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 Hewell in August 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 of a man from a drugs overdose at HMP Hewell in August 2014. He was 32 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received at Hewell was undertaken. The prison cooperated fully with the investigation.

The man had a history of alcohol and drug misuse. When he arrived at Hewell on 7 August, reception staff who assessed him did not see information about his risk which a nurse at court had completed. He later told staff that he had recently taken overdoses, but no one began suicide and self-harm prevention procedures. After detoxification treatment for the symptoms of drug withdrawal, he appeared to settle well. The clinical reviewer was satisfied that he received appropriate clinical treatment for drug dependency and support for his drug and alcohol problems.

The man's cellmate found him unresponsive one morning in August and it was evident that he had died sometime during the night. An officer used an emergency code, but control room staff did not call an ambulance automatically as they should have done. A post-mortem examination found that he had died from an overdose of different medications, some of which are not prescribed at Hewell, and it is unclear how he came by these drugs.

The investigation found that reception procedures at Hewell were poor and the prison needs to improve arrangements for assessing risk of suicide and self-harm for new arrivals. Although it did not affect the outcome for the man, emergency procedures need to be followed properly, a matter I have raised with Hewell previously.

While we do not know whether the man intended to overdose deliberately, it is of considerable concern that he could obtain such a significant amount and range of medication, much of which he must have obtained illicitly. The prison needs to take more effective action to tackle the problems of trading of medication and the availability of illicit drugs. There is also a need to educate prisoners about the risks involved in mixing drugs, however obtained, and for staff to be trained to monitor those at risk and be able to spot signs of drug intoxication.

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 **June 2015**

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SUMMARY

1. The man had a history of substance misuse problems and had been to prison before. On 7 August 2014, he was sentenced to eight weeks in prison. A mental health nurse at court completed a suicide and self-harm warning form to alert the prison to his risk and asked healthcare staff at the prison to complete a mental health assessment, as he had recently deliberately overdosed on heroin twice. Despite this information, no one in reception recorded any significant concerns about him or began ACCT suicide and self-harm prevention procedures. In the course of the next few days, he told a number of staff about his recent overdoses, but none of them began ACCT procedures as they considered there was no other indication that he was at risk of suicide and self-harm.

2. On the man's first night, a doctor prescribed a reducing dose of diazepam for benzodiazepine withdrawal. The next day he received medication for depression and epilepsy, in line with his community GP's prescription. On 9 August, a substance misuse worker assessed him and a doctor prescribed methadone (a heroin substitute). A nurse referred him for a mental health assessment that day.

3. Substance misuse workers checked the man for withdrawal symptoms for the next four days. They had no concerns and he appeared stable on a methadone programme. On 11 August, a mental health nurse assessed him and considered he had mild depression but no serious mental illness or signs of suicidal thoughts. He planned to review him two weeks later.

4. At a 5.00am roll count several days later, the night patrol officer had no concerns about the man. Just before 8.00am, his cellmate alerted staff when he woke up and he realised that he was not breathing and his body was cold. A prison officer radioed an emergency code, but the control room staff did not call an ambulance automatically as, contrary to national instructions, the local practice is to wait for the orderly officer to confirm that one is needed. A nurse appropriately decided not to attempt resuscitation as it was clear that he had died. Fourteen minutes after the officer called the emergency code, a manager advised the control room that they did not need to call an ambulance. The post-mortem examination found that he died from an overdose of a number of different medications.

5. The investigation found that important information about the man's risk was not passed to reception staff. Other indicators of his risk of suicide and self-harm were discounted or missed. We do not know how he got the drugs that caused his death, but we were concerned about the apparent easy availability of drugs on his houseblock. There is also a need to educate prisoners about the risks involved in mixing drugs and for staff to monitor those at risk and be able to spot signs of drug intoxication. The prison did not call an ambulance immediately the emergency code was called, something we have been critical about in a number of previous investigations into deaths at Hewell. We make four recommendations about these matters.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP Hewell about the investigation, inviting anyone with relevant information to contact him. No one responded.

7. The investigator visited Hewell on 21 August and collected copies of the man's clinical and relevant prison records. Cell bell records for 16 and 17 August were unavailable because of a computer fault. He interviewed 13 members of staff at Hewell in September and October and conducted three interviews by telephone. He listened to the telephone calls that the man made when he was at Hewell and watched CCTV footage. He informed the Governor about the initial findings of the investigation.

