



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in HMP
Belmarsh in May 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 investigation report into the death of a man at HMP Belmarsh on 22 May 2013. The cause of the man's death was methadone and chlordiazepoxide toxicity, and atherosclerotic stenosis (narrowing) of the coronary arteries. He was 45 years old. I offer my condolences to the man's family and friends.

The investigation was carried out by an investigator. A clinical reviewer reviewed the man's clinical care at Belmarsh. The investigation was suspended until June 2014 until the results of the post-mortem examination and toxicology report were received. I am sorry that this led to a delay in issuing this report.

The man had arrived at Belmarsh four days before his death. Assessments for opiate and alcohol dependence indicated that he was suffering from withdrawal from both substances and a prison GP prescribed detoxification regimes. Healthcare staff conducted physical observations of the man each day and welfare checks at night, but noted no concerns about his condition. The man's cellmates thought that he had been affected by his medication, but did not report this to staff.

The night before his death, one of the man's cellmates heard him snoring. The man was lying on top of his bedcovers with his legs hanging over his bed. He spoke briefly to the man and suggested he get into the bed. The healthcare assistant who checked his welfare during the night noted nothing unusual and neither did the prison officer who checked prisoners early the next morning. However, the officer who unlocked prisoners around two hours later, found the man unresponsive. He was still lying in the same position noted by his cellmate the night before.

The clinical reviewer concluded that the man received a standard of care at Belmarsh that was equivalent to that he could have expected in the community. He noted that prison staff had unnecessarily attempted to resuscitate the man in spite of evidence of rigor mortis when he was found.

I am satisfied that the man began appropriate detoxification programmes but I am concerned that the GP who prescribed the treatment did not have the required level of training to deliver substance misuse services, a matter the Chief Inspector of Prisons and I have raised before at Belmarsh. I am also concerned about the efficacy of welfare checks at night for prisoners on a methadone maintenance programme as it was not noted that the man remained in the same unusual position without moving all night. While it did not affect the outcome for the man, staff did not follow the required emergency response procedures, which led to a delay in calling an ambulance and obtaining some emergency equipment. A number of these issues reflect those found during previous investigations into deaths at Belmarsh and the new Governor needs to ensure that my recommendations are fully implemented.

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.

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SUMMARY

1. The man had been released on licence from prison in April 2008. On 17 May 2013, he took an accidental overdose of heroin and was taken to Croydon University Hospital. Hospital staff contacted the police, who arrested him. The man appeared at court the next day, and was sentenced to six weeks in prison and recalled to prison for not living at the address given on his licence.
2. At an initial health screen at HMP Belmarsh on 18 May, the man told a nurse that he regularly used heroin and crack cocaine and drank five cans of strong lager a day. The nurse referred him to the prison's substance misuse team and a GP. Assessments showed he was suffering mild drug and alcohol withdrawal and a GP prescribed a five-day methadone regime for opiate withdrawal and a seven-day chlordiazepoxide regime for alcohol withdrawal. The man shared a cell in the prison's first night centre with two other men.
3. Healthcare staff carry out frequent physical checks of all prisoners undergoing detoxification, including welfare checks during the night, to ensure that the prisoner is not reacting adversely. No concerns about the man were identified. The man's cellmates thought that he seemed sleepy and slurred his speech at times. The man mentioned to them that he might have received too much medication, but they did not report any concerns to staff.
3. On the night of 21/22 May, a healthcare assistant checked the man four times and an officer carried out general checks of prisoners at 9.00pm and 6.00am. Neither noticed anything that concerned them, although the thoroughness of these checks is questionable. At around 11.30pm that night, one of the man's cellmates said he had heard him snoring and noticed that he was lying on his bed with his legs hanging over the edge.
4. The officer who unlocked the man's cell at 8.19am on the morning of 22 May noticed that the man's leg was hanging over the bed in the same position his cellmate had noted the night before. His cellmate was unable to wake him so the officer went in to the cell and found him cold and stiff. She immediately called for assistance, but did not use an emergency medical code. Colleagues requested an ambulance at 8.24am. Although it appeared that rigor mortis had set in, officers and nurses attempted resuscitation. Paramedics arrived at 8.40am and instructed them to stop. After carrying out checks, the paramedics pronounced the man dead at 8.56am.
5. The investigation found that, while the detoxification regimes prescribed were appropriate, the doctor who prescribed the man's treatment was not fully trained in substance misuse. We are also concerned that staff did not request the man's medical records or conduct roll and night welfare checks thoroughly. After he was found, staff did not follow the expected emergency response procedures and attempted to resuscitate him in spite of the presence of rigor mortis. There was a delay in holding a staff debrief. Several of the recommendations in this report have been made in previous investigations at Belmarsh.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Belmarsh, announcing the investigation and asking anyone with relevant information to contact her. No one responded.
7. The clinical reviewer reviewed the man's clinical care at the prison.
8. The investigator went to Belmarsh on 28 May 2013. She met a manager and interviewed two members of staff. She also spoke informally to the man's two cellmates. The investigator carried out additional interviews with the clinical reviewer on 11 June and a further interview at the Ombudsman's office on 18 June.
9. We informed HM Coroner for South London of the investigation, who provided a post-mortem and toxicology report. We have sent a copy of our investigation report to the Coroner.
10. One of the Ombudsman's family liaison officers spoke to the man's family to explain the investigation. They identified no issues for the investigation to consider.
11. The investigation was suspended pending the results of the post-mortem and toxicology report, which we did not receive until 6 June 2014. We regret the consequent delay in issuing this report.
12. The man's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP BELMARSH

