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 Exeter in January 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, who was found hanged in his cell at HMP Exeter in January 2014. He was 42 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at Exeter was conducted. The prison cooperated fully with our enquiries.

The man arrived at Exeter on 30 December after being sentenced to 42 days imprisonment for theft. He died during his second night at the prison. He had a long history of substance use problems and had previously served a number of short sentences at Exeter. He had been on a methadone maintenance programme in the community and was also dependent on heroin and alcohol. His escort record from court noted that he suffered from depression and anxiety but that he had denied any thoughts of self-harm. On his first night, a prison doctor prescribed medication to alleviate opiate and alcohol withdrawal symptoms. In line with the usual protocol, the doctor prescribed only a low dose of methadone until his community prescription could be confirmed and referred him to the prison's substance misuse service for further management.

The next day, New Year's Eve, other prisoners said that the man appeared to be suffering from withdrawal symptoms but two nurses who assessed him during the day did not identify any significant physical symptoms. None of the staff or prisoners had any concerns that he intended to harm himself. That night, his cell mate raised the alarm when he found that he had hanged himself. Sadly, he could not be resuscitated and was pronounced dead shortly afterwards.

The clinical reviewer considers that the standard of healthcare the man received at Exeter was adequate and comparable to that he could have expected in the community, but identified some areas for improvement. In particular, he found there were weaknesses in the night welfare checks for prisoners on a methadone maintenance programme and the arrangements were not compliant with the requirements set out by the National Treatment Agency for Substance Misuse.

I consider that it would have been difficult for staff at the prison to have predicted the man's actions, but I am concerned that his risk of suicide and self-harm, taking into account all of his risk factors, was not fully considered when he arrived at the prison. Although it would not have affected the outcome for him, the emergency response was poor and did not follow local or national guidelines. A number of the findings of the investigation reflect those found after a death at Exeter in November 2012 and the Governor needs to ensure that these recommendations are fully implemented.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **October 2014**

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SUMMARY

1. On Saturday 28 December 2013, the man was arrested for theft and detained at a police station. On Monday, 30 December, he was convicted and sentenced to 42 days imprisonment and was taken to HMP Exeter later that day. He had a history of drug misuse and had been in custody at Exeter several times before. He had last been released from prison in August 2013.

2. During the reception process, a nurse and a safer custody officer interviewed the man and neither assessed him as at risk of suicide or self-harm. A prison GP examined him shortly afterwards. Although the nurse had identified some signs of opiate withdrawal, the doctor did not identify any significant symptoms. He said he had been prescribed 40mls of methadone in the community but, in line with the usual protocol, the doctor prescribed ten mls of methadone for his first night, until healthcare staff were able to confirm his community prescription. The doctor also prescribed medication to alleviate the symptoms of withdrawal from alcohol. A prisoner wing representative who saw him that evening believed he was agitated because he was withdrawing from drugs and therefore difficult to engage with.

3. The next day, New Year's Eve, the man's community prescription of 40mls of methadone was confirmed. As it had now been three days since he had received this dose, he was given 20mls as part of a stabilisation programme. He complained to two prisoners that day that he was suffering from withdrawal symptoms and reported to a nurse that he was having hot and cold sweats and feeling anxious and emotional. The nurse did not consider his withdrawal symptoms were significant but did not use a clinical opiate withdrawal scale to assess this. Another substance use nurse, reviewed him shortly afterwards and did not identify any concerns.

4. That evening, the man and his cell mate watched television in their cell. His cell mate said that he went to sleep at about 11.00pm, while the man continued watching television. When he awoke, shortly after 3.00am, he got up to turn the television off and saw him hanging by a ligature made from a bed sheet and attached to the window bars. He immediately called for help.

5. The officer who arrived first did not go into the cell straight away and believed she needed permission from a manager before she could do so. She did not use an emergency code but shouted for help and waited for other staff to arrive. A custodial manager arrived, authorised staff to go into the cell, and requested that an ambulance be called. By this time, it was five minutes after the man's cell mate had raised the alarm. Staff and paramedics, when they arrived, attempted to resuscitate him but, at 3.35am, he was pronounced dead.

6. The investigation identified some significant concerns about the man's short time at Exeter. When he arrived at the prison there was too much reliance on his personal presentation and what he said, rather than a considered objective evaluation of all risk factors when considering his risk of suicide and self-harm. Appropriate treatment for drug and alcohol withdrawal was

prescribed but a substance misuse nurse did not use a recognised assessment tool to assess his opiate withdrawal when he reported symptoms. Night welfare checks for prisoners receiving drug treatment were not conducted in line with national guidelines and were not thorough enough to determine their physical or mental condition. When he was found, staff did not follow the expected emergency procedures, resulting in a delay in calling an ambulance and vital emergency equipment was not taken to the cell. It is also unfortunate that the police broke the news of his death to his next of kin before prison staff visited her.