8. A clinical reviewer reviewed the man's clinical care at the prison on behalf of NHS England.

9. We informed HM Coroner for Worcestershire of our investigation, who provided a copy of the post-mortem report and toxicology tests. We have sent the Coroner a copy of this report.

10. One of our family liaison officers contacted the man's family to explain the investigation process. On 7 October, he and the investigator visited the man's father and his partner to discuss the investigation. They asked us to describe his time in prison and for more information about the medication he might have had access to. The family liaison officer also made contact with the man's mother, who is represented by a solicitor.

11. We provided the man's father and mother with copies of our draft report. Neither identified any factual inaccuracies. They provided some comments which our family liaison officer will address in separate correspondence.

HMP HEWELL

12. HMP Hewell comprises two separate sites – a closed local prison (formerly HMP Blakenhurst) and an open prison known as The Grange Resettlement Unit (formerly Hewell Grange). The closed site, where the man lived, takes prisoners from courts in the West Midlands, Warwickshire and Worcestershire and holds up to 1074 men in six houseblocks. Worcestershire Health and Care NHS Trust provides 24 hour health care.

Her Majesty's Inspectorate of Prisons

13. Her Majesty's Inspectorate of Prisons (HMIP) last inspected Hewell in July 2014. Inspectors were concerned about reception, first night and induction processes. Prisoners often had to wait for long periods in reception, and inspectors described the first night and induction unit as a chaotic environment where prisoners were not supported appropriately, and were not always assessed properly. Officers opened a higher number of ACCTs than at similar establishments, and the level of self-harm was also higher, although it had reduced since the previous inspection. Inspectors found that many prisoners self-harmed because their issues, such as medication or shop orders, were not being resolved.

14. Inspectors found that, although security was applied proportionately, illicit drugs and diverted prescription drugs were readily available. They had also raised this as an issue at their previous inspection.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. The IMB's most recent published annual report for the year to November 2013 noted concerns about the management of medication.

Previous deaths at Hewell

16. There have been 14 deaths at Hewell since 2012, including the man. Seven of these were the result of hanging, one of murder, four were from natural causes, one prisoner died shortly after release and the man died from an overdose.

17. During our investigations into three previous deaths in June 2013 and May and June 2014, we found there were unacceptable delays in calling an ambulance in an emergency, which was also an issue in this investigation, partly because medical emergency response codes are used incorrectly.

18. Our investigation of the death in June 2014 also found that a suicide and self-harm warning form was not seen or signed for by the reception nurse. The same issue arose in this investigation.

Assessment, Care in Custody and Teamwork (ACCT)

19. ACCT is the care planning system the Prison Service uses to support prisoners at risk of suicide or self-harm. Once a prisoner has been identified as at risk, the purpose of the ACCT process is to try to determine the level of risk, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Part of the ACCT process involves assessing immediate needs and drawing up a caremap to identify the prisoner's most urgent issues and how they will be met. Regular multi-disciplinary reviews should be held. Guidance on ACCT procedures is set out in Prison Service Instruction (PSI) 64/2011.

KEY EVENTS

20. The man had served previous prison sentences and had been released from HMP Hewell on 27 December 2013. He had a history of alcohol and drug problems (including opiates and benzodiazepines) and suffered from depression, but had not engaged with drug treatment or mental health services in the community.

21. On 7 August 2014, the man was sentenced to eight weeks in prison for theft and handling stolen goods. A nurse from Birmingham and Solihull Mental Health NHS Foundation Trust Forensic Services was working at the court that morning and assessed him, who was tearful and distressed at times. He was upset that his prison sentence would affect his benefits and accommodation and said that he had recently taken two deliberate heroin overdoses.

22. The nurse completed a notification form to ask prison healthcare staff to complete a mental health assessment and recorded that the man had already been referred to the local community mental health services by his GP, but had not attended the appointment. She noted that he said that he had suffered from post-traumatic stress disorder (PTSD), anxiety and panic attacks and had twice overdosed on heroin in recent months. She also completed a suicide and self-harm warning form to alert prison staff that he had recently deliberately taken two heroin overdoses. She handed both forms to court custody staff to go with him to the prison

23. Court custody staff completed the man's Person Escort Record (PER), a document which accompanies all prisoners when they move between police stations, courts and prisons. They wrote that he had thoughts of self-harm, was dependent on heroin, cocaine and alcohol, was epileptic and had hepatitis C, but did not tick the record to show that a suicide and self-harm warning was enclosed. The escort record, the suicide and self-harm warning form and the notification form all went with him to Hewell.