13. HMP Belmarsh is a high security and local prison serving the courts of South East London and South West Essex. It holds over 900 adult men. Care UK runs healthcare services in the prison. The healthcare department provides 24-hour care and has facilities on all the houseblocks, as well as in reception, and the first night centre.

Integrated Drug Treatment System (IDTS)

14. The Integrated Drug Treatment System aims to increase the volume and quality of substance misuse treatment available for prisoners, with particular emphasis on those in the early days of custody and improving the integration between clinical and other drug workers.
15. Methadone is used to treat people who enter prison with a dependence on opiates such as heroin. Prisoners who need a methadone prescription have to provide evidence of opiate use (a urine sample, evidence of withdrawal or both). In the absence of an existing prescription, or if it is unclear what amount was being used in the community, the dose of methadone is gradually increased until a safe level is reached.
16. Prisoners are reviewed after 13 weeks and, unless there are specific reasons such as being on remand, a short sentence or health reasons, they are gradually detoxified by slowly reducing their dosage of methadone.
17. At Belmarsh, a substance misuse nurse assesses new prisoners with drug and/or alcohol problems and detoxification treatment starts immediately. Prisoners dependent on alcohol and/or opiates are given symptomatic relief on the first night and a prison doctor subsequently reviews them. Those who experience severe withdrawal are admitted as healthcare inpatients. The others are located on the induction spur on houseblock three, which is also the prison's stabilisation unit.

Emergency response team

18. HMP Belmarsh has a mixed team of emergency responders, including wing and healthcare staff. All are trained in immediate life support and, at the time of the man's death, they all had up to date training.

HM Inspectorate of Prisons

19. HM Inspectorate of Prisons carried out an unannounced inspection of Belmarsh in September 2013. Inspectors found that all newly-arrived prisoners received a detailed risk interview, regardless of the time they arrived and staff ensured that their immediate needs were identified and met. Prisoners started a two-day induction the day after their arrival.
20. The inspectorate concluded that the clinical management of substance-dependent prisoners had improved, with first night treatment, appropriate facilities for administering controlled drugs and 24-hour nurse cover. However, they identified a need for training of those responsible for substance-dependent prisoners. Treatment regimes were flexible and clinical staff were well supported by four drug strategy officers. There was a good range of drug and alcohol intervention courses and a well-established peer support scheme.

Independent Monitoring Board

21. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. The most recent IMB report, for 2012-2013, noted that the prison had received additional funding for healthcare services and had awarded a contract for a new drug treatment and recovery service. There was a good working relationship between healthcare and prison staff.

Previous deaths at Belmarsh

22. The man's death was the sixth of nine deaths at Belmarsh since 2011. In previous deaths between 2011 and 2013, we made recommendations on issues similar to those identified in this report, including compliance with the emergency response procedures, requesting GP records, checking prisoners' well-being, issuing guidelines on resuscitation, training for doctors and carrying out a debrief after an emergency incident.