7. The investigation into a death at Exeter in 2012 highlighted similar concerns to those in this report about the symptoms of methadone withdrawal, monitoring a prisoner on a drug maintenance programme and the emergency response. Although the recommendations in that report were accepted, it is apparent that they were not followed on this occasion..

THE INVESTIGATION PROCESS

8. The investigator issued notices about the investigation to staff and prisoners at Exeter, inviting anyone with relevant information to contact her. Two prisoners responded and agreed to be interviewed.

9. The investigator went to Exeter on 21 February 2014 and interviewed staff and prisoners, including the man's cell mate.

10. A clinical reviewer assessed the man's medical care at Exeter on behalf of NHS Devon. He joined the investigator for all but one of the interviews.

11. The investigator notified HM Coroner for Exeter and Greater Devon District of the investigation and we have sent the Coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's family to explain the investigation process and invite them to identify any relevant issues they wanted the investigation to consider. They had a number of questions and concerns, including:

    - Was his previous medical record available to staff?
    - How often was he monitored and by whom?
    - What medication did he receive?
    - Did he receive methadone while in police custody?
    - Were the staff on duty trained to monitor high risk prisoners?
    - Why was he not offered a higher level of support?
    - As he was sharing a cell, how was he able to harm himself?

13. The family received a copy of the draft report as part of the draft review period. His partner raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

HMP EXETER

14. HMP Exeter is a local prison serving the courts of Cornwall, Devon and West Somerset. It holds just over 500 men.

15. At the time of the man's death, Dorset Healthcare University NHS Foundation Trust provided healthcare services at the prison. The prison's substance misuse service delivers drug treatment services, with three full-time substance misuse nurses and a drug support team.

Her Majesty's Inspectorate of Prisons

16. HM Inspectorate of Prison carried out an unannounced inspection of Exeter in July and August 2013. Inspectors considered that reception arrangements were generally satisfactory. Staff paid attention to safety and vulnerability issues and initial identification of risk of self-harm and suicide was regarded as very good. However, there was little support for newly-arrived prisoners and night staff were unaware of their increased vulnerability. The Inspectorate recommended that night staff should make regular checks on such prisoners. Although there was excellent clinical care and support for prisoners with substance misuse issues, healthcare staff at the medication hatch engaged poorly with those receiving opiate substitutes and did not follow the correct protocols when prisoners asked to see a drug misuse worker. There was a lack of joint care planning for prisoners with both mental health and substance misuse problems.

17. Prisoners managed under the Assessment, Care in Custody and Teamwork (ACCT, a process to support and manage prisoners at risk of harming themselves)) procedures were positive about the support they received, but the inspection found that the level of care for those at risk of self-harm was variable and ACCT documents were poorly completed with weak action plans.

Independent Monitoring Board

18. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help ensure that prisoners are treated fairly and decently. In its most recent report for the period 1 January 2013 to 31 December 2013, the IMB said that the Assessment, Care in Custody and Teamwork (ACCT) process needed to be improved by closer management of the prisoner.

19. The IMB also noted that, at the start of 2013, a substance misuse service had been established. This team comprised clinical and psychological intervention staff. All drug and alcohol dependence services were carried out under the substance misuse service and in close co-operation with the primary care and mental health teams.

Previous deaths

20. The man's was the fourth of six deaths at Exeter since 2011. An investigation into the death of a prisoner in November 2012 raised similar concerns to those in this report about the management of prisoners on methadone detoxification and the emergency response procedures.

21. In a previous report after the death of a prisoner in 2009, Exeter accepted a recommendation that more defibrillators should be installed in the prison and that staff should be made aware of this and be prepared to take them to an incident. The prison said that a notice to staff had been published in April 2010, informing staff where the defibrillators were kept and to take them to an emergency. This investigation found that a defibrillator was not taken to the emergency incident.

KEY EVENTS

26. The man was arrested on Saturday 28 December, on suspicion of theft and detained at a police station. He had a long history of substance misuse. He was addicted to heroin and, after an eight year abstinence, had relapsed in 2010. Police custody records noted that he said he was prescribed 40mls of methadone daily and had taken a dose two hours earlier but subsequently said he had not received his methadone that day. (Methadone is a synthetic opioid used to treat heroin addiction.) He agreed to see an independent drug worker because he was worried that he would begin to experience withdrawal symptoms and needed to be prescribed methadone. There is no record that he saw the drug worker and he did not receive methadone during his time in police custody.

27. The man said that he had tried to kill himself by taking 100 valium tablets the year before. The police custody record noted that he had no current thoughts of harming himself but he was checked every 30 minutes and held in a cell with a camera. A nurse assessed him at 7.16pm and noted no concerns about his health and that he appeared stable during observations. He was assessed as fit to be detained.

