welfare checks but had no explanation for not doing them.

36. Healthcare Assistant B finished work at around 6.35pm. He told us that the nurses had already left and he was the last member of healthcare staff to go. The healthcare assistant said that he had spoken to the area manager for Care UK, before he left and said that the man had not taken his promethazine, an anti-histamine medication. The area manager for Care UK told us that she did not remember that conversation and was not certain that she was in Thameside at the time. It appears that, although there was an officer present, there was a period of around half an hour when there was no nurse or healthcare assistant on duty in the inpatient unit.

37. At around 7.05pm, Healthcare Assistant C arrived in the inpatient unit for evening duty. He told us that there was no other member of healthcare staff there when he arrived and so he did not receive any handover.

38. Healthcare Assistant C signed the sheet to indicate that he had completed five welfare checks, every 30 minutes from 7.00pm to 9.00pm. Each time, he recorded that the man was asleep. CCTV shows that he made only three checks during this period, at 7.18pm, 7.57pm and 9.07pm. Healthcare Assistant C told us that he could not remember why he had only done three checks rather than the required five.

39. Healthcare Assistant C said that when he first checked at 7.18pm, the man was lying on his side on the floor against the back wall of the cell. The healthcare assistant said he could not see the man's chest and head as they were underneath the bed. He said he saw the man's hand twitch, as it might do during sleep.

40. Healthcare Assistant C could not remember clearly what the man was doing when he returned to the cell at 7.57pm, but thought he was lying in the same position as before.

41. Prison Custody Officer A, the night patrol officer, arrived in the inpatient unit at around 8.00pm and, at 8.20pm, began a check to establish that all prisoners were present in their cells. She told us that the man was lying on his back on the floor at the back of the cell and she could not see his head and chest as they were underneath the bed. She could not therefore see whether he was breathing. The officer said she shook the door but the man did not respond and she carried on with her roll check. She said she assumed that the man was a mental health patient, as is the case for nearly all inpatients.

42. Officer A went back to the man's cell just over a minute later. There was no change to the man's position. She did not speak to Healthcare Assistant C about what she had seen or take any further action.

43. At 8.38pm, Officer A looked briefly into the man's cell again. She told us that she did this because she was not entirely happy with what she had seen before. She said that the man was in the same position, but his right hand had moved since she had last been to the cell; his fingers had now slightly curled, when previously his hand had been flat on the floor.

44. Healthcare Assistant C conducted his final welfare check at 9.07pm. He said he could not recall this very well but thought the man had now rolled onto his back and that he seemed fine.

45. Around 9.30pm, Healthcare Assistant C finished work and Healthcare Assistant, A took over for the night shift. She told us that she did not receive a handover from Healthcare Assistant C.

46. Shortly after 9.30pm, Healthcare Assistant A began her first welfare check and arrived at the man's cell at 9.32pm. She said the man was lying on the floor with his head and the top half of his torso underneath the bed. She called to him but he did not respond. After around two minutes, Officer A joined her at the cell after hearing her calling to the man. The healthcare assistant told us that the man appeared to be in a very deep sleep, although she thought it was possible he had died. They agreed that Officer A would contact the night orderly officer (the senior officer in charge of the prison overnight) to ask him to send some officers so they could open the cell and check the man. The healthcare assistant checked the man's medical record to see if he had been prescribed sleeping tablets. They both left the cell at 9.35pm.

47. A minute later, at 9.36pm, Healthcare Assistant A and Officer A returned to the cell. The officer said that she did not open the cell at this point because the last time she had done this the prisoner had been pretending to be ill. She also said she assumed that the man, like most inpatients, was there because he was mentally ill and she was concerned about their safety.

48. At 9.43pm, Officer B and Officer C arrived and opened the man's cell. Officer C found blood around the man's head and radioed a code red medical emergency, indicating a life threatening incident involving a significant loss of blood. When he looked more closely at the man, Officer C found that he was not breathing and appeared to be dead. He then changed the emergency call to code blue, used for a life threatening situation when the prisoner is unconscious, has difficulty breathing or has stopped breathing. Officer B and Officer D, who had also arrived at the cell, began cardiopulmonary resuscitation. Officer B told us that the man's body was very cold and very stiff.