24. When the man arrived at Hewell, the member of staff who booked him in at the front desk did not sign the suicide and self-harm warning form. The records show that an officer interviewed him after he arrived. She told the investigator that she did not recall him. She did not sign the suicide and self-harm warning form to indicate that she had seen it and neither did any other member of staff. She told the investigator that she could not remember seeing the warning form, the notification form or the escort record. She said that suicide and self-harm warning forms usually went directly from the reception front desk to the reception nurse, missing out the officer conducting the reception interview, and the escort record would have been with the officer who was completing his cell sharing risk assessment. She completed a 'First Night and Induction Plan' but this does not specifically require the reception officer to ask about suicide and self-harm. However, she ticked the section of the plan titled 'Vulnerability' to indicate that she had no concerns about him.

25. A nurse then assessed the man. He told the nurse that he drank 150 units of alcohol every week and injected heroin and crack cocaine daily. His urine tested positive for opiates, cocaine, buprenorphine (a heroin substitute), cannabis and benzodiazepines (diazepam), but he showed no obvious withdrawal symptoms. He reported a history of epilepsy, depression and

anxiety and said that he was currently prescribed mirtazapine (an antidepressant) and pregabalin (for epilepsy). He gave the nurse his community GP's contact details.

26. The nurse noted on the man's clinical record that he had seen the escort record but he did not refer to the suicide and self-harm warning form or the notification form which the nurse had completed at court. His signature is not on the suicide and self-harm warning form to indicate that he had received it and he said that he did not remember seeing either the warning form or the notification form. He told the nurse that he had tried to kill himself by overdosing on heroin four or five weeks earlier when life was getting on top of him, but did not have any current suicidal thoughts. Based on his presentation, the nurse decided that he did not need to be monitored under ACCT procedures.

27. Because the man had reported substance misuse, anxiety and depression, the nurse referred him to a GP and to the Integrated Substance Misuse Service (ISMS). He did not make a mental health referral. A locum GP prescribed diazepam at a gradually decreasing dose as part of the standard benzodiazepine detoxification scheme starting that night, but did not see him in person.

28. An officer completed the man's cell sharing risk assessment and recorded that he was suitable to share with another prisoner. He noted that the man should sleep on the bottom bunk because he was epileptic. He shared a cell with another prisoner in cell B1-19 on Houseblock 4, the substance misuse treatment unit and chose to sleep on the top bunk. He was not allowed to keep any medication in his cell and had to take it in front of a nurse at the medication hatch on the houseblock each day.

29. The next day, 8 August, the mental health team manager saw the man as there was no GP available. There is no explanation in the clinical record for the GP's absence. She recorded that she could not prescribe subutex or methadone as an opiate substitute, because he had already been prescribed diazepam. He said he was experiencing withdrawal symptoms but she saw no obvious evidence of this and he declined medication for symptom relief. He asked about his prescribed medication and she confirmed this with his GP surgery and prescribed mirtazapine and pregabalin (at the maximum dose of 300mg twice daily).

30. On 9 August, a substance misuse support and advice worker assessed the man. He said that he usually drank 24 units of alcohol every day. He injected heroin and crack cocaine and also used cannabis and benzodiazepines and said that he had used drugs since he was 15. She did not see any sign of withdrawal symptoms. She advised him about the dangers of overdosing after he was released and stressed the increased risk of overdosing if he suddenly injected heroin and mixed this with alcohol and diazepam. She was satisfied that he was aware of the dangers. As a harm minimisation plan, she advised him that if he continued to use drugs after release, he should not inject them, but should smoke small amounts to build up his tolerance levels gradually.

31. The man told her that he had overdosed six times that year by injecting heroin and crack cocaine. He said that two of the overdoses had been deliberate, because of relationship problems with his partner. However, he said that he did not have any current thoughts of suicide. She told the investigator that he was very cooperative, did not seem vulnerable and she had had no serious concerns about him. She did not think that he needed ACCT monitoring. He engaged fully with her and was willing to accept further support from the substance misuse team before he was released.

32. Also on the morning of 9 August, a nurse completed a second health screen with the man and arranged a mental health assessment for him because of his recent suicide attempts. She did not see the notification form from the nurse at court, who had recommended this.