28. On Sunday 29 December at 3.30pm, a nurse examined the man and noted that his observations were stable and he did not need opiate withdrawal medication at the time. He was not happy about this. Another nurse checked him at 10.32pm when he said he felt unwell. His baseline observations were stable and he scored two on the Clinical Opiate Withdrawal Scale (COWS) scale. (A score of between 5-12 indicates mild withdrawal.) She noted that he did not need any medication and should continue to be checked every 30 minutes. The nurse saw him again at 2.20am but he was argumentative and abusive and she was unable to take his blood pressure or pulse because of his aggression. She found no visual evidence of withdrawal symptoms.

29. The man was charged with theft and went to court the next day, Monday 30 December. At court, he was convicted of theft and sentenced to 42 days imprisonment and sent to HMP Exeter. The person escort record (PER) which accompanied him to the prison noted that he was a heroin user and suffered from depression and anxiety but it did not mention his suicide attempt by overdosing on valium.

30. A nurse, who knew the man from previous sentences, assessed him when he arrived at the prison. He said that he was prescribed 40mls of methadone daily and gave the nurse the address of the pharmacy which dispensed his medication and the details of his community drug worker and doctor. He tested positive for methadone and opioids and was restless and sniffing – signs of withdrawal. She said that he told her that he had taken an overdose of valium three years before but he had no current thoughts of harming himself. She recorded this in the medical record. She told the investigator that she had access to his previous medical notes when she assessed him.

31. A doctor then reviewed the man because of his substance use problems. She asked him about his previous drug use and drug treatment in prison. He said that he had been prescribed subutex when he was at HMP Channings Wood but he did not think the blocking effects of subutex (another drug used to treat opiate addiction) had been fully explained. When he left the prison in August 2013, he had stopped using subutex and started using heroin again. He said he was prescribed 40 mls of methadone daily but used heroin on top. He said he had not received any methadone since 28 December, the day he was arrested.

32. The doctor noted that the man looked tired said that he felt awful, that he was achy and could hardly walk. The doctor noted that his pupils appeared normal, his blood pressure and pulse appeared good, he was not yawning, tearing (showing involuntary tears), vomiting or retching and so there were no clear objective signs of withdrawal.

33. The doctor told the investigator that, if the prison had been unable to confirm a prisoner's methadone dose with the pharmacy on the day he arrived, the standard protocol was to given them ten mls on the evening of reception, 20mls the next morning and the 30mls on the third day. Prisoners were then usually maintained on 30mls. In the man's case the plan was to confirm his dose with the substance misuse service the next day and restart him on that, subject to when he had had the last dose. As he had reported high alcohol use, the doctor prescribed an alcohol detoxification programme of librium four times a day, with a reduction of five mls every 24 hours for eight days and sodium valporate, an anti-convulsant.

34. The prison's safer custody officer saw the man in the first night centre. He completed a cell sharing risk assessment, which concluded he was a standard risk and able to share a cell. The officer said that he had seemed quite jovial when he interviewed him. Despite the information about him, he said that the man had told him he was not dependant on drugs or alcohol and he did not observe any signs of withdrawal. He told him that he had no thoughts of harming himself and laughed at the suggestion. The officer said that at this point his assessment of a prisoner's risk of suicide and self-harm was mainly based on the prisoner's presentation and what he had told him unless there were identified concerns. The officer recorded in his records that during a previous period in Exeter in February 2013, he had been noted as having a history of self-harm.

35. The man shared a cell with another prisoner on A wing. Although the prison has a landing specifically to house those undergoing treatment for substance misuse, this was a standard residential wing. The cellmate said that the man had seemed all right that evening, except he noticed that he was 'rattling' (suffering heroin withdrawal symptoms). He said he did not mention this to anyone.

36. A prisoner violence reduction representative saw all new arrivals and met the man that evening. He told the investigator that the man had asked him what time he could have his medication and said he had been prescribed only ten

mls of methadone. He told him that this was the standard procedure until his community prescription was confirmed. The man told him that he was 'rattling' and needed medication. He said that as the man was experiencing withdrawal symptoms and was agitated he found it difficult to engage. He advised him of the support available in the prison but said that he did not consider him to be at risk of harming himself. He thought he seemed stressed but he had attributed this to methadone withdrawal. He did not mention this to anyone.

37. As the man was on a detoxification programme, he was required to have three welfare checks at night. Healthcare staff we interviewed seemed unsure of the purpose of a welfare check and whether a prisoner should be disturbed during such checks. They said that the usual procedure was to look into the cell, but if the prisoner appeared to be asleep they did not disturb him. A healthcare assistant carried out the welfare checks on the night of 30 December and morning of 31 December. She made an entry in the medical record at 5.14am on 31 December that she had had no concerns about him during the checks. The actual times of each check were not recorded.

