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 in May 2013 at hospital while in the custody of HMP Dorchester

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 Dorchester. He died of brain hypoxia (lack of oxygen to the brain) due to fentanyl poisoning, at hospital in May 2013. He was 27 years old. I offer my condolences to his family and friends.

A clinical review of the care the man received in prison was conducted.

The man had a history of drug misuse. When he arrived at the prison he began a detoxification and stabilisation programme for which he was prescribed methadone. In addition, he continued to use other drugs illicitly which he was able to acquire in the prison. On the morning of 23 May, he was found collapsed in his cell. There were indications that he had been injecting drugs. He was taken to hospital but, sadly, never recovered.

It is unclear how the man obtained fentanyl, an opiate analgesic which is similar to but more potent than morphine. It is therefore of concern that the investigation found that security intelligence was not always shared or acted upon at Dorchester and better communication was required between clinical and security staff to help reduce the availability of illicit drugs. When he was found collapsed, staff swiftly administered cardiopulmonary resuscitation. Although an ambulance was not called automatically, this was done shortly afterwards and paramedics were able to re-establish a pulse and breathing. It took over an hour for the prison to inform his family of his emergency admission to hospital but they were able to be with him before his death. In making recommendations in this report, I recognise that HMP Dorchester is scheduled for closure soon but there are lessons for all prisons, particularly about the need to be vigilant about illicit drug use among prisoners with known severe substance use problems.

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 **April 2014**

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SUMMARY

1. The man was recalled to prison on 6 February 2013 from a previous sentence and charged with a further offence of burglary.

2. During an initial health screen, the man reported that he had been injecting fentanyl (a powerful opioid painkiller) and took methadone illicitly, as well as a number of other drugs. He was epileptic and had a history of deep vein thrombosis (blood clots). He said a local community addiction centre had prescribed him subutex to treat his opioid addiction.

3. The man began a drug detoxification and stabilisation programme under the supervision of healthcare staff and drug support workers at the prison. He did not seem to comply well with the programme and asked to extend the detoxification period. Healthcare staff assessed him as having mild withdrawal symptoms, but he said he found the withdrawal process very difficult. He admitted to healthcare staff that he was continuing to obtain illicit drugs, which he said were freely available on the wing. (This information was not always shared with security staff.)

4. On the morning of 23 May, a prisoner told an officer that the man had collapsed. The officer found him lying unconscious on the floor of his cell and bleeding from his mouth. He did not appear to be breathing and the officer could not find a pulse.

5. The officer called an emergency code, but an ambulance was not called automatically. Another officer who arrived about two minutes later asked for an ambulance to be called. Officers and healthcare staff started cardiopulmonary resuscitation (CPR) until paramedics arrived. The paramedics found a pulse and he began breathing. He was taken to hospital, where he remained in intensive care. Sadly, he did not recover, and he died in hospital several days later.

6. The investigation found that the man was able to obtain illicit drugs in the prison with apparent ease and that there is a need for better reporting and management of security intelligence about drugs. Despite his history of significant substance misuse, the prison did not contact the local community addiction team to check his recent treatment. Emergency response protocols need to ensure that an ambulance is called automatically in an emergency and prisoner's families should be notified immediately when a prisoner is seriously ill.

THE INVESTIGATION PROCESS

7. The investigator issued notices informing staff and prisoners at HMP Dorchester of the investigation and asking anyone with relevant information to contact her. No one responded.

8. The investigator visited the prison on 5 June 2013 and obtained copies of the man's relevant prison and medical records. She met the Governor and other prison managers and spoke to the prison's family liaison officer.

9. NHS England (Wessex) appointed a clinical reviewer to review the medical care that the man received at the prison. The investigator and clinical reviewer jointly interviewed staff at Dorchester on 1 July.

10. HM Coroner for Dorset was informed of the investigation. A copy of this report will be sent to the Coroner.

11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation. His family did not have any specific issues for the investigation to consider. They received a copy of the draft report, but did not raise any additional questions or make any comments.