33. Later on 9 August, a locum GP saw the man and prescribed methadone (the standard opiate substitute treatment which is given as a liquid), building from 10ml each day to a maximum maintenance dose of 40ml a day. He collected his methadone from a nurse at the medication hatch each day.

34. On 10 August, a worker from the substance misuse team reviewed the man. She did not identify any withdrawal symptoms. He said that he felt much better now he had been prescribed methadone.

35. On 11 August, the man attended the education department for an induction and saw a careers officer. A substance misuse worker reviewed him and observed mild withdrawal symptoms.

36. Later that morning, a mental health nurse assessed the man after the nurse's referral. He recorded that he was polite, calm and happy to discuss his issues. He said that he had had contact with the mental health team at Hewell during previous sentences, but had been waiting four months to see a psychiatric nurse in the community.

37. The man said that he suffered from post–traumatic stress disorder (PTSD), anxiety and depression after he had witnessed his brother's murder ten years earlier. He told the nurse that he had overdosed five or six weeks previously in the community because of personal issues that had upset him at the time. He said that did not have any current suicidal thoughts. The nurse did not see any signs of low mood or mental disorder and did not think it was necessary to begin ACCT support.

38. The nurse thought that the man had mild depression because of the trauma he had experienced and planned to review him two weeks later. He decided to keep him on his caseload until he was released to provide ongoing support for his drug and alcohol misuse problems, but did not think he needed to see a psychiatrist or any additional medication. He considered that the man showed no signs of a mental illness and did not seem either deeply depressed or particularly anxious.

39. On 12 August, a substance misuse support and advice worker reviewed the man and did not observe any signs of withdrawal. He mentioned his recent overdoses in the community and she said that because of this, she checked to see if he was on an ACCT and whether he still felt the same as he had

done at the time he overdosed. He said that he was all right and she decided that she did not need to open an ACCT. He said that the reduced dose of diazepam was inadequate but she was satisfied that it was in line with the detoxification protocol and he showed no apparent signs of heightened anxiety, which would warrant an increase.

40. The man asked another prisoner if he would share a cell with him. He said that he had received a letter informing him that his partner had been raped. (There is no evidence that he ever told staff about this.) He said he was upset about the news and wanted a cellmate he could talk to, as he did not really get on with his current cellmate. The prisoner agreed and they asked staff for permission to share. The prisoner moved in with him on 15 August.

41. The prisoner told the investigator that the man had seemed really positive while they shared a cell. He had talked about going to live with his mother in Doncaster to start a new life.

42. On 15 August, the man began a job in the prison workshops and an officer noted in his prison record that he had worked well. He spoke to his mother and did not suggest that anything was wrong. The prisoner recalled that the man had seemed happy after he spoke to his mother. On 16 August, he telephoned his partner and again gave no indication that he was upset.

43. The prisoner said that the man told him that he had taken a double dose of pregabalin, as he had obtained another prisoner's dose. He said that the man was very drowsy on Friday 15 and Saturday 16 August and could hardly keep his eyes open. His head kept dipping down because he was so sleepy, and he spilt a bowl of soup but was unaware he had done so. He thought that the staff would have noticed how drowsy he was. There is no evidence that anybody did and none of the staff recorded any concerns. From Friday afternoon, both men spent most of the time locked in their cell with only limited staff interaction.

44. The prisoner said that the man was asleep in the top bunk by 6.00pm on 16 August. He said that he himself fell asleep at about 8.00pm. He said that he had woken up twice in the night. The first time, he felt something dripping on him. He assumed the man had wet himself and moved his position in the bed. He did not wake him as he did not want to embarrass him. He said he woke again sometime during the night because of a noise, which he thought was the man using the toilet.

45. The night patrol officer on Houseblock 4 checked prisoners at about 10.00pm on Saturday night and again at about 5.00am. Essentially these are security checks to ensure that prisoners are present in their cells. He had no concerns about the man and did not have any interaction with him that night.

46. Shortly before 8.00am, the prisoner woke up and filled the kettle. He said he nudged the man to ask him if he wanted a cup of tea and he felt cold. He put his hand on the back of his face and realised that he was not breathing. He was lying face down, was cold, stiff, and had vomited. He had bled from his mouth and nose onto the floor below. He pressed the cell emergency bell, kicked the cell door and shouted for help.

