



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man in May 2014 at
HMP Elmley**

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, a prisoner at HMP Elmley, in May 2014. He was 38 years old. He died from methadone toxicity. I offer my condolences to his family and friends.

A clinical review of the care the man received at Elmley was undertaken. Elmley co-operated fully with the investigation. I regret that the need to wait for the results of toxicology reports led to a delay in issuing this report.

The man was a long-term user of illicit drugs. When he arrived at Elmley on 6 May, he started a drug detoxification programme for benzodiazepines and continued to be prescribed methadone, which he had been taking in the community. A prison GP subsequently diagnosed a chest infection, for which he prescribed antibiotics and steroids. In the community, he had been prescribed pregabalin for pain relief, which he also continued to receive in prison, at an appropriate therapeutic level.

On 24 May, the man told another prisoner that he had stolen a packet of pregabalin (pain relief and anticonvulsant medication) from a wing treatment room. Pregabalin is often misused in prison and its inappropriate use with methadone can make the effects of methadone more powerful. Other prisoners said that it was apparent that he had taken a lot of additional drugs on the afternoon of the next day, including quetiapine and pregabalin. In the morning, a prisoner found him apparently unconscious and alerted an officer. Staff began to attempt to resuscitate him, although it was apparent from the presence of rigor mortis that this would be futile. A prison doctor pronounced him dead shortly afterwards.

I do not consider that prison staff could reasonably have foreseen or prevented the man's death, but the investigation identified a need for improvements in the secure storage of medication and in unlock and emergency response procedures. While it would not have affected the outcome for him, I am concerned that the officer who unlocked his cell did not ensure that he got a response from him, which meant that another prisoner found him dead. As I have found in several previous investigations into deaths at Elmley, the emergency response was poor and I hope that procedural improvements that I observed on a recent visit to the prison will ensure that this does not recur.

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. On 6 May 2014, the man was charged with burglary and remanded to HMP Elmley.
2. Healthcare staff did not identify any immediate physical health problems when the man arrived at Elmley, but he had longstanding substance misuse problems. He began a detoxification programme for benzodiazepines and a doctor prescribed methadone (an opiate substitute), as he had been on a methadone maintenance programme in the community. Healthcare staff assessed him several times subsequently, after he reported chest problems and a doctor prescribed steroids and antibiotics. On 24 May, he had an ECG test and told friends that he had stolen a packet of pregabalin from the treatment room. (An internal prison investigation after his death found no evidence of this.)
3. One morning a few days later an officer unlocked the man's cell and mistakenly believed that he had responded at the time. At approximately 9.08am, another prisoner went to the cell and told an officer that he thought he was dead. The officer shouted for help but did not radio an emergency medical code. Control room staff did not call an ambulance until a manager requested one, over ten minutes later. Staff tried to resuscitate him, although it was apparent he had died. At 9.44am, a prison doctor confirmed that he had died. A post-mortem examination found that he had died from methadone poisoning. Two packages of an unknown substance were hidden on his body.
4. The investigation found that staff at Elmley could not have anticipated or prevented the man's death. The clinical reviewer was satisfied that he received appropriate treatment for his substance misuse and it appears that he took illicit drugs in addition. We consider that the officer who unlocked his cell on the morning of his death should have assured himself of his wellbeing. The emergency response was poor and it took too long to call an ambulance. While this did not affect the outcome for him, in other cases such a delay could be crucial. This is a matter we have raised with the prison a number of times before, but we understand that the prison has now taken action to address this. Staff tried to resuscitate him when there were clear signs that he had died and we consider they need better guidance about this. We make three recommendations.