KEY EVENTS

18 May

23. The man was released on licence from HMP Whatton on 19 April 2008, after serving a sentence for sex offences. As an offender on the violent and sex offender's register, one of his licence conditions was a requirement to inform police of any change to his personal circumstances, including any change of address, within the next seven years.
24. On 17 May 2013, the man was taken to Croydon University Hospital after accidentally overdosing on heroin. Hospital staff alerted the police, who later arrested him in hospital and detained him at Croydon Police Station. The next day, he appeared at Camberwell Magistrates' Court, where he was sentenced to six weeks imprisonment and recalled to prison, for breaching the conditions of his licence.
25. The man arrived at HMP Belmarsh on 18 May. The Person Escort Record (PER) which accompanied him from the court to the prison recorded that he was alcohol and drug dependent and that he had taken an accidental overdose of heroin the previous day. During the reception procedures, he told a nurse that the overdose had not been an attempt to kill himself. A short time later, at 2.25pm, the nurse assessed the man's physical and mental health and risk of self-harm. He said that he regularly used heroin and crack cocaine and drank five cans of strong lager daily. He gave no indication that he had thoughts of suicide or harming himself. The nurse referred the man to the substance misuse team.
26. Just after 3.00pm, a substance misuse nurse, assessed the man using the clinical opiate withdrawal scale (COWS) to assess the level of drug withdrawal. COWS rates eleven common opiate withdrawal signs (pulse rate, sweating, restlessness, pupil size, bone aches, runny nose, stomach upset, tremor, yawning, anxiety and gooseflesh skin). The man reported some joint aches and anxiety and scored two, which indicated mild withdrawal.
27. The substance misuse nurse then assessed the man's alcohol withdrawal. This assessment rates ten common withdrawal signs and symptoms (nausea, tremor, sweats, anxiety, agitation, tactile disturbances, auditory disturbances, visual disturbances, headache and orientation). The man was anxious and said he had a headache. He scored three on the alcohol withdrawal scale, which again signified mild withdrawal. The man's physical observations showed slightly raised blood pressure and a normal pulse rate. The substance misuse nurse referred the man to the prison GP to begin his detoxification programme and prescribe medication.
28. At 4.31pm, the GP assessed the man and found signs of opiate withdrawal. He noted, "flushed face, sweaty, normal size pupils". The doctor prescribed a five-day standard methadone¹ regime for opiate withdrawal. As it was unclear

¹ Methadone is a substitute for morphine and heroin, which reduces and stops the symptoms of withdrawal.

how much heroin the man had been using, he started with a low dose of methadone to be gradually increased. The doctor also prescribed a standard seven-day chlordiazepoxide² regime for alcohol withdrawal, to be taken three times daily for the first two days, then reduced and stopped after a further five days. A review by the substance misuse team was planned for 23 May. That day, the man received 10mls of methadone and 25mg of chlordiazepoxide. He was also given a thiamine and vitamin B tablet and an inhaler for asthma, which he was allowed to keep in his possession. There is no entry in the medical records to suggest that his respiratory function had been assessed. No-one requested his community health records, although he provided his GP's details. .

29. After the healthcare assessments, staff allocated the man to a cell on the prison's first night centre, which he shared with two other prisoners.
30. During the night, healthcare staff check prisoners in the first night centre who are detoxifying. They are not expected to wake the prisoners, but they observe whether the prisoner is asleep, their position and that they are breathing normally. On the night of 18 May, a healthcare support worker, recorded that he had checked the man four times during the night and early hours of 19 May and had no concerns.

19 May

31. The next morning, a nurse assessed the man and noted that his pupils were dilated and he had transient gooseflesh. The nurse concluded that he had very mild opiate withdrawal and mild alcohol withdrawal. His care plan was to continue detoxification until reassessed on 23 May. He also planned for the man to see a member of the Pathways team (who provide psychological support for those with mental health disorders). At 10.07am a healthcare assistant noted the man's blood pressure and pulse rate, which were within the normal range.
32. In the afternoon, the nurse examined the man. His physical observations remained within the normal range, although his blood pressure was slightly raised. He referred the man to an infection control nurse who arranged a chest X-ray. This was normal practice for all prisoners who had been homeless at some point to determine whether they had TB (tuberculosis). The nurse offered the man smoking cessation advice and hepatitis B immunisation, but he declined.
33. At 3.50pm, the healthcare assistance assessed the man's physical observations again. His blood pressure was normal. His pulse was slightly high, but this was consistent with opiate detoxification. The man had received 10mls of methadone twice that day, as well as three doses of chlordiazepoxide (25mgs), thiamine and vitamin B.

² Chlordiazepoxide is a drug used as a sedative and to reduce the symptoms of alcohol withdrawal

34. An officer checked the man four times throughout the night and early morning, at 10.29pm, 12.57am, 2.42am and 6.21am. He noted no concerns.