49. Nurse B and Nurse E, who had been working on the drug treatment wing, responded to the emergency and took over resuscitation when they arrived. Nurse E told us that the man was cold and stiff and appeared to be dead. They attached a defibrillator, which found no shockable heart rhythm and they continued to try to resuscitate him. Paramedics arrived at the cell at 9.54pm and, shortly afterwards, recorded that the man was dead.

Contact with the man’s family.

50. The man did not name a next of kin when he arrived at Thameside, but the police found an address for his sister. An operational manager, A, and a prison chaplain and family liaison officer, visited the man’s sister on the morning of 5 December and informed her of his death. In line with Prison Service policy, the prison contributed to the costs of the funeral.

Support for prisoners and staff

51. After the man’s death, Operational Manager B debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and offered his support and that of the staff care team. No one raised any immediate issues.

52. The prison posted notices informing other prisoners of the man’s death, and offering support. Staff reviewed all prisoners assessed as a risk of suicide and self-harm, in case they had been adversely affected by the man’s death.

Post-mortem report

53. A toxicology test, as part of the post-mortem examination, found a high concentration of methadone in the man’s blood. The toxicologist reported that this methadone concentration was within the range of values detected in individuals on methadone maintenance therapy, although this particular concentration would be expected following a high dose. The toxicologist commented that the concentration was also within the fatal range for some individuals with a degree of tolerance. The pathologist concluded that the man’s death was consistent with the acute toxic effects of methadone. He did not discuss the DVT in his report.

Findings

Methadone prescribing

54. The man had a long history of substance misuse and dependence. He had been prescribed methadone, as a substitute for heroin, during previous periods of imprisonment and in the community. Before he arrived at Thameside, the man took a daily 110ml dose of methadone, which is a high dose. Pharmacy records show that he received the dose in each of the six days before his imprisonment (we have not seen earlier records).

55. As he was in police custody, the man did not collect his methadone from the community pharmacy on 3 December 2014. When he arrived at Thameside that evening, Dr A did not consider it safe to give the man the high dose of methadone, owing to his low pulse rate. The clinical reviewer considered that this was appropriate and in line with national guidelines. The man did not receive any prescribed methadone between the dose he took on 2 December at the pharmacy and the 55ml Dr B prescribed on the afternoon of 4 December.

56. The pathologist gave the cause of death as acute methadone toxicity. The clinical reviewer considered that methadone was administered appropriately at Thameside in line with accepted policy and procedure. We have not seen any evidence that the man obtained or took illicit methadone or any other opiate-based drug at Thameside, although this possibility cannot be ruled out.

Clinical observations

57. At around 4.30pm on 4 December, when he agreed that the man could have methadone, Dr B asked healthcare staff to check the man's pulse rate and blood pressure every 30 minutes. He said that he asked Nurse D and healthcare assistant B to do this, and he made a note of this in the electronic medical record. Dr B did not record how long the observations should continue, but told us that he expected them to continue until reviewed by a GP.

58. Healthcare Assistant B took observations at around 5.00pm and 5.40pm. He told us that he stopped taking observations because he thought they had returned to normal levels. The healthcare assistant did not discuss this with Dr B or any other member of healthcare staff.

59. Rigor mortis was present when the night staff went into the man's cell at around 9.40pm. Depending on the room temperature and other variables, rigor mortis usually begins between two and six hours after death. Had the 30 minute clinical observations continued as Dr B requested, it is certain that the staff would have identified that the man was unresponsive or unconscious much earlier. We cannot know that this would have made a difference to the outcome, but it would have given healthcare staff a much better chance of preventing the man's death. We make the following recommendation:

    The Head of Healthcare should ensure that healthcare staff take clinical observations as instructed, understand why they have been ordered and how long they should continue.