THE INVESTIGATION PROCESS

5. On 27 May 2014, one of our investigators issued notices to staff and prisoners at Elmley, informing them of the investigation and inviting anyone with relevant information to contact her. No one responded.
6. The investigator visited Elmley on 9 June, and obtained copies of the man's prison and medical records.
7. NHS England commissioned a clinical reviewer to review the man's care at Elmley.
8. The investigator informed HM Coroner for Mid Kent and Medway of the investigation. At first it was thought that the man had died from natural causes, but there was some uncertainty. We therefore suspended the investigation until we received the cause of death. Toxicology reports, received at the end of September 2014, indicated that he had died from methadone toxicity. Another investigator then began the investigation and confirmed that the original notices about the investigation were still displayed. We regret the consequent delay. He interviewed seven members of staff and two prisoners at Elmley in November 2014.
9. One of the Ombudsman's family liaison officers contacted the man's family about the investigation and explained the reasons why it had been suspended. He invited them to raise relevant issues they wanted the investigation to consider. His family had no specific issues for the investigation to consider.
10. The family received a copy of the draft report. The solicitor representing the family wrote to us pointing out some factual inaccuracies and omissions. The report has been amended accordingly. They also raised a number of questions that do not impact on the factual accuracy of this report. We have provided clarification by way of separate correspondence to the solicitor.

HMP ELMLEY

11. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves the courts in Kent and holds more than 1,200 men in five wings, with a mixture of single, double and triple cells.
12. NHS England, Kent and Medway commission Integrated Care 24 Ltd (IC24) to provide primary healthcare services at Elmley. The prison's healthcare centre includes a 29-bed inpatient unit.

HM Inspectorate of Prisons

13. The most recent inspection of Elmley was in July 2014. Inspectors found that although the facilities and environment for the administration of controlled drugs had improved, the timing of opiate substitution medication administration was inconsistent because there were frequent shortages of officers to supervise. This meant that prisoners did not know if they would get opiate substitution medication in the morning or afternoon. Inspectors also noted that inexperienced officers often supervised medication and were not always alert to potential trading in medication. The integrated drug treatment unit (Houseblock 3) did not have a consistent officer team, which led to a lack of continuity in addressing the complex needs of substance users.
14. In their survey, inspectors found that 40% of prisoners, more than in comparator prisons, said that it was easy to get drugs at Elmley. Inspectors found that mandatory drug testing arrangements were flawed and did not detect the use of new psychoactive substances such as 'Spice', which were common.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In its most recent annual report for the year to 31 October 2014, the IMB was concerned about a shortage of staff at the prison and the effect on all areas of prison life. The IMB was concerned about the high numbers of prisoners prescribed tradable medication such as pregabalin and the challenges faced by prisoners misusing prescribed medications and illicit substances. Security searches had resulted in substantial drug finds, which the IMB thought might be indicative of a larger problem.

Previous deaths at Elmley

16. From January 2014 to May 2014, there were four deaths at Elmley, including that of the man. We have made recommendations about delays in the emergency response in each of the previous cases.

KEY EVENTS

17. On 6 May 2014, the man was remanded to HMP Elmley, charged with burglary. He had been in prison before and had been released from a previous sentence at Elmley in January 2014.
18. The clinical service manager of the substance misuse team assessed the man when he arrived. She recorded that he had been taking methadone (an opiate substitute, 88mls), mirtazapine (an antidepressant, 15mg) and pregabalin (an anticonvulsant drug that is sometimes used as a painkiller, 150mg). He said that he had also been taking benzodiazepines on top of his prescribed medication. He tested positive for cannabis, cocaine and benzodiazepines.
19. The clinical service manager noted that he had swollen ankles and was wheezy and said that he had had chest pain for months. Although he had tested negative for opiates, she observed several signs of opiate withdrawal, including sweating and flushing and extraneous movement of his arms and legs. She prescribed methadone (20mls) until his community prescription could be confirmed.
20. The clinical service manager recorded that the man was low in mood and had been crying in court. He told her that he had taken an overdose of tablets in the past, but did not have any current thoughts of suicide or self-harm. She said that he appeared quite dejected and upset to be back in prison, but did not indicate any intention of taking his own life or harming himself.
21. A nurse screened the man for general health issues as part of the reception process. The nurse recorded that he had been in prison before, including at Elmley, and looked unkempt. The man said that he had recently gained a lot of weight, had a wheezy chest and chest pains, and had been prescribed pregabalin for back pain. He asked the nurse to refer him to the mental health team as he was depressed, although he said he had no thoughts of harming himself. The nurse referred him to the doctor and the mental health team.
22. A prison GP examined the man and noted that he complained of back pain, for which he received pregabalin, and also took mirtazapine and lansoprazole. The GP re-prescribed his medication and told him that if he had any ongoing concerns, he should ask to see the doctor.
23. The next day, 7 May, a nurse from the substance misuse team reviewed the man and noted that he was sweating and flushing and reported having chills. His pupils appeared larger than normal, he had some stomach cramps and a slight tremor. All of these were indicators of drug withdrawal and she referred him to the drug treatment team. Nurses confirmed his methadone prescription in the community and, from 7 May, he received 88ml of methadone daily.
24. On 9 May, following a nurse's referral and a discussion at a multidisciplinary meeting, a mental health nurse assessed the man. He recorded that the man had taken crack cocaine three weeks earlier because he had been worried about his trial, but said he had not used heroin for five years. Although he had