20 May

35. At 8.56 am on 20 May, the records indicate that the officer checked the man's blood pressure and pulse and the readings were normal. He also had a chest X-ray which was normal. His blood pressure and pulse checks were repeated in the afternoon when his pulse rate was slightly high.
36. That day, the man received 15mls of methadone twice, three 25mg of chlordiazepoxide, thiamine and vitamin B. At 11.23pm that night, the officer returned to duty. He noted that the man was asleep and breathing normally. He noted no concerns after the other three observations that night.

21 May

37. At 9.41am on the morning of 21 the officer recorded the man's blood pressure and pulse and both readings were higher than the normal range. The man took 15mls of methadone that morning and 20 mls in the afternoon, three 20mgs of chlordiazepoxide, thiamine and vitamin B.
38. In the evening, the man chatted to his cellmates. They said that he appeared very sleepy and tired and that he was falling asleep while sitting up smoking a cigarette. Their cell was locked at approximately 7.00pm. They recalled that, at about 9.00pm, the man appeared "out of it" and was sitting on his bed doubled over. One prisoner asked if he was all right and whether he had received too much medication. The man replied that he thought he had. Neither the man nor his cell mates alerted staff to this.
39. When we interviewed them, both prisoners said that the man had been a heroin user, but perhaps not as frequent or heavy a user as he had told healthcare staff. The prisoner said that two days before the man died, he had wondered whether the man had been over-medicated as he seemed "off his face". He had found it difficult to keep awake and his speech had been slurred, although he said he was fine. The prisoner said that he was not aware that the man had taken any illicit drugs at Belmarsh. The prisoner said he thought that the man had been prescribed too much methadone as he seemed very sleepy.
40. At 10.24pm, while carrying out the night observations a healthcare assistant, noted that the man was asleep in bed and breathing normally. There were no other entries in the man's medical record that day.
41. At approximately 11.30pm, the prisoner said he had woken up and heard the man snoring. He noticed that he was lying on top of his bed with his legs dangling over the edge. As it was a cold night, he suggested to the man that he should get into bed. The man said he would.

22 May

42. The healthcare assistant was on duty on the night of 21 and 22 May and was expected to check the man every two hours as he was still detoxifying. He noted on an observation record sheet that he had checked him at 10.00pm, midnight, 2.00am, 4.00am and 6.00am. However, on SystmOne, the electronic medical record, the healthcare assistant had logged the times as 10.24pm, 2.10am, 4.04am and 6.23am. (The clinical reviewer estimated that it is likely that the man had died by 6.15am.) There was also one untimed entry. When interviewed, the healthcare assistance said there were discrepancies between the timings of the two records as he made entries in the medical record some time after he had made the checks. He said that the correct times were those recorded on the observation sheet. Each time, the healthcare assistance noted that the man was asleep and breathing normally and he reiterated this at interview. He did not note whether the man was in the same position each time and did not appear to move throughout the night.
43. An officer carried out a roll check (count of prisoners) on the morning of 22 May at approximately 6.00am. She noticed nothing unusual. She recalled that another member of staff had also checked the man at that time, but she did not know his name.
44. Just after 8.00am, an officer started to unlock prisoners to allow them a period of time in the open air in the exercise yard. She opened the man's cell at approximately 8.19am and asked whether any of the three occupants wanted to go for exercise. The man's cell mates, who occupied the bunk bed, were just waking up, but the man, who was lying on a single bed on top of the covers. The officer said that he seemed to be asleep. She said it appeared that he had fallen over to one side and that his legs were hanging over the side of the bed.
45. The officer asked the prisoner who was on the top bunk and seemed more awake, to give the man a nudge to wake him up. He was unable to get a response. As the man appeared to be in a very deep sleep, the officer went into the cell to try to wake him. She shook him, but could not get a response and noticed that he felt very cold and quite stiff. The officer told the investigator it was clear that something was wrong, so she left the cell and asked other officers who were unlocking prisoners for urgent assistance. She asked someone to call "Hotel 99" (a request for a medical responder from the healthcare department, indicating an emergency). She said that staff carrying out particular duties are detailed to carry a radio, but she did not have one.
46. An officer responded to the other officer's call for help, but he was not carrying a radio either. He went to the wing office and asked the officer to radio the healthcare department for urgent assistance and then went to the man's cell. An officer made the code 99 emergency call over her radio. Another officer said the man was about two feet from the head of the bed and was wearing a tee-shirt and boxer shorts. He was lying in a slightly open foetal position with his legs hanging over the bed. He checked for signs of breathing and a pulse, but found none and told officer that he thought the man had died. At that point, the officer noticed that there was a dark stain on the bed which looked

like blood. A nurse who was already on the houseblock, then arrived with emergency equipment and the officer left the cell with the other two prisoners.