47. An officer went to the cell at 7.58am. (We have based our timings on CCTV footage, which was two minutes ahead of the control room log.) The prisoner was very distressed and said that the man was not breathing. The officer saw congealed blood in his nose and mouth and a pool of blood on the floor below. He immediately radioed a code blue emergency. (Code blue is used for life-threatening situations, such as when a prisoner is not breathing or unconscious, and should result in control room staff calling an ambulance immediately.)

48. Two officers were working in the control room. One officer relayed the code blue across the radio network and asked the orderly officer (in charge of the operation of the prison) and the emergency response nurse to go to the cell. The staff did not automatically call an ambulance as local and national instructions require. She said that they waited for the orderly officer to decide whether an ambulance was needed, which was the usual practice at Hewell.

49. At 7.59am, a minute and a half after the officer had arrived at the cell, more staff joined him. He then unlocked the cell door. (He said he had waited because he was unsure of the risk at that stage.) The prisoner immediately left the cell and an officer looked after him. The other officers went in and concluded that the man had died. They radioed a nurse, the emergency response nurse, to confirm that he needed to attend the scene.

50. A nurse had been in the healthcare centre when he heard the code blue. He collected an emergency response bag and defibrillator from Houseblock 4's treatment room and reached the cell at 8.02am. He checked the man and had no doubt that he was dead. He therefore decided that it would be inappropriate and futile to attempt resuscitation.

51. CCTV shows that an officer locked the cell at 8.03am after the nurse left. Nobody waited outside the cell. An entry in the control room log shows that, fourteen minutes after the officer first radioed, an officer in the control room was told that an ambulance was not needed and to stand down the code blue alert. The control room staff did not call an ambulance. Funeral directors removed the body at lunchtime.

52. An officer and an assistant orderly officer looked after the prisoner, who was very upset. They took him to the houseblock office and gave him a cigarette. They then moved him to a crisis suite with Listeners (prisoners trained by the Samaritans to support other prisoners in distress) before finding him a new shared cell. A mental health nurse reviewed him the next day. Staff reviewed prisoners subject to ACCT monitoring in case they had been affected by the news of the man's death. At 9.45am, managers debriefed the staff involved in the emergency response to check their welfare and offer them support.

53. The man had not named his next of kin but had given an address. At 9.15am, the deputy governor and a prison chaplain went to this address, but nobody there knew him. They then found the man's father's telephone number in his prison records and called him, but there was no answer, so they left a message asking him to contact them. They then tried his partner's telephone number and she answered. They visited her at 12.45pm to break the news. She told them that the man's mother lived in Doncaster, so they arranged for

South Yorkshire police to visit her and inform her of his death. His father telephoned the prison a little later on and spoke to the deputy governor.

54. The police found a six page letter in the cell which the man had been writing to his partner. In the letter, he said that he was not finding prison easy, said that he was concerned about her and reflected on their relationship problems. He did not express any suicidal thoughts.

55. The funeral was held on 29 August. The prison contributed towards the cost of the funeral in line with Prison Service guidance.

56. The post-mortem examination and toxicology tests found that the man had died from an overdose of a number of different medications. Methadone was present at a level higher than he was prescribed and which could be toxic or fatal. He was prescribed diazepam, pregabalin and mirtazapine, and all of these medications were present, the latter at a higher level than expected. Quetiapine, tramadol, olanzapine and zopliclone were also present. These drugs are prescribed at Hewell but he was not prescribed them. Prisoners are not usually allowed them in their possession and they are mainly administered under supervision. We do not know how, or from where, he obtained these drugs.

ISSUES

The risk of suicide and self-harm

57. During the reception process, neither the officer at the front desk, an officer nor a nurse signed the self-harm warning form that a nurse had completed at court, as they should have done if they had seen it. Neither the officer nor the nurse could remember seeing the warning form or the accompanying notification form. There is no evidence that anybody in reception saw the suicide and self-harm warning form and we are very concerned that no one at Hewell acted on this important information about the man's risk when he arrived.

58. Prison Service Instruction (PSI) 74/2011, about early days in custody, sets out mandatory reception procedures and requires reception staff to examine the 'Person Escort Record (PER) form that must accompany each new prisoner, *and any other available documentation* (our emphasis) *,*…to identify any immediate needs and risks already recorded'. As there is no evidence that anyone read the suicide and self harm warning form from the court or the court nurse's notification form, highlighting the man's risks, we do not consider that the prison complied with this instruction.