not expected to come to prison, his mood appeared bright and he said he had no thoughts of suicide or self-harm. They agreed that he did not need further input from the mental health in-reach team, but the mental health nurse advised him to refer himself to in-reach again after he had finished his detoxification programme.

25. On 11 May, the man told a nurse he was short of breath and had had several recent chest infections. On 12 May, a GP examined him and diagnosed a chest infection for which he prescribed antibiotics and steroid medication. Later that day, another GP reviewed his drug treatment. He told her that he thought he might have had a fit the previous evening as he had wet himself and bitten his tongue. He was in a single cell so no one else had witnessed him having a fit. He did not have a history of epilepsy, but said he had been taking large amounts of benzodiazepine in the community. He asked a GP to increase his dose of diazepam but she offered him carbamazepine (an anticonvulsant and mood stabiliser) instead, which he did not want. The GP recorded that he should continue his methadone treatment at the same dose and she would discuss a diazepam detoxification with the substance misuse team.
26. On 14 May, a GP assessed the man, after he became short of breath. He said that he had not been taking the steroids as prescribed and that he had been wheezing and coughing for the previous nine months. The GP recorded that he had no history of asthma and he smoked. He diagnosed possible Chronic Obstructive Pulmonary Disease (COPD) or asthma and prescribed him an inhaler to use when he became short of breath. The GP wanted to admit him to the prison's inpatients unit for monitoring overnight, but he declined, even though the doctor told him an attack during the night could be life threatening. The GP referred him for a chest X-ray and booked him to attend an asthma clinic and to see a GP again, on 22 May.
27. On 23 May, a healthcare assistant checked with the man's wing as he had not attended his appointments the day before. Wing staff said that all prisoners with appointments had been unlocked and given the opportunity to attend the healthcare centre, but some had chosen not to. There was no record of him attending and no reason given.
28. The same day, the man told the clinical service manager that he was worried about his health as he had a sore throat. He also said that, when he bent or lay down and ate, he was sometimes sick. He said that he had diarrhoea, had been incontinent when asleep and had coughed up blood several times. He had gone to the healthcare centre the day before, but had left because there was an incident while he was there. He had not known that he had scheduled appointments at the asthma clinic and with the doctor. She referred him for an electrocardiogram test (ECG) which is commonly used to detect abnormal heart rhythms and to investigate the cause of chest pains.
29. On Saturday 24 May, a nurse carried out the ECG in a consultation room just off the residential wing. After the man died, another prisoner said that the man had told him that he had stolen a full box of pregabalin from the room. The nurse told the investigator that he was certain that he did not have the

opportunity as he had never been in the room on his own during the ECG test and never out of his sight.