47. One of the emergency response team had heard a radio call for a medical emergency over the radio and arrived a few moments after the nurse at 8.19am. A few seconds later, another nurse who had been treating a prisoner on the houseblock, arrived at the cell after hearing the emergency call for Hotel 99. She had the emergency bag with her, but not a defibrillator³ (which are kept on the houseblocks).
48. A custodial manager was in charge of the prison at that time, responded to the emergency call. When he arrived at the cell, he contacted the control room and requested an emergency ambulance. He estimated this to be at 8.24am, nine minutes after the man was found and several minutes after the emergency was raised.
49. An officer and the nurses placed the man on the floor. He noticed that the man's face was blue, with a black substance around his nose and mouth. There was also some discolouration of his skin and signs of rigor mortis in his arms. At 8.28am, the officer asked someone to bring a defibrillator and he began cardiopulmonary resuscitation (CPR), initially by administering chest compressions only.
50. At 8.28am, another member of the emergency response team arrived and assisted with chest compressions. The officer noticed that the man's limbs were rigid. The other officer tried to administer rescue breaths, but he was unable to insert an airway as the man's mouth was too rigid to open. Another officer continued the chest compressions, but the man remained unresponsive throughout.
51. The defibrillator arrived at 8.32am. The officer attached the defibrillator to the man's chest and it indicated that no shock should be administered as there was no heart activity. The officer repeated this at 8.34am, 8.36am and 8.38am. No heart activity was detected.
52. Paramedics arrived at the prison at 8.32am, but did not reach the man's cell until 8.40am, eight minutes later. They asked the prison staff to stop CPR and connected their own defibrillator. After carrying out checks, the paramedics pronounced the man dead at 8.56am.

Care for prisoners

53. All the prisoners on the man's houseblock were given the opportunity to speak to a member of staff, chaplaincy, a Listener (a prisoner trained by the Samaritans to support other prisoners in distress) or telephone the

³ A defibrillator is a life saving device that restarts the hearts by administering an electric shock in some cases of cardiac arrest.

Samaritans. Wing staff reviewed prisoners subject to the suicide and self-harm prevention procedures.

54. The two prisoners were initially taken to the segregation unit while the police investigated the scene. They returned to the first night centre that night and were closely monitored.

Care for staff

55. An operational manager held a debrief the day after the man's death for all the staff involved.

Family liaison

56. The prison's family liaison officer and a custodial manager visited the man's brother (who he had designated as his next of kin) at 11.50am on 22 May, to inform him of his death. After the visit, they telephoned the man's mother to break the news to her and she arranged for another son to liaise with the prison on her behalf. The man's funeral was held on 7 June and the prison contributed towards the cost, in line with Prison Service guidelines.

Post-mortem

57. Toxicology tests established that methadone and chlordiazepoxide were detected in the man's blood, within the therapeutic range. However, both are sedative and respiratory depressants that, in combination, can cause excessive drowsiness and, in extreme cases, can affect a person's ability to breathe. The post-mortem report concluded that the cause of the man's death was methadone and chlordiazepoxide toxicity and atherosclerotic stenosis (narrowing) of the coronary arteries.
58. The clinical reviewer asked the pathologist to test specifically test for the presence of quetiapine, an anti-psychotic medication used principally in the treatment of schizophrenia, which was held in-possession by one of the man's cellmates. No quetiapine was detected.