38. On the morning of 31 December, a prisoner equality representative for A wing spoke to the man as part of his induction. He recalled that the man appeared physically unwell and in pain. He said he was sweating and shaking. He told the representative that he was unsure about the length of his sentence but said that his medication was in hand. He said that he would visit him the next day and, if a member of the substance misuse service had not seen him by then, he would help him to complete an application to be seen. He told the investigator that he was a coordinator for the Listeners (prisoners trained by the Samaritans to provide emotional support to fellow prisoners in distress) and was used to dealing with suicidal prisoners. He said that the man did not give any indication that he might harm himself.

39. That day, a nurse telephoned the GP surgery whose details the man had given. The surgery said he was no longer registered there so she was unable to obtain his GP records. A nurse confirmed his daily prescription of 40mls of methadone with the pharmacy which said that he had last received this on 27 December. As it had now been more than three days since he had taken that dose, the plan was that he would remain on a stabilisation dose of 20 mls that day and then receive 30 mls.

40. In the afternoon of 31 December, a member of the substance misuse team saw the man, who told him that he had been taking a £10 bag of heroin daily in the community and had last used some on 27 December. He reported having hot and cold sweats and said he felt anxious and emotional. He also said that he had had a seizure a few months earlier. The nurse noted no signs of sneezing, runny nose, tearing, goose bumps, yawning, nausea or tremors - all signs of opiate withdrawal. His pupils also appeared normal. The nurse did not carry out a formal Clinical Opiate Withdrawal Scale assessment at the time, but in retrospect, believed that he would have had a low score on the scale. He said he did not have any suicidal thoughts.

41. The nurse said that at first the man seemed a little irritable and was very frustrated and disappointed that he had relapsed from a previous very successful period of rehabilitation. The nurse noted that he had initially been reluctant to participate in the assessment but started to relax once it was underway. They agreed that he would remain on the stabilisation programme and the nurse gave him 20mls of methadone. He asked if he could transfer to buprenorphine (subutex). The nurse advised him to apply for this when he had a release date.

42. A member of the substance misuse service then reviewed the man. He had been referred to her as a result of his reception screening and she was aware that he had already seen a member of the misuse service. She noted he was on a methadone and alcohol detoxification and alerted Exeter and North Devon Addiction Service (ENDAS).

43. The man's cell mate said that he and the man had watched television in their cell that day and throughout the evening, but they had not talked much. He said that he went to bed (the lower bunk) at 11.00pm, while the man continued to watch television.

44. During the night of 31 December/1 January, a healthcare assistant was responsible for the night welfare checks. She said that the purpose of a welfare check is to speak to the prisoner to ensure they are well and to check whether they have any withdrawal symptoms. She said that she checked him at 11.00pm, when he and his cell mate were both awake and he had told her he was okay.

45. The cell mate told the investigator that he was aware that welfare checks were conducted on prisoners detoxifying from drugs. However, he did not recall the healthcare assistant making a check at that time or at any time during that night.

46. The healthcare assistant said she carried out the second welfare check between 1.30am and 1.45am and on this occasion the cell was in darkness. She said she did not switch on the cell light as prisoners do not like to be disturbed. She said she shone her torch into the cell and saw that both men appeared to be asleep and the television had been switched off. She recorded these checks in the medical record at 5.04am after the final check of the night, in line with the usual requirement – although in this case after the man had died.

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47. The cell mate said that at approximately 3.00am, he woke up and got out of bed to switch off the television as it was still on. (This conflicts with the healthcare assistant's account that the television was off when she did the second check after 1.30am.) As he got up, he saw the man hanging by a ligature made from a bed sheet attached to the window bars. He immediately pressed the cell bell (recorded as 3.04:44) to call for help and kicked the cell door repeatedly. He said that he believed it took ten to 15 minutes for a

member of staff to respond. However, records show that an officer had answered the bell at 3.05:36am.

48. The officer told the investigator that she had been less than 100 yards from the cell and responded immediately. She said she looked through the observation panel and saw the cell mate pointing to the man. She immediately shouted for staff to help. An operational support grade (OSG) said that he heard the officer call and immediately went to alert the healthcare staff (a nurse and the healthcare assistant). The OSG said he did not hear any radio message.

49. Staff responded to the officer's call for help. The custodial manager was in the centre office and said he had been able to see the cell from there. At night officers on wings do not carry cell keys on their key chains but have a key in a sealed pouch for use in an emergency. The officer said that while she waited for the other staff to arrive, she opened the sealed key pouch but she would not go into the cell alone as this was not permitted. The manager said that as the night orderly officer he did not carry a cell key so he helped the officer get hers out of the sealed pouch and the staff went in. The nurse said he had been in a consulting room close to the cell when he had heard someone shouting. He could not make out what was said, but heard that there was an emergency. He followed staff who were running towards the cell and said he waited for a few seconds while the door was opened. The cell mate ran out of the cell in a distressed state and an officer took care of him.