HMP DORCHESTER

12. HMP Dorchester is a small local prison serving the courts of Dorset and the surrounding area and holds more than 290 male prisoners. In September 2013, the Ministry of Justice announced that the prison would close by March 2014. At the time of writing, the prison was expected to close by the end of December 2013.

13. Healthcare services are provided by NHS Dorset Hospital University Foundation Trust (DHUFT). GP services are available daily and there is out of hours provision.

Her Majesty's Inspectorate of Prisons

14. The most recent inspection of HMP Dorchester was an unannounced short follow up inspection in July 2012 of a full inspection in 2009. At the 2009 inspection, the Inspectorate reported that security and drug treatment services linked well and there were comprehensive supply reduction services. At the 2012 inspection, the Inspectorate found that prisoners identified as opiate dependent when they arrived at prison were provided with treatment starting on their first night. A consultant psychiatrist was available when required and the out of hours service was used appropriately.

Independent Monitoring Board

15. Each prison has an Independent Monitoring Board (IMB) made up of unpaid volunteers from the local community who oversee all aspects of prison life to help ensure that prisoners are treated fairly and decently. In its most recently published report, the IMB reported that the prison's drug strategy had reduced the number of illegal drugs being brought into the prison. The report commented on the great pressures on detoxification services, increased by a lack of administrative support.

Previous deaths at Dorchester

16. There was one death at Dorchester in the year before the man died. There were no direct similarities of circumstances.

KEY EVENTS

February 2013

17. The man was recalled to prison on 6 February 2013 after being released on licence from a previous sentence and charged with a further offence of burglary. He arrived at Dorchester prison at approximately 7.00pm that evening.

18. At the man's initial health screen, a nurse noted that he wanted to see a doctor because of concerns about his physical health, epilepsy and his drug use. He had a number of abscesses on his legs from injecting fentanyl intravenously. He said he took valium and nitrazepam (both benzodiazepines) when he could and that a community addiction centre had prescribed him subutex to treat his opiate addiction. He said that he took methadone when he could, although he was not prescribed it. The nurse arranged for him to see a doctor and a prison substance misuse worker the next day.

19. The next day, 7 February, a substance misuse worker assessed the man, who told him that he had been prescribed subutex in the community, but had lost the script so no longer took it. He said he used up to 150ml of methadone daily. (The usual maximum prescribed dose for opiate dependency is 120ml.) He said he was also taking 50mg nitrazepam daily and injected 50mg of fentanyl daily. Both of these are high doses and he was not prescribed either of the drugs. He also said he took illicit diazepam every day. The drugs worker referred him to be assessed by the CARATs team (Counselling, Assessment, Referral, Advice and Throughcare services which provides interventions and services for prisoners with drug and alcohol problems.) The drugs worker planned to monitor and assess him for the next five days and completed an opiate screening test which suggested that he had mild withdrawal.

20. A doctor assessed the man an hour later. They discussed his history of deep vein thrombosis (DVT) and his drug use. He said that he had started taking fentanyl, methadone, heroin and benzodiazapines after his father had died recently.

21. The doctor examined the man's lower legs and calves and found them bruised and swollen around the injection sites. He also had skin abscesses. The doctor planned for him to be prescribed heparin, an anti-coagulant, and wear stockings for DVT. The doctor recorded that his pulse was 113 beats per minute (the normal range is between 50-100). The doctor began him on a methadone stabilising and monitoring programme (60 ml in the morning and 30 ml in the evening), a diazepam detoxification (5 ml oral solution of diazepam on a reducing dose) and continued his epilim prescription. The doctor also prescribed him flucloxacillin, an antibiotic, and sodium valproate which is used to treat epilepsy.

22. An hour later the man saw a nurse. She recorded that he had previously taken an antidepressant, sispin, for mental health problems and that he had been referred to a psychiatrist when he was a teenager. She recorded that his pulse rate had reduced slightly to 111 beats per minute.