59. When interviewed, neither an officer nor the nurse were particularly surprised that they had not seen these forms and they described a reception process which did not ensure that they received risk information about prisoners. Our recent investigation of the self-inflicted death of another man at Hewell in June 2014, two months before this man died, also found that the reception nurse did not see or sign for a suicide and self-harm warning form about the man who died.

60. In a PPO thematic report, published in April 2014, about risk factors in self-inflicted deaths, we identified that too often assessments of risk place insufficient weight on known risk factors and too much on staff perceptions of the prisoner's behaviour and demeanour. We consider that, even without the information sent by a nurse on the warning form, staff should have begun ACCT suicide and self-harm monitoring procedures because the man had several risk factors for suicide and self-harm.

61. The man alerted staff to some of these risk factors during different assessments. He told a nurse, the ISMS worker who completed his substance misuse assessment on 9 August, the nurse who completed his mental health assessment and another ISMS worker who saw him on 12 August that he had deliberately overdosed in the recent past. He also had a history of alcohol and drug misuse and told a mental health nurse about his depression, anxiety and post traumatic stress disorder. None of these staff thought that ACCT suicide and self-harm procedures were necessary or assessed his risk holistically. They all relied on his assurances that he did not have any suicidal thoughts, despite his relatively recent suicide attempts and other risk factors.

62. We do not know whether the man intended to deliberately overdose when he died. However, when he arrived at Hewell, he had several risk factors which should have alerted staff that he was at risk of suicide and self-harm. It is a

serious concern that processes designed to highlight risk for newly arrived prisoners were not followed and staff responsible for assessing prisoners did not have access to information about his risks. We make the following recommendation:

The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception, induction and substance misuse staff:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.**
- **Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.**

Mental health

63. A nurse did not make a mental health referral in reception and said that he did not see the nurse's written recommendation for a mental health assessment. He told the investigator that he did not identify any mental health concerns that warranted a referral. However, as we have noted, the man told the nurse that he had recently deliberately overdosed. We are surprised that he did not make a mental health referral based on this information alone.

64. After a referral at the second health screen from a nurse, the mental health nurse conducted a mental health assessment on 11 August and had no serious concerns. The clinical reviewer considered that the amount of interaction with mental health and substance misuse staff the man had at Hewell probably exceeded that he could have expected to receive in the community. Although he should have been referred to the mental health team in reception, the clinical reviewer found that the standard of mental health care that he subsequently received was satisfactory.

Substance misuse

65. The man reported diazepam misuse in the community and a doctor prescribed diazepam for detoxification in a reducing dose from his first night in prison. He later complained that the dose was not enough. The clinical reviewer was satisfied that healthcare staff followed the detoxification protocol and he did not show significant withdrawal symptoms or heightened anxiety. The clinical reviewer noted that the prescription of diazepam helped to treat any possible withdrawal symptoms from alcohol.

66. Because the man also misused opiates, a doctor prescribed methadone in a gradually increasing dose from 9 August. For the next four days, substance misuse workers monitored him for any concerns about his withdrawal but he showed only mild withdrawal symptoms. By 12 August, he had stabilised on a daily dose of methadone and the substance misuse team agreed with him that he would be maintained at that level until his release because he was serving

only a short sentence. The clinical reviewer was satisfied that he received appropriate treatment for his alcohol and drug misuse.

Illicitly-obtained medication

67. The man died from an overdose of a number of different medications. It is extremely concerning that he was able to obtain such a large quantity of different drugs. We do not know how he got these drugs. Some were prescribed to him and some to other prisoners. He was not allowed to keep any of his medication in his possession. He had to take his prescriptions at the hatch each day in front of a nurse. (Diazepam, methadone and pregabalin are never given in possession to any prisoners at Hewell.) His cellmate was not prescribed any of the medication which he had taken.

68. Several members of healthcare and substance misuse staff told the investigator that they were not surprised that the man had managed to obtain illicit medication. They said that, since a recent national Prison Service efficiency programme, known as 'benchmarking', the likelihood of illicit medication circulating on houseblocks had increased. They said that a reduction in the number of prison officers meant that there were no longer officers to supervise hatches for routine medication administration, although they are supposed to be present to oversee dispensing of controlled opiate-based drugs such as tramadol and methadone.