Welfare and roll checks

60. Local policy at Thameside is that a healthcare assistant should check inpatients every half an hour from 7.30am to 9.30pm and every hour overnight. This is a basic welfare check and involves looking through the observation panel in the cell door to check on each patient. Healthcare assistants sign a form, which is supposed to give assurance that they have completed each check.

61. Healthcare Assistant, B, signed that he had completed welfare checks at 6.00pm and 6.30pm, but CCTV footage shows that he did not go to the man's cell (or any other cells in the unit) after he last took clinical observations at 5.40pm. He wrote on the form that the man was awake at these checks, but told us that he just guessed when completing the form.

62. Healthcare Assistant C signed that he had completed five welfare checks from 7.00pm to 9.00pm inclusive. CCTV footage shows that he only did three checks. The healthcare assistant had no explanation for this.

63. Healthcare Assistant C said that at his first check, at 7.18pm, the man was lying on his side against the back wall of his cell. He could not see the man's chest and head as they were underneath the bed. He thought the man was lying in the same position when he completed his next check, at 7.57pm. He could not remember well the final check at 9.07pm, but thought the man was now lying on his back.

64. Healthcare Assistant C told us that a requirement of the welfare check is to ensure that the patient is alive and breathing. He said that the man seemed fine at each of his three checks. As rigor mortis was present when the man was discovered at 9.40pm, it is likely that the man was dead at some, if not all, of these checks. It is difficult to understand how the healthcare assistant could have been satisfied that the man was breathing at this time, particularly as his view of the man's chest was obscured. We are not satisfied that healthcare staff conducted these checks properly and they should have gone into the cell to check him properly.

65. Local Instruction 07.09 gives staff at Thameside guidance about the purpose, method and frequency of roll checks at night. It states that:

> "Night patrols must assure themselves that prisoners are in the correct cell by obtaining a clear view of their face, if necessary waking them. Staff must always obtain a response from the prisoner if they have any concerns."

66. When Officer A conducted the roll check at 8.20pm, the man was lying on his back and she could not see his head or chest. The officer shook the door, but the man did not respond. While the officer went back to the cell twice more, but as his head and chest were obscured, she could not have seen that the man was breathing. We do not consider that it would have been possible for her to have established that the man was safe and well without going into the cell. On the evidence available, it appears that the man was dead at the time, so it is unlikely that earlier intervention would have made a difference at this stage. However, a more thorough check might make a difference in other circumstances.

67. As well as the inexplicable failure of the staff to intervene more actively when the man was lying unresponsive on the floor, we are concerned that none of the staff appeared to recognise that he might be suffering the effects of drug intoxication. Typically, people who die from the effects of methadone are deeply unconscious, unrousable and are often heard to be snoring heavily before they stop breathing. These warning signs have been evident in a number of deaths we have investigated. None of the staff reported that the man was snoring heavily, but the gap in checks might mean that even if this was the case, this was missed. He was evidently unable to be roused.

68. As the man was in the healthcare unit for observation, the healthcare staff should have been aware of his substance misuse problems and the risks for prisoners undergoing drug treatment. Nevertheless, the staff should have attempted to get a conscious and lucid response from the man and sought further medical help immediately when he did not respond.

69. Since the man's death, the healthcare provider at Thameside has changed and the healthcare assistants involved no longer work at the prison. Otherwise, we would have recommended a disciplinary enquiry into the actions of the staff that evening. However, the failure to complete welfare checks appears to have been common, and a managerial failure, as well as that of the individuals. It is questionable how well a single healthcare assistant could be expected to make adequate half-hour checks of up to 18 patients as well as other duties. The clinical reviewer noted that there was no qualified nurse presence in the unit at night and wondered whether this was appropriate. She has made a recommendation about the staffing of the unit, which the Head of Healthcare will need to address. We make the following recommendations:

The Director and Head of Healthcare should ensure that staff complete and record welfare and roll checks in line with local policy, and satisfy themselves at each check that the prisoner is breathing and does not need immediate medical assistance.