23. The prison contacted the man's GP surgery, but they had not seen him since September 2012. There is no record that the prison contacted the local community addiction team to confirm his treatment for substance misuse or his subutex prescription.

24. That afternoon, the substance misuse worker monitored the man's opiate withdrawal, and confirmed that he was still going through mild withdrawal.

25. The next morning, 8 February, the man reported abdominal cramps and sweating and asked for his methadone prescription to be increased. A nurse referred him to the lead nurse manager for substance misuse for an assessment. He told the nurse he was not sleeping well and, when he did, he had nightmares. He seemed very tearful when he spoke about his father's death and asked to engage in all drug group work including the SPARK course, a therapy group for substance users. The nurse prescribed an increase in methadone to begin the next day. He reported no further withdrawal symptoms that day.

26. Over the next few days, the man continued to be monitored twice daily. On 10 February, a doctor increased his methadone dose by 10ml. On 13 February, a nurse noted that apart from a rapid heart beat, he showed no other signs of withdrawal. She referred him to the SPARK course and noted that he should remain on the current methadone dose.

27. A nurse submitted a security information report on 13 February after several prisoners, including the man, told her that there was a lot of subutex available on the wing. The security information report was passed to the security department, which confirmed that there was a lot of intelligence about a supply of subutex on the wing. As a result, two prisoners were moved. Wing officers were told about the security intelligence and the Governor asked them to monitor the situation.

28. On 18 February, a nurse noted during a general observation that the man appeared "very spaced" with small, fixed pupils. He suspected that he might have taken something other than his prescribed medication and planned to monitor this. There is no evidence that the nurse spoke to officers about this, or submitted a security information report.

29. On 19 February, the man told a nurse that he was finding it difficult to cope with a reduction in diazepam and she agreed to slow down his benzodiazepine detoxification. She decided that he was not ready to begin a methadone detoxification at that stage, as he was unsettled by ongoing court appearances. She said she would review this once he had completed the diazepam detoxification.

30. A nurse referred the man for a mental health review, because he said he felt anxious about abuse in his childhood.

March 2013

31. A mental health nurse assessed the man on 1 March. He told her that some of his problems stemmed from his father's recent sudden death. He

said that he had been in a coma after he had been released from a previous prison sentence and that he had been diagnosed with post-traumatic stress disorder (PTSD) because of this and a previous sexual assault. She referred him to the mental health in-reach team for a further assessment.

32. On 14 March, the nurse contacted the in-reach team as they had still not assessed the man. A psychiatrist saw him the next day. He said the man displayed clear evidence of PTSD complicated by opiate and benzodiapine withdrawal. The psychiatrist prescribed him 50 mg amitriptyline, an antidepressant, to be increased over three weeks, after which he needed to be reviewed.

33. A nurse noted on 22 March that the man was coping well with the detoxification programme and that he had requested to move from methadone to subutex in a few days with a view to detoxification. He started the subutex detoxification on 25 March.

34. A CARATs worker submitted a security information report on 25 March, because the man had told him that needles were being used and shared by other prisoners on the wing. Officers were asked to record this information in the wing observation book and the Governor asked for officers to be made aware of the situation.

April 2013

35. On 2 April, the man did not attend an appointment with a nurse, but no reason is recorded. He saw the psychiatrist again on 5 April who noted some improvement and he said that his flashbacks were less frequent. The psychiatrist planned to review him in three weeks and increased the dose of amitriptyline to 200mg.

36. On 12 April, a nurse prescribed the man lofexidine to alleviate his withdrawal symptoms as he was finding it difficult to complete the subutex detoxification. He then finished detoxifying on 16 April and was prescribed lofexidine until 25 April, to manage his withdrawal.

37. On 26 April, the psychiatrist reported that the man was unhappy with the amitripyline medication as he said it made him feel aggressive and irritable. He planned to gradually reduce and withdraw the amitripyline and begin another antidepressant, paroxetine, instead. A doctor spoke to him that day about his family history of DVT and he told her he should be on warfarin. She agreed to contact his community doctor again for more information. Two days later, a nurse noted in his medical record that the doctor had prescribed warfarin.