30. Two friends of the man at Elmley told the investigator that when he came back to the wing after the ECG test, he told them he had stolen some pregabalin. Prisoner A said that the man had given him five tablets. Both prisoners had known him a long time and said that his physical health appeared to have deteriorated. They said that he had previously always been keen to look after himself but had put on a lot of weight and was not so active. The man had told them that in the community he had been drinking heavily, misusing prescribed medication and taking illegal drugs. They said that he often asked other prisoners for their medication.
31. The clinical service manager said that she saw the man just before lunchtime on Sunday 25 May, after he had come back from the gym. He told her that he had not yet seen a GP. She said she requested a GP appointment for the next day, using the SystmOne electronic medical record, for the GP to review him and his ECG results.
32. The clinical service manager told the investigator that, when she spoke to the man on 25 May, she did not think that he was under the influence of drugs and he appeared upbeat. She advised him that using the gym before a GP had checked his chest pain was not advisable. He said that he needed to do something to lose weight.
33. Prisoner B said that he had spoken to the man that Sunday afternoon, and he thought that he had taken a large amount of medication. Prisoner A said that the man had told him that he had obtained additional pregabalin and some quetiapine (an antipsychotic drug which can affect blood pressure, breathing and heart rate). Prisoner B said that he had warned him about the effect of taking more medication, in particular with his methadone dose.
34. Prisoners collected their meals between 4.30pm and 5.00pm before officers locked them back in their cells for the night. An officer recalled seeing the man as he collected his meal, and said that he had joked with him about his weight. He said that he knew him from his previous time at Elmley and always had a 'bit of banter' with him. He said that he did not notice anything unusual about him that afternoon and did not think that he was under the influence of drugs.
35. Prisoner A told the investigator that he had been concerned about the man and had pressed his cell bell at around 1.15am on 26 May to ask the night patrol officer to check on him. He claimed that no one answered the cell bell and he had gone to sleep at around 4.15am. The cell bell records for the night of 25 May and morning on 26 May do not indicate that the prisoner used his cell bell at any time that night. The officer who was working on the wing that night told the investigator that there were many cell call bells that evening and night, but none were from Prisoner A or the man. The records confirm this.

36. The next morning a wing manager asked Officer A to help unlock prisoners on A spur, where the man lived. The officer said that he started unlocking at the man's cell, cell 12 on the first floor, (known as the "twos").
37. Officer A said in a statement that, when he unlocked the cell, at about 8.30am, he had said 'Good morning' and he heard someone say 'Good morning' in reply, as he moved to the next cell. He told the investigator that when he unlocked cells he usually looked in to make sure somebody was there. He said that he expected the man to be in his cell and thought he had responded, but told the investigator that it was possible that he had heard another prisoner say good morning to him, as he walked past. He did not fully open the door, or see him, but said he would have done if he had thought that he had not responded.
38. Prisoner B said that after his cell was unlocked, he went to the man's cell to have a cup of coffee with him. As he walked down the landing, he said that he passed Officer A, who said good morning to him. He could not recall whether he had replied, but thought it likely he had.
39. Prisoner B said that when he went into the cell the man was lying on the bed with the top half of his body hanging over the side. He said that, although this was a strange position, he did not think it was unusual for someone like him, who had taken so many drugs the day before. He said that he spoke to him to wake him as he was concerned that if staff saw him like that, they would know he had taken drugs and he would get into trouble.
40. At first Prisoner A thought that the man had chocolate on his face and he noticed that his stomach was bloated. He still thought he was under the influence of drugs and tried to lift him fully back onto the bed, but found his whole body moved and was rigid. He then realised that it was blood and not chocolate around his mouth. At this point, at approximately 9.08am, Officer B arrived to begin routine cell fabric checks. The prisoner told him that he thought the man was dead. (Prisoner A told the investigator that he had also been in the cell that morning, but this does not fit with Prisoner B's or the accounts of staff. Prisoner B thought that Prisoner A might have been just outside the cell at the time.)
41. Officer B said that he immediately shouted to Officer C that he had a code blue. (A code blue is a medical emergency code used in prisons to indicate a life-threatening situation such as when a prisoner is unconscious or not breathing. It should alert healthcare staff to attend with emergency equipment and result in the control room calling an ambulance immediately.) He said that he also gestured to the wing office and shouted that he had a code blue to alert the wing manager, the Supervising Officer (SO). He said that he did not radio a code blue, as his first thought was to alert officers who were nearby.
42. Prisoners began congregating outside the man's cell and both officers prevented them from going in. The SO radioed a code blue and also pressed an emergency alarm bell, just outside the man's cell. He told the other prisoners to go back to their cells. Officer C said that he and Officer B then went in, followed quickly by a nurse. They began cardiopulmonary

resuscitation and the nurse radioed and asked for other healthcare staff to bring emergency equipment.