The Director and Head of Healthcare should ensure that all staff working with prisoners receiving drug treatment are trained to recognise the commons symptoms of drug-induced unconsciousness and methadone toxicity and know how to respond.

Handover of care and staffing in the inpatient unit

70. Healthcare Assistant B said that he was the last member of operational healthcare staff remaining when he left the inpatient unit at 6.35pm on 4 December. He thought that he had spoken to the Care UK area manager before he left, although she did not remember that conversation and was uncertain that she was in the prison at the time. It appears that there was no member of operational healthcare staff present on the unit until Healthcare Assistant C arrived at around 7.05pm. Healthcare Assistant C told us that there was no one present when he arrived and he did not therefore receive a handover. Healthcare Assistant A said that she did not receive a handover from Healthcare Assistant C when she started her night shift at around 9.30pm.

71. We are concerned that the healthcare inpatient unit, which holds some of the most vulnerable people in the prison, was staffed by just one prison custody officer without a member of healthcare staff for around half an hour on the night of the man's death. This meant that half hour checks at that time were not possible. We are also concerned that this meant there was no handover of care and therefore any issues, such as the need to carry out clinical observations on the man, were not communicated between different shifts. The clinical reviewer commented that this was not an acceptable standard of care and not equivalent to community care. We make the following recommendation:

The Head of Healthcare should ensure that there is always a member of healthcare staff working in the inpatient unit, and that there are recorded comprehensive handovers to ensure continuity of care.

Emergency response

72. At night, officers have a cell key in a sealed pouch for use in an emergency. Prison Service Instruction 24/2011, which covers management and security at nights, states that staff have a duty of care to prisoners, to themselves, and to other staff. The preservation of life must take precedence over usual arrangements for opening cells and where there is, or appears to be, immediate danger to life, then cells may be unlocked without the authority of the night orderly officer and an individual member of staff can enter the cell on their own. Staff are not expected to take action that they feel would put themselves or others in unnecessary danger. What they observe and any knowledge of the prisoner should be used to make a rapid dynamic risk assessment.

73. Both Officer A and Healthcare Assistant A were concerned about the man, and the healthcare assistant said she thought it was possible he had died. They were unable to see if the man was breathing due to the position of his body. It took around 10 minutes after they asked for help for other officers to arrive and open the cell. Officer A said that she did not open the cell earlier because she did not know the man and was concerned that he might be pretending to be ill.

74. We appreciate that Officer A had little knowledge of the man, but Healthcare Assistant A had spoken to him the night before and knew about his background. The officer said that she was concerned that the man might have mental health problems and be dangerous but healthcare assistant knew that was not the case. While it can be difficult for staff in such situations to make instant decisions, when someone is in an apparent life-threatening situation it is essential to act quickly. Unless there are evident risks, we would normally expect staff to go into a cell as soon as possible, in case there is a chance of saving someone's life. We accept that the staff were unsure about the man's condition at the time, but if they were unprepared to open the cell, they should have ensured that they asked for urgent, immediate assistance. We make the following recommendation:

The Director and Head of Healthcare should ensure that staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life. If they assess the risk to themselves as too great, they should request urgent and immediate help.

Resuscitation

75. Several members of prison and healthcare staff attempted to resuscitate the man. However, Officer B and Nurse E both said that his body was cold and stiff. It is apparent that he had been dead for some time.

76. The clinical reviewer commented that the attempted resuscitation of the man was inappropriate as rigor mortis was clearly present. European Resuscitation Council Guidelines 2010 state that “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile”. The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014 about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual’s situation. These decisions should never be dictated by ‘blanket’ policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

    The Director and Head of Healthcare should give clear guidance to staff about the circumstances in which resuscitation is inappropriate.

Prisons & Probation
Ombudsman
Independent Investigations

PO Box 70769
London, SE1P 4XY

Email: mail@ppo.gsi.gov.uk
Web: www.ppo.gov.uk

T | 020 7633 4100
F | 020 7633 4141