69. The purpose of prison officers monitoring the medication queue is to ensure good order, stop prisoners concealing medication instead of taking it and ensure the safety of nurses. However, the nurses we spoke to described the medication queue at Hewell as a 'free for all' with little oversight or management. At an inspection shortly before the man died, inspectors were also very critical about the lack of supervision of medication queues. The Head of Healthcare said that the lack of prison officer supervision had resulted in increased aggression towards nurses. A lack of visibility either side of the medication hatch also meant that it was very difficult for the nurses to see what the prisoners did with their medication after it had been dispensed.

70. It seems likely that some of the medication the man obtained came from diverted prescribed medication. However, it is also apparent that he either smuggled other drugs into the prison or obtained them from other prisoners. At their July 2014 inspection, inspectors noted that the prison had no drug supply reduction strategy. We make the following recommendation:

The Governor should ensure that there is an effective supply reduction strategy to reduce the availability of illicit drugs and diverted medication, including prison officers closely supervising medicines administration.

Mixed drug toxicity

71. The man was prescribed pregabalin, a medication that substance misuse doctors acknowledge is associated with abuse and addiction, particularly among opiate-dependent patients. It can amplify the effects of opiate drugs and has diazepam-type effects. We are satisfied that he was appropriately prescribed pregabalin for epilepsy after checks with his community GP, but his cellmate said that he had taken additional pregabalin, which he had obtained from another prisoner. He took a number of drugs in addition to methadone and pregabalin and, because of the large amounts of additional illicit medication he took, we do not know how much the interaction between pregabalin and methadone was a factor in his death.

72. Nevertheless, in the light of the man's prescriptions, we consider that the prison should have considered whether he was at increased risk of toxicity and needed to be observed and monitored by healthcare staff in addition to regular medication dispensation times. We made a recommendation to the prison about the need for additional monitoring in such cases in an investigation report issued in 2012. His cellmate said that the man was very drowsy on the Friday and Saturday before his death. While we appreciate that opportunities for staff interaction with prisoners at weekends are limited, it is important that staff who work in specialist substance misuse units understand and are alert for the signs of drug intoxification.

73. We note that a substance misuse worker advised the man about the dangers of using drugs when he was released from prison. We also consider it would be a useful precaution to educate and warn prisoners at risk, of the dangers of using a combination of drugs in prison, particularly in addition to methadone. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that healthcare staff monitor prisoners at high risk of toxicity, that all staff who work with prisoners in the substance misuse unit are alert to the symptoms of drug intoxication and that prisoners are warned about the potentially fatal consequences of using sedating drugs with methadone.

Emergency response

74. Prison Service Instruction (PSI) 03/2013 requires that prisons have a medical emergency response code protocol to ensure that an ambulance is called automatically in a life-threatening situation. This guidance explicitly states that all prison staff must be made aware of and understand the protocol and their responsibilities during medical emergencies. Hewell's local policy about medical emergency response codes and calling an ambulance, published on 18 June 2013, is in line with PSI 03/2013. It requires staff to call a code blue immediately on their radio if they discover a prisoner not breathing. Control room staff should then automatically request an ambulance. Although an officer called a code blue emergency, the control room staff did not call an ambulance and none of the managers or other staff queried this.

75. An officer, who was working in the control room that morning, told the investigator that, despite the local policy, at the time of the man's death, the actual practice was to wait for the orderly officer to attend the scene first. The

control room staff would not call an ambulance until the orderly officer instructed them to do so. This is the practice that staff followed on the day of the incident and she believed that she would have been criticised if she had called an ambulance before the orderly officer gave permission.

76. We are concerned that the failure to call an ambulance automatically was not an isolated incident. This is a matter we have identified in other investigations. We were told that emergency codes were often misused at Hewell and routinely used to call healthcare staff quickly rather than for genuine life-threatening emergencies. PSI 03/2013 makes it clear that it should not be a requirement for healthcare staff or a manager to attend before calling an ambulance. It says that it is better to request an ambulance that can be cancelled if healthcare staff assess that one is not required. The prison needs to ensure that staff use emergency codes appropriately and follow the national and local instructions.

77. While the failure to call an ambulance did not affect the outcome for the man, in other emergencies any delay could be crucial. Previous recommendations and their own local policy do not appear to have changed staff practice at Hewell, and it is unacceptable that prison managers do not appear to have conveyed the importance of this emergency procedure to prison staff. We make the following recommendation:

The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.