43. The control room log shows the following timings:
- 9.19am – Code Blue HB3 (Houseblock Three.)
 - 9.22am – Call for emergency equipment HB3
 - 9.28am – General Alarm HB3
 - 9.29am – Request for GP from segregation to attend HB3
 - 9.31am – From Governor ambulance and paramedic called for
 - 9.43am – Ambulance in establishment
 - 9.44am – Man pronounced dead
44. The duty governor that day said that he was in the administration corridor a couple of minutes walk away from Houseblock 3 when he responded to a general alarm. He said that he that he had not heard a code blue and, when he arrived on A spur, he saw some officers restraining a prisoner on the floor. He thought that had been the reason for the alarm. (The prisoner had become confrontational when officers had asked him to leave the area and go back to his cell.) However, one of the officers directed him to the man's cell, where he said a number of staff were treating him, and he tried to establish what had happened. None of the officers was clear that an ambulance had been called. He said that healthcare staff arrived shortly after and he stood back.
45. The duty governor said that he went back to the cell to ask whether anyone had called an ambulance and a nurse told him that this had been done. A few minutes later, he checked with the control room when the ambulance was expected but the control room staff told him that no one had asked them to call an ambulance. He then instructed them to call an ambulance immediately. This was at 9.31am; 12 minutes after the control room had recorded the code blue call.
46. At around 9.29am, a prison GP responded to a call to attend Houseblock Three. The GP said that, when he arrived, staff were administering cardiopulmonary resuscitation and the emergency medical equipment was there. Nurses had attached a defibrillator to the man, which had indicated no heart activity. The nurses had completed around eight cycles of cardiopulmonary resuscitation and continued after the GP arrived. After 20-25 minutes there had been no change. The GP then asked the nurses to stop and confirmed death. Paramedics arrived at 9.43am. The GP later recorded in the medical record that, when he arrived at the cell, the nurse had told him that the man's skin was mottled and his body was stiff.

Actions after the man's death

47. The duty governor debriefed the staff involved in the emergency response later that afternoon and the staff care team offered support. However, several members of staff told us that they felt that the prison could have offered better support, rather than staff having to seek support themselves. Members of the prison chaplaincy team offered support to prisoners living in Houseblock Three.

Prisoner B spent some time with a friend of his for support and said he knew that other support was available if he needed it.

48. A chaplain acted as the prison's family liaison officer. The man had nominated a family friend as his next of kin and the chaplain and another prison manager went to see her that afternoon and informed her that the man had died. His friend gave them some contact details for the man's family, and the chaplain spoke to the man's sister later that day and his mother the next day to offer condolences and support. In line with national guidance, the prison contributed to the funeral costs.
49. After a prisoner claimed that the man had stolen some pregabalin on 24 May, the healthcare team investigated and carried out an audit of medication. They found that a quantity of pregabalin was unaccounted for, but attributed this to another prisoner who admitted the theft when challenged. The investigation found no evidence that the man had stolen medication.

Post-mortem

50. A post-mortem examination found that the man had died from methadone toxicity. The level of pregabalin in his blood was within the range expected in line with his prescription. There was no mention of quetiapine in the toxicology report. During the post-mortem examination, the pathologist found two cling film packages, one under his foreskin and one in his rectum. Neither the post-mortem nor the toxicology report identified what was in these packages.