50. The custodial manager radioed the control room to request an ambulance at 3.09am. Neither the officer, nor he used an emergency code. He told the investigator that the communications room would not automatically call an ambulance on receiving a code blue (an emergency call to indicate that a prisoner is unconscious or has breathing difficulties) as it could signify a prisoner suffering an asthma attack.

51. The nurse used his anti-ligature knife to cut the ligature and, as there was little room in the cell, he and the officer carried the man out onto the landing. The nurse told the investigator that his immediate impression was that he was dead. His face, neck and hands were cold and there were no signs of life. Nevertheless, he began cardiopulmonary resuscitation (CPR) by administering chest compressions and asked the healthcare assistant to bring the emergency bag and oxygen. No one asked for a defibrillator (a life-saving device that gives the heart an electric shock in some cases of cardiac arrest).

52. When the healthcare assistant returned with the emergency bag (which did not contain a defibrillator) and oxygen the nurse asked the custodial manager to take over the chest compressions while he inserted an airway into the man's mouth and administered breaths. The manager recalled that he looked very pale, his lips appeared purple, his eyes were open, but he did not feel particularly cold. The nurse noted that the top half of his body was cold, the bottom half warm and his hands were very dark which he considered to be a sign of lividity (livor mortis) but rigor mortis had not set in. (Livor Mortis occurs when the heart stops and the skin becomes bluish purple. It sets in at a

variable time, but usually after one hour and up to three hours after death.) He noted no changes in his appearance while carrying out CPR.

53. The custodial manager asked the officer to remove all the double locks from the gates, so the ambulance could get into the prison quickly and she left the cell to do so. The ambulance arrived at the prison at 3.15am and paramedics took approximately three minutes to get to the cell. A second ambulance arrived at the prison at 3.16am. The paramedics applied a defibrillator to the man, but it indicated that there was no cardiac activity (asystole). At 3.35am, the paramedics pronounced him dead.

54. Two letters to the man's partner were found in his cell. The first requested money and tobacco and asked her to visit. He said that he was going to arrange to go to a rehabilitation facility as soon as possible and not to worry. He also said that the prison was unbearable but asked that she should wait for him. The second letter apologised for not getting 'clean' and for the pain he had caused her and his parents. He wrote that being back in prison was 'killing him'.

Support for prisoners and staff

55. Immediately after the man's death, staff took the cell mate to the wing office and allowed him to stay there for an hour, before moving him to another cell. They also offered him a counsellor and healthcare staff assessed him.

56. The custodial manager held a debrief with staff. No one raised any concerns. He spoke to each member of staff before they went off duty and the care team also saw them individually.

Informing the man's next of kin

57. The deputy governor and the prison chaplain visited the man's partner, who was recorded as his next of kin, at 12.00pm to break the news of his death, but the police had already told her earlier that morning.

Post-mortem

58. A post-mortem examination found that the man had died from hanging. Analysis of blood samples identified methadone and chlordiazepoxide (librium) in keeping with prescribed use.

ISSUES

Clinical care

59. The clinical reviewer concludes that the man was appropriately placed on a drug maintenance programme and alcohol detoxification programme, his care planning was in line with guidelines and, overall, his daytime monitoring was adequate, although not strictly within prison protocol. This was because the COWS withdrawal scale was not used and there is no record that his clinical observations were taken and recorded twice on 31 December as they should have been. However, his monitoring at night was inadequate. There was no evidence that he was suffering from severe opiate withdrawal. The clinical reviewer comments that the CPR attempt, while competent, was unlikely to succeed as he appeared to have been dead for some time when he was found.

Drug maintenance programme

60. Exeter's drug maintenance strategy protocol is that each new prisoner who tests positive for methadone is given a ten mls stabilising dose that day and reviewed the next day. It is usual to adjust it to 30mls, although it would be exceptional to prescribe a higher dose as 30mls is usually enough to stop severe withdrawal.

61. When the man arrived at Exeter on 30 December, he tested positive for opiates. He started a methadone maintenance programme and an alcohol detoxification programme to minimise the risks associated with withdrawal. The doctor thoroughly assessed him and arranged for him to receive a dose of methadone that evening, in line with the prison protocol. His subsequent care was handed to the substance misuse service for follow-up and prescription of further opiate substitution treatment.

62. Devon Prisons Healthcare Partnership Integrated Drug Treatment System (IDTS) protocol on the clinical management of opiate dependency for prisoners likely to be suffering from opiate withdrawal, says that new prisoners should be given a ten mls dose of methadone on the first night. They should be seen the next day, including weekends and receive enhanced observation for the next five days. Additionally, a substance misuse nurse should assess the prisoner, using an opiate withdrawal scale.