ISSUES

Clinical care

Treatment for opiate and alcohol dependency

59. The man was dependent on drugs and alcohol and had accidentally overdosed on heroin the day before he was recalled to prison. When he arrived at Belmarsh, a nurse conducted comprehensive assessments of substance misuse, using relevant diagnostic tools and found that the man was suffering mild withdrawal from both alcohol and drugs. One of the prison's GPs also noted signs of withdrawal and the man began alcohol and opiate detoxification regimes. The GP indicated that his care plan should be reviewed after five days.
60. An internal review into the man's death found that:

“On arrival at HMP Belmarsh, [the man] gave a history of alcohol and opiate addiction for a period of 15 years. His subsequent urinalysis confirmed opiates in his blood stream. He was however not exhibiting signs and symptoms of withdrawal, nevertheless he was prescribed a starting dose of 10mls of methadone on the day he arrived at HMP Belmarsh. This contradicts best practice and potentially presents a clinical risk to the patient.”
61. The findings of the internal enquiry conflict with those of the clinical reviewer and the evidence of the clinical record which show that when the man was assessed, he displayed signs of mild withdrawal and also gave a positive urine test.
62. The clinical reviewer notes that the GP had not undertaken the Royal College of General Practitioners (RCGP) level 2 clinical substance misuse training, which is a requirement of Prison Service Instruction (PSI) 45/2010, Integrated Drug Treatment System (IDTS). This training had been developed with the Prison Health unit of the Department of Health for professionals working in a secure environment and delivering a clinical misuse service, in line with the clinical guidelines on the clinical management of drug misuse 2007.
63. In a previous investigation in 2012, we raised concerns about the GP's assessment and treatment of a drug dependent prisoner. We understand that since the man's death, the GP is no longer working at the prison and has been referred to the General Medical Council in response to a recommendation made as a result of that investigation. While we have found nothing in this case to indicate that the GP's prescribing or the man's detoxification regime was inappropriate, we consider it is important that all clinicians receive appropriate training. We repeat a recommendation which the prison accepted in July 2013:

The Governor and Head of Healthcare should ensure that all GPs and nurses responsible for the clinical management of substance-dependent

prisoners undertake the Royal College of General Practitioners (RCGP) level 2 clinical substance misuse training.

Night welfare checks for prisoners undergoing detoxification

64. Newly-arrived prisoners receiving treatment for opiate dependency are required to have enhanced observation for five days, in line with National Treatment Agency guidelines. PSI 45/2010 requires prisoners with substance use problems, who are undergoing clinical stabilisation, to have clinical observations for a minimum of five days. Although the man's cellmates reported that he appeared very drowsy, which would have been a contraindication to further prescription of methadone, they did not report this to any staff and the man's clinical observations identified no concerns.
65. Ongoing monitoring includes non-medical welfare checks during the night. The healthcare assistant responsible for conducting welfare checks on the night before the man died, the healthcare assistant noted in his medical record at 10.24pm, 2.10am, 4.04am and 6.23am, the man appeared to be asleep and that he was breathing normally. The entries in the clinical record are later than the actual checks as they were made after the healthcare assistant carried out a number of other checks on the houseblock. We are satisfied about this explanation for the discrepancies in timing but ideally the clinical record should also state the actual time the check was made. The clinical reviewer indicates that the man appears to have died no later than 6.15am, so the last entry is particularly important. The healthcare assistant said he made the check at 6.00am but the entry in his medical record was made at 6.23am.
66. The clinical reviewer concluded that staff monitored the man's condition and detoxification in accordance with the prison's IDTS policies. However, we are concerned that the man's night checks were not sufficiently thorough. Healthcare assistants monitoring prisoners during a detoxification programme should satisfy themselves that the prisoner is not showing signs of opiate withdrawal, or toxicity, otherwise the check is of little value. There was no note of the man's position during any of the checks and we consider that his apparent lack of mobility should have caused concern. In other guidance we have seen, the healthcare assistant conducting welfare checks at night is expected to monitor any change or movement since the previous check (for example whether they have moved or turned over in bed). If the prisoner has not moved, consideration should be given to opening the cell and asking a nurse to make a clinical assessment. We make the following recommendation:

The Head of Healthcare should ensure that thorough night welfare checks are carried out for prisoners withdrawing from drugs and alcohol and that the time that checks are made are entered in the clinical record.

Obtaining GP records

67. Healthcare staff did not request the man's community GP medical records after his secondary health screen, which is a mandatory standard for every prisoner admitted to Belmarsh. His records would probably have listed his past medical history and current medication, which would have helped inform his treatment. We therefore make the following recommendation:

The Head of Healthcare should ensure that healthcare staff routinely request prisoners' GP records.

68. In spite of the deficiencies identified above, the clinical reviewer concludes that the clinical care the man received at Belmarsh was equivalent to that he could have expected in the community.