ISSUES

Medical care

51. The clinical reviewer concluded that the overall standard of clinical care that the man received at Elmley was equivalent to that which he might have expected to receive in the community.
52. In relation to his substance misuse treatment, the clinical reviewer was satisfied that the man received appropriate treatment. He noted that nurses assessed him appropriately when he arrived, recognised that he was withdrawing from opiates and benzodiazepines and monitored him as necessary. He arrived with information about his prescriptions, but a nurse practitioner initially prescribed 20 ml methadone, until the level of his dose could be confirmed with his community pharmacy. The clinical reviewer noted that this was good practice and in line with prescribing guidelines for drug treatment. Once his methadone maintenance dose was verified, there was an appropriate plan to increase it to 88ml. However, the clinical reviewer noted that it was not clear from his medical record exactly when this was done.
53. The clinical reviewer noted that prison GPs were treating the man for a chest infection. He considered that the decision to offer a chest X-ray was appropriate, as the man had a history of coughing up blood. He noted that GPs had prescribed steroid treatment, which would have been appropriate if he had asthma or chronic obstructive pulmonary disease. However, some basic observations and tests such as peak expiratory flow rate had not been recorded and it was not apparent that he had ever been fully diagnosed with either of these conditions. This meant that, if anything, he might have been over-treated. However, the clinical reviewer did not consider that this was related to the cause of his death.
54. The clinical reviewer examined the ECG trace taken on 24 May. Although a nurse had retrospectively noted that he thought the ECG results were abnormal, he considered that the results were within normal limits.
55. The pathologist gave the cause of death as methadone toxicity. The clinical reviewer considered that it was likely that the man died of methadone toxicity associated with other sedating medication, which he had obtained both on prescription and illicitly. He was satisfied that the man received appropriate doses of methadone and pregabalin in line with what he had been prescribed in the community. However, pregabalin is a medication that substance misuse doctors acknowledge is associated with abuse and addiction, particularly among opiate-dependent patients. In December 2014, seven months after the man's death, the NHS issued new advice for prescribers on the risk of misuse of pregabalin and gabapentin, of which all prescribers in the prison need to be aware. It draws particular attention to the risks for patients in secure settings where there is a propensity to misuse and divert drugs, which places them at greater risk. As the guidance was issued after his death, we do not make a formal recommendation about this.

56. There is no clear evidence that the man stole pregabalin on 24 May as other prisoners claimed. However, there is some evidence that he had a propensity to use illicitly obtained medication and drugs, in addition to the medication he was prescribed. The pathologist found two concealed packages during the post-mortem, which suggested that he had access to other drugs. Although there is no firm evidence that he took the box of pregabalin from the treatment room, we know that at least one other prisoner was able to obtain such medication. The clinical reviewer noted that pregabalin and other medication, such as quetiapine, are drugs with high potential for abuse, especially in prisons. He considered that all healthcare staff administering medication need to be aware of the risk of leaving it unattended and that medication should never be left in open cupboards or on work surfaces when prisoners are in treatment rooms. We make the following recommendation.

The Head of Healthcare should ensure that all healthcare staff are aware of the risks of leaving medication unattended and that it is properly secured at all times.

Unlocking cells

57. Officer A, who unlocked the man's cell on 26 May, told the investigator that he always said good morning to prisoners as he went along the landing and that he looked into cells before opening the doors. When he opened the man's cell he thought that he had replied to his greeting, so had no concerns. He did not see him. As the man had rigor mortis when he was found, it is apparent that he could not have replied and the officer must therefore have been mistaken.
58. Following an investigation into a death at Elmley in 2011, we recommended that, when staff unlock cells, they should satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention. The Prison Service accepted the recommendation, and said that staff had been reminded that they should undertake visual checks to establish the safety of prisoners when they unlocked them.
59. While we understand that Officer A genuinely believed that the man had responded to his greeting, the circumstances underline the need for officers to be fully satisfied about the welfare of prisoners when they unlock them. Although it would not have made a difference to the outcome for him, it could be crucial in other cases. It would have avoided another prisoner having to find him dead and would have helped staff to manage the emergency more smoothly, without having to deal with a number of prisoners on the wing at the same time. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, officers take active steps to satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