63. The clinical reviewer indicates that, although a nurse carried out a thorough assessment of the man on 31 December, it was not in line with the Devon Prisons' protocol as he did not use an opiate withdrawal scale to record his findings. Neither did he take his pulse or blood pressure as he should have done. We make the following recommendation:

The Head of Healthcare should ensure that healthcare staff follow the protocol for the assessment and management of prisoners undergoing treatment for substance misuse.

The man's location

64. Prison Service Instruction (PSI) 45/2010, Integrated Drug Treatment System, stipulates that all drug or alcohol dependent prisoners who arrive in prison must always be offered immediate admission to a stabilisation unit and prisons must have a system in place to ensure that sufficient places are always available on such units. It also states that healthcare hatches should be installed in all stabilisation units and ideally should remain open at all times to permit the unrestricted clinical observations required by the Clinical Management of Drug Dependence in the Adult Prison Setting (DH 2006 and PS0 [Prison Service Order] 3550 Clinical Services for Substance Misusers 2001).

65. We are concerned that the man was not offered a cell in the stabilisation unit and that staff were unable to observe him adequately in his cell in A wing. We therefore make the following recommendation:

The Governor and the Head of Healthcare should ensure that newly arrived prisoners dependent on alcohol or drugs are offered a place in a stabilisation unit which allows unrestricted observation by healthcare staff at all times.

Assessment of the man's risk of suicide or self-harm

66. Prison Service Instruction (PSI) 64/2011, about safer custody and PSI 74/2011 (Early Days in Custody) both list a number of risk factors and potential triggers for self-harm and suicide. These include early days in custody, previous self-harm, substance misuse, mental health problems such as depression and non-compliance with treatment. All staff who have contact with prisoners must be aware of the triggers that may increase the risk of self-harm and take appropriate action. PSI 74/2011 requires new prisoners to be interviewed in reception to assess the risk of self-harm or suicide and expects all staff to be alert to the increased risk posed by prisoners who fall in these categories. This includes opening an ACCT.

67. The man had a history of substance misuse, which was well known at Exeter because he had served recent sentences there. The PER noted that he was dependent on heroin and alcohol and had depression and anxiety. He told staff that he had taken a serious overdose three years earlier and was taking heroin as well as methadone and drinking alcohol daily. He told other prisoners that he was withdrawing and 'rattling', although this was not obvious to healthcare staff and the prisoners did not pass on this information to anyone. The NHS document, 'Clinical Management of Drug Dependence in the Adult Prison Setting' notes that much of clinical substance misuse practice is directly concerned with the management of risk and identified heightened suicidal risk among opiate dependent prisoners in the first 24 hours. It notes that their risk remains raised throughout the first 28 days and in particular during the first seven days in custody. This risk is also identified in PSI 45/2010.

68. In the short time that the man was in custody at Exeter he had been interviewed by a nurse in reception, the prison's safer custody officer and examined by a doctor. He had also spoken to prisoners and other nurses. The reception nurse referred him to see the doctor, but it was a routine referral in line with the prison's protocol because he was dependant on drugs and alcohol, not because of any immediate concern about his welfare.

69. Staff who had contact with the man relied on his personal presentation and his assurances that he did not intend to harm himself. A prisoner's presentation is obviously important and reveals something of their level of risk. However, it is only a reflection of their state of mind at the time they are seen and should be considered as a single piece of evidence used to make a judgement of risk. All risk factors must be collated and considered to ensure that a prisoner's level of risk is holistically judged.

70. We are concerned that prison staff placed too much reliance on what the man told them and did not fully consider the weight of other risk-related information. He had several risk factors which should have been considered carefully in the context of suicide and self-harm, but it is not apparent what weight, if any, was given to them.

71. We cannot know whether managing the man under the ACCT procedures would have affected the outcome, and it is possible that full consideration might still have concluded that he was not at serious risk. However, it is essential that staff consider whether to provide additional support for prisoners with known risk factors and that the rationale for their decision is recorded. 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, first night staff and all others who assess risk:

- **Have a clear understanding of responsibilities and the need to share all relevant information about risk.**
- **Note and consider all information from suicide and self-harm warning forms and person escort records.**
- **Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.**
- **Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.**

Night welfare checks

72. Newly-arrived prisoners receiving treatment for opiate dependency are subject to enhanced observation for five days. This should include a non-medical welfare check at three-hourly intervals during the night, conducted by a healthcare assistant. The checks are not recorded contemporaneously, but at the end of the night once all three checks have been completed. These checks were carried out on 30 December and recorded in the medical record

at 5.14am on 31 December. On the night of the man's death, the healthcare assistant said that both he and his cell mate were awake when she completed her check at 11.00pm and she spoke to him. The cell mate said he could not recall any welfare checks that night (31 December) and that he had gone to sleep at about 11.00pm.