May 2013

38. The man told a nurse on 9 May that he was finding it difficult to stay off drugs as they were freely available on the wing. He asked to see another nurse again to discuss a further course of lofexidine. There is no evidence that this information was shared with officers on the wing, or that a security information report was submitted. He told the nurse he had attended the

SPARK course and other groups and had received information on relapse prevention.

39. The man saw a psychologist on 16 May. He said that that the charges against him had been dropped and that he should be released when his licence expired on 1 July. They spoke about his history of drug use, his PTSD and his plans on release. He said he intended to try to get into residential rehabilitation or intensive day therapy to help him stay away from drugs. He planned to live with his grandmother. The psychiatrist suggested some relaxation techniques which the man had requested.

40. On 20 May, the man asked to see a nurse. He told her he had started to snort 1mg of subutex a day from other prisoners on the wings. He said he had returned to illicit use about five days after completing the detoxification programme and wanted the nurse to consider prescribing him naltrexone. (Naltexone blocks the euphoria effect of opiates and helps people committed to remaining drug free.) She telephoned another nurse for advice about prescribing him naltrexone, because he had hepatitis. The nurse was unavailable but her clinic said she would call her back. The nurse subsequently spoke to another nurse and said she would assess him at her clinic in the prison the next day. There is no evidence that the first nurse spoke to officers about his misuse of subutex, or that a security information report was submitted.

41. The man's urine sample that day was negative for all drugs. He admitted to a nurse the next day that he had bought a clean urine specimen and she informed another nurse. Again there is no evidence that this was discussed with officers, or that information was passed to the security department.

23 May

42. On the morning of 23 May, officers saw the man on the wing. He did not raise any concerns. He spoke to other prisoners during the association period when prisoners are able to mix with each other. He then went back to his cell at 10.00am. At approximately 10.30am, a prisoner saw him lying on the floor of his cell. He did not go in but told Officer A that he had collapsed. The officer was very near the cell and went straight in. He found him slumped face down on the floor, between the toilet and the wall with his trousers and boxer shorts around his ankles.

43. The officer could not get a response from the man, whose eyes were open and there was blood coming from his mouth. The officer turned his head and saw blood pooling underneath. He appeared to be jammed between the toilet, the heating pipe running along the bottom of the cell and the bed. The officer managed to pull him round so he was lying on his back. He then checked his airway, breathing and circulation but could not find a pulse or signs of breathing.

44. Two prisoners joined the officer in the cell and asked whether they should press the general alarm bell. Instead, he radioed a code red emergency (used for a medical emergency involving blood) at 10.32am. Officer B quickly arrived at the cell and could not find a pulse either. The man's feet were wedged under the heating pipe and between them they freed him and moved him to the middle of the cell.

45. Officer C heard the emergency call over the radio and arrived next. He immediately started chest compressions. Officer A gave him his face shield from his belt and he started rescue breaths. At 10.34am, Officer C requested an ambulance and the control room telephoned for one.

46. A nurse was nearby and got to the cell at 10.36am and assessed that it was a code blue emergency because the man was not breathing. She immediately radioed the healthcare centre and asked them to bring appropriate equipment to the cell. She then took over rescue breaths, while Officer C continued with chest compressions.

47. A doctor arrived at the cell with a defibrillator which she applied to the man. It advised that no shock was required and resuscitation continued. The doctor oversaw the emergency until paramedics arrived at 10.43am. The paramedics managed to get him breathing and established a pulse. They took him to hospital at 11.35am. No restraints were used.

48. Officer A found a syringe and a needle, a small plastic cup of water and a freshly cut lemon. (Lemon juice is often used to dissolve heroin for injection.) A prisoner suggested that he might have taken heroin.

49. The man arrived at hospital at 11.44am. He was provisionally diagnosed with a cardiac arrest and an opiate overdose. Two hours later he was moved to the hospital's intensive care unit where he remained on a ventilator.