Emergency response

69. PSI 3/2013 (Medical Emergency Response Codes) contains mandatory instructions for governors to have in place by 28 February 2013, a protocol to provide guidance to staff about communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and ensuring there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand the PSI and their responsibilities during medical emergencies. The Governor of Belmarsh issued a Governor's Order (36/2013) to staff in February 2013, reiterating the guidance in the PSI. However, staff involved in the emergency response did not act in line with the procedures, a problem we have identified in other cases at Belmarsh.

Use of emergency codes

70. Neither of the first two officers at the cell were carrying a radio. One officer went to the wing office and asked another officer to radio an emergency call. The officers used code 99 (the prison's emergency code) to indicate a medical emergency. None of the staff used the code system stipulated in PSI 3/2013. Therefore, the other staff who responded were not immediately alerted to the nature of the emergency. In a subsequent investigation into a death at Belmarsh in November 2013, we were also concerned that officers were not carrying radios, which delayed the emergency response.

Calling an ambulance and escorting it to the cell

71. The control log shows that the staff did not request an ambulance until five minutes after the man was discovered and we have found similar delays in other cases at Belmarsh. Paragraph 5.4 of PSI 3/2013, requires that:

“When the emergency is called over the radio network an ambulance must be called immediately.”

72. The ambulance arrived at the prison at 8.32am, but did not get to the man's cell until 8.40am, a delay of eight minutes. Staff told the investigator that this was because they had to check the ambulance and unlock internal gates. This seems too long in an emergency. Although, sadly, this would have made no difference to the man, such a delay could affect the outcome in future emergencies. We are concerned that staff did not follow the guidance on what to do in a medical emergency and make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and Governor's Order 36/21013 and their responsibilities during medical emergencies, including:

- **Efficiently communicating the nature of a medical emergency;**
- **Ensuring staff take to the scene relevant emergency equipment such as a defibrillator; and**
- **Ensuring there are no delays in calling, directing or discharging ambulances.**

The resuscitation attempt

73. The evidence indicates that the man had been dead for some time when he was discovered: he was not breathing, he had no pulse and it was evident that rigor mortis had set in as his arms and jaws were stiff.
74. The European Resuscitation Council Guidelines for Resuscitation 2010 state, "Resuscitation is inappropriate and should not be provided where there is clear evidence that it will be futile." The presence of rigor mortis is given as an example of when resuscitation attempts are not appropriate.
75. The clinical reviewer found that the current policy at Belmarsh is healthcare staff should continue CPR until a prison GP or paramedics pronounce death. He comments:

"The attempted resuscitation of the man, who was clearly in rigor mortis, was inappropriate. It was also not consistent with the principle that the deceased be treated with respect and dignity."

We agree that the attempted resuscitation was unnecessary and would have been distressing for the staff involved. We understand the commendable wish to continue resuscitation until death has been formally pronounced, but staff should understand that they are not required to carry out CPR in these circumstances. We repeat the following recommendation which we previously made to Belmarsh in October 2013:

The Governor and Head of Healthcare should ensure that all staff receive guidance about the circumstances in which resuscitation is not appropriate.

Roll checks

76. Prison staff at Belmarsh conduct roll checks (count of prisoners) at 9.00pm and 6.00am each day. Local Security Instruction (LSI) 2.91 gives guidance on how the checks should be conducted, including ensuring that:

“A response is obtained from the prisoner and/or there are signs of breathing. If there is any doubt whatsoever the prisoner should be woken.”

77. An officer carried out these checks on 21/22 May, (in addition to the healthcare welfare checks by the healthcare assistant). She noticed nothing of concern, although it is likely that the man was already dead by the time of the morning check, as he was later found in the same position as he had been in at 11.30pm. This reinforces the need for officers conducting the 6.00am check, in particular, (as prisoners are usually awake for the 9.00pm check) to satisfy themselves that a prisoner is alive and take action if there is no sign that the prisoner is breathing. This issue arose in a recent investigation report about another death at Belmarsh, published in October 2013 and the prison agreed to remind staff of the requirements when conducting checks. We make the following recommendation:

The Governor should ensure that staff check on a prisoner’s well-being if there are no signs of breathing during a roll check.