73. Guidance issued by Exeter's healthcare department say that the checks are to be conducted in accordance with the National Treatment Agency guidelines for the management of drug dependence in a prison setting and that prisoners should be in a unit that offers staff the opportunity to observe them. The clinical reviewer indicates that the purpose of the welfare checks at Exeter is not clarified in the local guidance but his assumption is that they are aimed at monitoring and detecting concerning signs of opiate withdrawal or toxicity. No formal nursing observations are carried out until the prisoner requires them and night time welfare checks are not a substitute for medical intervention which should be carried out by a trained nurse.

74. Dorset Healthcare produced guidance on welfare checks for Exeter. It says that the healthcare assistant who conducts the checks is expected to note whether the prisoner has any nausea or sickness; whether they are cold or shivering; whether they are having trouble sleeping; whether they are sweating, have a running nose or appear anxious. If the prisoner is asleep after 11.00pm (the time of the first check), the healthcare assistant should adopt the same principle as when a prisoner is being managed under the ACCT procedures and monitor any change or movement since the previous check (for example whether they have moved or turned over in bed). If the prisoner has not moved, consideration should be given to opening the cell and asking a nurse to make a clinical assessment. However, there is no written protocol about when a healthcare assistant should be concerned or the threshold for referral to a nurse and neither the healthcare assistant nor the nurse could recall opening a cell as a result of a welfare check.

75. As staff are reluctant to turn on a cell light during the night and rely on a torch to look through a small spy glass (as in the man's case), it is impossible to see how an effective and worthwhile check can be carried out. (As noted above, his cell did not have a healthcare hatch which would have aided observation.) The symptoms that staff are supposed to note are difficult to check in a dimly-lit cell, therefore they are recorded as negative (for example no sweating or shivering) if the prisoner is asleep when checked.

76. The clinical reviewer comments that the welfare checks carried out for the man recorded that he had not complained about any symptoms, but that this assessment was inaccurate. No record of his sleeping position or movements had been made, and no meaningful clinical picture obtained. He concludes that Exeter's welfare check system is inadequate and needs to be reviewed to ensure that the purpose is explicit and clear to staff. In addition, they should be carried out strictly within protocols with clear guidance about when to take further action or obtain advice and recorded contemporaneously. We make the following recommendation:

The Head of Healthcare should ensure that welfare checks are compliant with the National Treatment Agency guidelines for the management of drug dependence and recorded contemporaneously.

Opening a cell at night

77. An officer said she was unable to go into the man's cell until she had sought permission from the custodial manager, as this was the procedure. The prison's local instruction 2.77 'Nights – Opening cells', says that staff have a duty of care to prisoners and themselves and to other staff. The preservation of life must take precedence over security concerns but night staff should not take action that would put themselves or others in unnecessary danger. Under normal circumstances, authority to unlock a cell at night must be given by the night manager and no cell will be opened unless a minimum of two or three members of staff are present, including the night manager. However, where there appears to be immediate danger to life cells may be unlocked without this permission. The cell may be unlocked with only one member of staff present and they may enter the cell on their own, but staff should not put themselves and anyone else in danger.

78. We are concerned that the officer's understanding of the protocol was that staff were not allowed to unlock a cell at night in any circumstances. It would have been understandable if she had decided against going into the cell alone for safety reasons, in line with the local protocol, particularly as his cell mate was upset and agitated. However, this was not the case.

79. In an emergency, time is of the essence and it is important that all staff who work in prison at night are prepared to enter a cell in order to preserve life. Staff can, and should, alert the night manager when they are doing so, which helps to ensure safety. We make the following recommendation:

The Governor should ensure that staff are aware of Local Instruction 2.77 and understand that, subject to a personal risk assessment and providing there is no obvious danger to themselves or others, they should enter a cell at night in an apparent life-threatening situation.

The emergency response

80. PSI 03/2013 Medical Emergency Response Codes, which was issued at the beginning of February 2013, requires governors to have a medical emergency response code protocol based on this instruction. The protocol should instruct staff how to communicate the nature of the emergency, use agreed emergency codes and ensure the control room calls an ambulance as soon as an emergency is called.

81. At the time of the man's death, Exeter had issued a local protocol, Notice to Staff 46/2013, in line with the PSI. It states that the purpose of the emergency code system is to ensure timely, appropriate and effective response to medical emergencies. It advises staff of the emergency codes (code blue and code red) and the mandatory responses required. It instructs that on

receiving a call, healthcare staff should collect the defibrillator from the centre office, or, if they are already at the incident, ask another member of staff to collect it. This did not happen. The protocol also says that the control room should routinely call an ambulance on receiving a code blue emergency call and alert healthcare staff.