50. The prison's family liaison officer telephoned the man's grandmother, his nominated next of kin, at 1.00pm to explain what had happened and that he had been taken to hospital. She than contacted his mother at the request of his grandmother. The prison arranged for his family to visit him in hospital.

51. After he was admitted to hospital, the man's condition remained unchanged. The duty governor visited the hospital at 12.30pm to see how him was and to check security arrangements. He remained unrestrained and still in the intensive care unit. At 8.00pm, the duty governor was told that a number of family members were at his bedside and that he was not expected to recover.

52. The next day the man's condition remained the same. A nurse from the hospital telephoned the duty governor and said that a brain scan showed that he had no brain activity and a decision had been made to withdraw his medication and review him.

53. A hospital doctor telephoned the duty governor at 9.55am for information about the circumstances in which the man was found to aid a report to the Coroner. She said that the police had been informed at the time of the incident and his cell had been sealed. The police reviewed CCTV footage of the incident and were satisfied that there were no suspicious circumstances.

54. At 9.40am the man was pronounced brain dead in the intensive care unit at the hospital. His family were with him at the time.

Post-mortem report

55. The post-mortem report concluded that the man died from hypoxic brain injury resulting from a fatal overdose of fentanyl administered intravenously.

Security Intelligence after the man's death

56. After the man died a number of prisoners gave names and information about who had supplied drugs in the prison and where. One prisoner said that he knew the man was injecting fentanyl but there was no specific intelligence about trading fentanyl or where it came from.

ISSUES

Detoxification

57. The clinical reviewer notes that the man was stabilised on methadone and on a very gradual detoxification from diazepam. Once his detoxification from diazepam was complete, he started an opiate detoxification, and was prescribed appropriate medication to support him through his withdrawal. A member of healthcare staff observed him twice a day when dispensing medication. The clinical reviewer notes that this level of monitoring was in line with expected practice.

58. The clinical reviewer notes that during his drug reduction programme, the man tried to be very prescriptive about the treatment he thought he should receive. Prison healthcare staff used formal withdrawal tools to assess his withdrawal symptoms, and prescribed medication accordingly. They considered that he engaged well with his detoxification and was enthusiastic about tackling his substance misuse. The clinical reviewer is satisfied that his substance misuse issues were managed appropriately.

Community records

59. When he arrived at Dorchester, the man gave his GP's details and said that he had been prescribed subutex by a community addiction team, although he had lost his prescription. The prison contacted his GP, but he had not visited the practice for months. There is no evidence that the prison contacted the community addiction team to check whether he was being treated for substance misuse and what had been prescribed and when.

60. PSO 3050 requires that efforts should be made to retrieve any information required from the prisoner's GP or other relevant service he or she has recently been in contact with to inform his clinical care in custody. It is particularly concerning that the prison failed to confirm the man's treatment for substance misuse, given his self-reported serious misuse of drugs in the community. We make the following recommendation:

    The Head of Healthcare should ensure that all relevant community records including from drugs services are routinely requested to ensure continuity of healthcare.

Security intelligence

61. The post-mortem report indicated that the man's death was caused by an overdose of fentanyl. The clinical reviewer reports that injecting an opioid such as fentanyl results in a rapid rise in blood levels and it was likely that he had injected himself only minutes before he collapsed.

62. This investigation was unable to establish how the man obtained the fentanyl. Only one prisoner at Dorchester was prescribed fentanyl patches at that time, for pain associated with cancer. The prisoner was on a different wing, had his patches changed by healthcare staff every three days and he was closely monitored. The visits records for him show that his last visit was on 7 May, more than two weeks before he died.

63. The empty syringe found in the man's cell tested negatively for all substances and we cannot be sure of how or where he administered the fentanyl. There was security intelligence that needles were widely available on the wing in March 2013 and staff were apparently monitoring the situation. There was no other intelligence reported between March and May about needle use and there is no evidence that any action was taken to tackle this issue, aside from monitoring. The security department told the investigator that cell searches are conducted in response to security intelligence. As they had received no security intelligence about his substance misuse, his cell was not searched while he was at the prison.