Debrief

78. PSI 64/2011 gives guidance to staff about actions after a death in custody. Chapter 12 specifies a mandatory action that a debrief should be held immediately after a death in custody. A debrief was not held for to support staff on the day of the man’s death, although one was held the next day. We therefore repeat a recommendation made in 2103 to Belmarsh:

The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved in the incident are invited.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that all GPs and nurses responsible for the clinical management of substance dependent prisoners undertake the Royal College of General Practitioners (RCGP) clinical substance misuse training.
2. The Head of Healthcare should ensure that thorough night welfare checks are carried out for prisoners withdrawing from drugs and alcohol and that the time that checks are made are entered in the clinical record.
3. The Head of Healthcare should ensure that healthcare staff routinely request prisoners' GP records.
4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, and their responsibilities during medical emergencies, and that Belmarsh has a medical emergency response code protocol which:
 - Efficiently communicates the nature of a medical emergency;
 - Ensures staff take to the scene relevant emergency equipment such as a defibrillator; and
 - Ensures there are no delays in calling, directing or discharging ambulances.
5. The Governor and Head of Healthcare should ensure that all staff receive guidance about the circumstances in which resuscitation is not appropriate.
6. The Governor should ensure that staff check on a prisoner's well-being if there are no signs of breathing during a roll check.
7. The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved in the incident are invited.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that all GPs and nurses responsible for the clinical management of substance dependent prisoners undertake the Royal College of General Practitioners (RCGP) clinical substance misuse training.	Accepted	<p>All GPs currently employed at HMP Belmarsh have undertaken the Royal College of General Practitioners (RCGP) 1 and 2 qualification.</p> <p>There are currently 12 nurses, 11 of which are RCGP 1 trained. In addition, five are RCGP 2 trained. Training will be arranged in RCGP 1 and 2 for all remaining nurses. Arrangements are in place for all new nursing staff and GPs to undertake training.</p> <p>An integrated drug treatment system (IDTS) cluster lead is now in post and will ensure that relevant health staff are trained.</p>	February 2015 Head of Healthcare	
2	The Head of Healthcare should ensure that thorough night welfare checks are carried out for prisoners withdrawing from drugs and alcohol and that the time that checks are made are entered in the clinical record.	Accepted	There is now an IDTS qualified nurse on night shifts. They will ensure that thorough night welfare checks are carried out for prisoners withdrawing from drugs and alcohol and that the times that checks are made are entered in the clinical records.	Completed and ongoing Head of Healthcare	

3	<p>The Head of Healthcare should ensure that healthcare staff routinely request prisoners' GP records.</p>	Accepted	<p>Healthcare admin staff will continue to routinely request prisoners' GP records. The GP's details are taken in the first night centre and passed to admin to action. In the event that the information is not gathered in the first night centre, a letter will be promptly sent to the patient from healthcare admin requesting this information.</p>	<p>Completed and ongoing</p> <p>Head of Healthcare</p>	
4	<p>The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, and their responsibilities during medical emergencies, and that Belmarsh has a medical emergency response code protocol which:</p> <ul style="list-style-type: none"> • Efficiently communicates the nature of a medical emergency; • Ensures staff take to the scene relevant emergency equipment such as a defibrillator; and • Ensures there are no delays in calling, directing or discharging ambulances. 	Accepted	<p>A notice to this effect has been published to all staff. It includes how to raise the alarm in a medical emergency and the response code for the incident they are involved in. This code then informs medical staff of the nature of the incident they are responding to and from that they know what medical equipment they will be attending with.</p> <p>Any medical emergency raised to the control room will result in an automatic request for an ambulance. Gate staff are contacted straight away so they can be ready for its arrival and escort the ambulance to the relevant area nearest to the incident.</p>	<p>Completed</p> <p>Head of Healthcare</p>	

5	The Governor and Head of Healthcare should ensure that all staff receive guidance about the circumstances in which resuscitation is not appropriate.	Accepted	In addition to the instructions contained in Prison Service Instruction 64/2011, NOMS will be developing further guidance in conjunction with NHS England for emergency responses to include the non-resuscitation of prisoners where there are clear signs of rigor mortis. This will be issued to all prisons.	31 December 2014 NOMS Equality, Rights & Decency Group	
6	The Governor should ensure that staff check on a prisoner's well-being if there are no signs of breathing during a roll check.	Accepted	HMP Belmarsh's local security strategy gives clear instructions on staff responsibilities when carrying out roll checks. Staff are briefed by managers on this issue and it is part of the job specification for those who carry out night duties.	Completed Head of Res & Security	
7	The Governor should ensure that a debrief is held promptly after the death of a prisoner and that all staff involved in the incident are invited.	Accepted	The healthcare manager, in conjunction with the duty governor, will ensure that debriefs are held promptly after a patient's death and that all staff involved in the incident are invited.	Ongoing Head of Safer Custody	