Emergency response

60. When Officer B discovered the man unresponsive, he alerted nearby staff by shouting to them but did not radio a code blue, although he was carrying a radio. This was at about 9.08am. The SO did not alert the control room to a code blue until 9.19am. Control room staff did not call an ambulance until 9.31am when the duty governor called to ask when they expected the ambulance to arrive.
61. Prison Service Instruction (PSI) 03/2013 requires all prisons to have an emergency code system to effectively communicate the nature of an emergency and ensure there is no delay in calling an ambulance. The instruction states that when a medical emergency is called, the control room should call an ambulance immediately. In this case, there was a delay originally in calling a code blue and then subsequently in calling an ambulance. We have made recommendations about poor emergency response procedures in seven previous investigations at Elmley since 2012 and there appeared to be an unwillingness to comply with the national instruction.
62. In our most recent investigation report into a death at Elmley in August 2014, we directed our recommendation to the Deputy Director of Custody for Kent and Sussex. We are now satisfied that action has been taken and therefore do not make another recommendation, but observe the need for the Governor to continue to ensure that all staff understand and follow the required emergency procedures.
63. It is apparent from all the evidence that the man had been dead for some time when he was discovered. Prisoner B said that his body was rigid and the GP noted that the nurse had told him that the skin was mottled and his body was stiff. Both of these are recognised signs of death and we consider that staff should not have felt obliged to attempt resuscitation.
64. European Resuscitation Council Guidelines 2010 state that “Resuscitation is inappropriate and should not be provided when there is clear evidence that it will be futile ...” The guidelines define examples of futility as including the presence of rigor mortis. More recently, the British Medical Association (BMA), the Royal College of Nursing (RCN) and the Resuscitation Council (UK) issued guidance in October 2014, about making appropriate decisions about resuscitation. The guidance says that every decision should be made on the basis of a careful assessment of each individual’s situation. These decisions should never be dictated by ‘blanket’ policies. Attempting resuscitation when someone is clearly dead is distressing for staff and undignified for the deceased. We make the following recommendation:

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

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all healthcare staff are aware of the risks of leaving medication unattended and that it is properly secured at all times.
2. The Governor should ensure that, when a cell door is unlocked, officers take active steps to satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.
3. The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate.

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that all healthcare staff are aware of the risks of leaving medication unattended and that it is properly secured at all times.	Accepted	<p>The Head of Healthcare will reinforce this message through line management briefings.</p> <p>In addition, notices have been sent to remind staff of this requirement, and following a “root cause analysis”, this matter was raised in an internal "lessons learned" report which was shared with all healthcare staff.</p>	<p>Head of Healthcare</p> <p>30 April 2015</p> <p>Complete</p>	
2	The Governor should ensure that, when a cell door is unlocked, officers take active steps to satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	Clear guidelines are being prepared for staff to set out the requirement that staff unlocking a cell door should satisfy themselves that there is no immediate threat/danger, and no obvious signs that a prisoner is in distress or may require assistance.	<p>Safer Custody Manager</p> <p>30 April 2015</p>	
3	The Governor and Head of Healthcare should ensure that staff are given clear guidance about the circumstances in which resuscitation is not appropriate.	Accepted	<p>In October 2014, the British Medical Association, RCN and Resuscitation Council issued new guidance on making decisions about attempting cardiopulmonary resuscitation (CPR).</p> <p>NOMS Equality, Rights and Decency Group met with NHS England colleagues in February 2015 to discuss the guidance. Work is ongoing to agree the content of a note to issue to prison staff,</p>	<p>NOMS and Head of Healthcare</p> <p>30 June 2015</p>	

Action Plan					
No	Recommendation	Accepted/Not Accepted	Response	Target date for completion and function responsible	Progress (to be updated after 6 months)
			<p>later this year.</p> <p>A new local policy has been published that gives clinical staff clear guidance on when not to attempt resuscitation.</p>	Complete	