64. The man told nurses on three occasions that he was misusing drugs on the wing. He also said that he had bought a clean urine sample to be tested. There is no evidence that this information was passed to officers or to the security department as a security information report. Had this been done, it is possible that he and his cell would have been the subject of a targeted search.

65. The security department told the investigator that the submission of security information reports is at a person's discretion. However, they would expect any threats of safety or security to be reported. Healthcare staff said they do not necessarily submit a security information report when a prisoner says they have been misusing drugs, but will if it is an issue of security or a risk to others.

66. The clinical reviewer comments that healthcare staff could have alerted officers and the security department to general substance misuse on the wing, without breaching the man's medical confidentiality.

67. We consider that it was healthcare staff's responsibility to report this intelligence to officers to manage the ongoing security threat posed by prisoners obtaining illicit drugs on the wing. However, there were times when healthcare staff did complete security information reports yet little appears to have been done as a result. When security intelligence was reported, more action should have been taken to investigate and tackle the issue, other than simply asking officers to monitor the situation. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that security reporting systems are used effectively to communicate, investigate and challenge substance misuse.

Delay in calling an ambulance

68. Prison Service Instruction (PSI) 03/2013 (medical emergency response codes) which came into effect from 28 February 2013, requires that prisons have Medical Emergency Response Code protocols which ensure that an ambulance is called automatically in a life-threatening medical emergency as soon as an emergency code is called. Even a short delay in such circumstances can have a significant impact on a person's chance of survival.

69. In response to the PSI, the Governor of Dorchester issued a Medical Emergency Response Code, on 24 April 2013, and circulated it as a Governor's Order. It clearly requires that an ambulance must be called by the control room immediately a code red or blue is called. In spite of the revised code, no one called an ambulance until Officer C got to the cell and radioed for one to be called. While there was a delay of only two minutes before an officer asked for an ambulance to be called, and the officers were commendably quick in beginning cardiopulmonary resuscitation, it is important in emergency incidents that the requirements of PSI 3/2013 are followed. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensure that an ambulance is called automatically as soon as an emergency code is called.

Informing the man's family

70. Prison Rule 22, about the notification of illness or death, states:

> "If a prisoner dies, becomes seriously ill, sustains any severe injury or is removed to hospital on account of mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed."

71. There was no difficulty obtaining the man's grandmother's telephone number, yet it still took over an hour to tell her that her grandson had been taken to hospital in a critical condition. As he was found unconscious and required resuscitation, the prison should have contacted his family immediately. The delay of an hour and a quarter could have meant the difference between his family seeing him alive or dead. We make the following recommendation:

The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that community all relevant records are routinely requested to ensure continuity of healthcare.

2. The Governor should ensure that security reporting systems are used effectively to communicate, investigate and challenge substance misuse.

3. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensure that an ambulance is called automatically as soon as an emergency code is called.

4. The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that community all relevant records are routinely requested to ensure continuity of healthcare.	Accepted	However, we are unable to follow up this recommendation because HMP Dorchester has now closed		
2	The Governor should ensure that security reporting systems are used effectively to communicate, investigate and challenge substance misuse.	Accepted	A review of the reporting of intelligence to the security department from the Healthcare will be undertaken and where necessary training afforded to healthcare colleagues in the completing of information reports.	HMP Dorchester has now closed. This recommendation will not be taken forward.	
3	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and ensure	Accepted	All staff will be reminded of the Governors notice to staff that was issued on the 24th April 2013 in respect of the calling of emergency vehicles.	HMP Dorchester has now closed. This recommendation will not be taken forward.	

	that an ambulance is called automatically as soon as an emergency code is called.			
4	The Governor should ensure that a prisoner's next of kin is informed at the earliest opportunity following an emergency admission to hospital.	Accepted	This will be reviewed and considered in contingency planning.	HMP Dorchester has now closed. This recommendation will not be taken forward.