82. The officer who found the man did not use an emergency code. During her interview with the investigator, she recalled that she called out to other staff for assistance as she was aware that there were staff close by. This meant that the other staff who responded were not immediately alerted to the nature of the emergency. The night manager radioed the control room to request an ambulance at 3.09am, five minutes after the man was first found. He did not use a code blue either and, at interview, seemed unclear whether calling a code blue would automatically trigger a request for an ambulance.

83. The prison's Notice to Staff 29/2013, issued on 1 March 2013, advised staff that a new defibrillator had been placed in the centre office. Staff were instructed to make themselves aware of its location and be prepared to take it to an emergency incident, or when requested to do so. They were also advised that details of the equipment, its use and location should be sought from the Deputy Primary Healthcare Manager.

84. None of the staff who attended the man's cell brought, or asked for, the defibrillator. Officers interviewed by the investigator either said they were unaware there was a defibrillator or that they had not been trained to use one. Anyone is able to use a defibrillator machine, the instructions are clear and they are sited in locations for the general public to use, for example in railway stations. The clinical reviewer comments:

> "Exeter has a fully automated defibrillator, which needs no clinical skill to use and issues verbal instructions to users when switched on. Automatic defibrillators are designed to be used with no training but training will improve outcomes".

85. There is no reason why staff should not use a defibrillator and, if they are uncertain how to use it, they should follow the Notice to Staff and seek guidance. The clinical reviewer suggests that the defibrillator should be kept with the emergency bag to remind staff to take it to an emergency. We accept that any deficiencies in emergency procedures would not have affected the outcome for the man as, although staff made commendable efforts to resuscitate him, it appears he was dead when he was discovered. We also acknowledge that, because of size of the prison and the proximity of his cell to the centre and to other staff, there was relatively little delay. However, in other emergencies a difference of minutes could be crucial. We make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, local instructions 46/2013 and 29/2013 and their responsibilities during medical emergencies, including:

- **Efficiently communicating the nature of a medical emergency;**
- **Bringing to the scene relevant emergency equipment such as a defibrillator and using it if necessary;**
- **Ensuring there are no delays in calling an emergency ambulance.**

86. None of the healthcare or prison staff interviewed were aware of any formal training in cardiopulmonary resuscitation and a nurse had organised his own training. The clinical reviewer recommends that all staff should have annual training in resuscitation and the use of the defibrillator. While we consider that it would be desirable for all prison staff to receive such training, as a minimum we consider all healthcare staff should be trained. We make the following recommendation:

The Head of Healthcare should arrange for healthcare staff to receive resuscitation and defibrillator training annually.

Informing the man's next of kin

87. PSI 64/2011 says that prisons should break the news of a prisoner's death to their next of kin, face to face, as soon as possible. Unfortunately, the police broke the news to the man's next of kin before prison staff had the opportunity to do so.

88. It is unfortunate that, despite the protocol in place between the police and the prison, police broke the news first without the knowledge and agreement of the prison. The paramedics had pronounced the man dead at 3.35am. Had the prison visited the family sooner, this situation might not have arisen. The prison's delay in notifying his next of kin is regrettable and we make the following recommendation:

The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that healthcare staff follow the protocol for the assessment and management of prisoners undergoing treatment for substance misuse.

2. The Governor and the Head of Healthcare should ensure that newly arrived prisoners dependent on alcohol or drugs are offered a place in a stabilisation unit which allows unrestricted observation by healthcare staff at all times.

3. 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, first night staff and all others who assess risk:

    - Have a clear understanding of responsibilities and the need to share all relevant information about risk.
    - Note and consider all information from suicide and self-harm warning forms and person escort records.
    - Consider and record all the known risk factors of a newly arrived prisoner when determining their risk of suicide or self-harm.
    - Open an ACCT when a prisoner appears at high risk, irrespective of his stated intentions.

4. The Head of Healthcare should ensure that welfare checks are compliant with the National Treatment Agency guidelines for the management of drug dependence and recorded contemporaneously.

5. The Governor should ensure that staff are aware of Local Instruction 2.77 and understand that, subject to a personal risk assessment and providing there is no obvious danger to themselves or others, they should enter a cell at night in an apparent life-threatening situation.

6. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013, local instructions 46/2013 and 29/2013 and their responsibilities during medical emergencies, including:

    - Efficiently communicating the nature of a medical emergency;
    - Bringing to the scene relevant emergency equipment such as a defibrillator and using it if necessary;
    - Ensuring there are no delays in calling an emergency ambulance.

7. The Head of Healthcare should arrange for healthcare staff to receive resuscitation and defibrillator training annually.

8. The Governor should ensure that, in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.