RECOMMENDATIONS

1. The Governor should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception, induction and substance misuse staff:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs.
    - Open an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent.

2. The Governor should ensure that there is an effective supply reduction strategy to reduce the availability of illicit drugs and diverted medication, including prison officers closely supervising medicines administration.

3. The Governor and Head of Healthcare should ensure that healthcare staff monitor prisoners at high risk of toxicity, that all staff who work with prisoners in the substance misuse unit are alert to the symptoms of drug intoxication and that prisoners are warned about the potentially fatal consequences of using sedating drugs with methadone.

4. The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.

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 should produce clear local guidance about procedures for identifying prisoners at risk of self-harm and for managing and supporting them. In particular, this should ensure that reception, induction and substance misuse staff: • Have a clear understanding of responsibilities and the need to share all relevant information about risk. • Consider and record all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, including information from suicide and self-harm warning forms and PERs. • Open an ACCT whenever a prisoner has recently self-harmed or	Accepted	The local policy will be updated to ensure that all relevant information is considered. This will be emphasised appropriately so all aspects of bullet points listed within recommendation one are covered, namely, staff having an understanding of responsibilities and the need to share all relevant information about risk; considering and recording all the known risk factors of a newly-arrived prisoner when determining their risk of suicide or self-harm, which includes information from suicide and self-harm warning forms and prisoner escort records (PERs), and opening an ACCT whenever a prisoner has recently self-harmed or expressed suicidal intent. We will also update our reception procedures to ensure that we have a comprehensive handover by the escort contractor in order to minimise the risk of key information not being actioned therefore ensuring that ACCT are opened in line with national guidelines	Target date for completion: 31 March 2015 Head of Residential Safety	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	expressed suicidal intent.				
2	The Governor should ensure that there is an effective supply reduction strategy to reduce the availability of illicit drugs and diverted medication, including prison officers closely supervising medicines administration	Accepted as a joint recommendation with Head of Healthcare	We are working with healthcare service providers to reduce supply of illicit substance and prescribed medication. Responsibility for supervising medicine administration is undertaken jointly by medical staff supplying the medication and the discipline staff managing the residential unit. A new post has been created as Head of Drug Strategy the manager in post monitors and oversees all aspects of drug services both clinical and illicit substances. He chairs a monthly meeting which includes multi disciplinary input. Key areas are monitored and strategies are put into place to respond to highlighted areas of concern. There are now procedures in place to monitor usage, numbers in receipt of prescribed drugs to ensure treatment remains appropriate and justified. Monitoring also occurs by the Head of Drug Strategy regarding oversight of treatment times and its management.	Completed Head of Drug Strategy and Head of Healthcare	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			Medicine administration is supervised by staff at all times. Nationally, NOMS will initiate a working group after April 2015, which will be made up of key stakeholders tasked with working up guidance for healthcare professionals plus a PSI for custody staff related to supervising medicine queues. We hope to have this signed off by the Autumn. Meds queue supervision is also covered in the National Partnership Agreement as part of the better management of medicines objective. The Partnership Agreement includes a workstream on the supervision of medicine queues as a response to the Gilvary review into unclassified deaths.		
3	The Governor and Head of Healthcare should ensure that healthcare staff monitor prisoners at high risk of toxicity, that all staff who work with prisoners in the substance misuse unit are alert to the symptoms of drug intoxication and that prisoners are warned about the	Accepted	The Head of Drug Strategy and the Head of Healthcare will formulate a local policy that identifies and monitors prisoners that are high risk of toxicity and issues them with guidance regarding the potential fatal consequences. This will be formally issued to all relevant staff as appropriate and in line with medical in confidence considerations. This will	Target date for completion: 30 April 2015 Head of Integrated Substances	

Action Plan

No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
	potentially fatal consequences of using sedating drugs with methadone.		be monitored monthly by the relevant managers as above. All clients who engage with the Integrated Substance Misuse Services are offered health promotion information.	Misuse Services/ Drug Strategy	
4	The Governor should make active efforts to ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including the appropriate use of emergency codes to ensure there is no delay in calling an ambulance.	Accepted	The Governor will formally write to all Custodial Managers and control room staff so that they are all fully aware of the instruction within PSI 03/2013.	Target date for completion: 14 April 2015 Head of Operations	