PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

Investigation into the circumstances surrounding the death of a man at HMP Durham in January 2011

Report by the Prisons and Probation Ombudsman for England and Wales

May 2012

This is a report of the investigation into the circumstances surrounding the death of a man, a prisoner at HMP Durham. He died in January 2011. He was 27 years old. I offer my sincere sympathy and condolences to his family for their loss.

The investigation was carried out on my behalf by an investigator. I would like to thank the Governor of Durham and his staff for their co-operation. I apologise for the delay in issuing this report.

A clinical review of the man's health care was commissioned by the local PCT. A clinical reviewer was appointed and attended some of the interviews with the investigator. I would like to thank her for her review.

The man had been in custody in Durham before and was known to some of the staff. On this occasion, he admitted to taking and mixing different drugs in the community and he agreed to take part in a drug and alcohol withdrawal programme. He appeared to comply with the programme until one night in January, when his cell mate said that he took two dihydrocodeine tablets as well as drug and alcohol medication.

The next morning his cell mate and prison staff were unable to rouse the man and it became apparent that he had died. The post mortem could find no anatomical cause of death, but attributed it to methadone toxicity combined with diazepam, dihydrocodeine and chlordiazepoxide which were also found in his body.

My office has investigated an increasing number of deaths in custody apparently caused by the combination of methadone with other illicit medication. Evidently, such combinations can have dangerous effects, and the results can be fatal. I have raised the issue with the National Offender Management Service and I pleased that senior staff have taken the matter seriously. They have commissioned an investigation to increase understanding of the issue and to see what steps may be needed to help prevent further sad and untimely deaths such the man's.

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 **May 2012**

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SUMMARY

1. The man was recalled into custody on 5 January 2011 and returned to Durham prison. His previous prison records contained relevant information so they were merged with his current file.

2. During the reception health screen the man gave a urine sample and tested positive for buprenorphine (subutex) and benzodiazepine (diazepam or valium, used to treat anxiety disorders). He admitted that his drug and alcohol use had escalated since his last time in custody and agreed to undertake a detoxification programme. He signed a disclaimer and agreed to abide by the terms and conditions of the programme. This included an agreement not to take any illicit drugs.

3. For three days the man was regularly monitored by healthcare staff and support workers and checked for any symptoms of withdrawal. He suffered from some stomach cramps and sleeping problems, but these were consistent with somebody withdrawing from drugs. Neither he, nor healthcare, were overly concerned about this.

4. The man received his detoxification medication regularly and at the appropriate times. However, there were problems with his clinical notes which were not always signed and dated by staff.

5. On an evening in January, the man illicitly acquired two dihydrocodeine tablets. These tablets are generally used as a painkiller. He offered one of these tablets to his cell mate, who was also on a methadone programme. His cell mate refused as he was worried about it reacting with the methadone they had both been prescribed. He took both tablets.

6. The man appeared very sleepy that evening and went to bed at approximately 6.30pm. He snored heavily. His cell mate heard him get up in the night to switch the television off, but heard nothing more. In the morning, he noticed that there were signs that he had been sick during the night. He appeared to still be asleep.

7. Just before 9.00am, an officer came to the cell to collect prisoners to take them for their medication. He asked the man's cell mate to rouse him, but he was unable to do so. On closer inspection the officer found that he appeared to have died. He was blue in colour and mottled and rigor mortis had set in. An ambulance was called and paramedics pronounced him dead at 9.25am.

8. Three recommendations are made. Two are to the Head of Healthcare and relate to clinical records and reminding prisoners of the dangers of mixing methadone with unprescribed drugs. The other is to the Governor and concerns the policy on requesting an ambulance in an emergency situation.

THE INVESTIGATION PROCESS

9. Another investigator opened the investigation at HMP Durham on 20 January as she was already visiting the prison that day on another matter. She met with the Governor, the Head of Healthcare, Head of Safety and Decency, a representative from the Prison Officers' Association (POA) and from the Independent Monitoring Board (IMB). She also took the opportunity to interview the man's cell mate. She collected copies of all prison documentation relating to him.

10. Notices of the investigation were issued to both staff and prisoners, inviting those who wished to provide further information regarding the man's death to make themselves known to the investigator. No further witnesses came forward. Another investigator visited the prison on 8 and 9 March to carry out interviews with staff. She also spoke informally with the man's brother, who was also in custody at Durham when his brother died.

11. The investigator wrote to the local PCT to commission a clinical review into the healthcare received by the man. They asked a clinical reviewer to carry out the review. She received a copy of the relevant medical documents and accompanied the investigator during the interviews on 8 March. The review was received in this office on 16 May. The delay in the publication of this report was caused by workload pressures in this office. .

12. The investigator also wrote to HM Coroner to inform him of the nature and scope of the investigation. A copy of this report will be forwarded to the Coroner to assist with his enquiries into the death of the man.

13. The investigator provided feedback to the Governor on 9 March and again in writing on 17 March. At that stage, the issues that were identified were that the man had taken drugs which had not been prescribed for him, the prison's in-possession drug policy and lack of communication between staff when calling for an ambulance. The Governor responded by letter on 31 March, and discussed the initial findings with the investigator on the telephone.

14. One of the Ombudsman's family liaison officers contacted the man's family at the beginning of the investigation. She informed them of the investigation process and offered them the opportunity to raise any questions or concerns they would like addressed during the investigation. (Another family liaison officer took over as family liaison officer in April 2011.) The family were concerned that a local newspaper recorded the man's time of death differently to the information given by the prison, and they asked for more clarification about what took place and specific timings.

15. The investigator also wrote to the man's family on 23 June, with a report of her initial findings. This was in response to a family member's request for early information due to personal circumstances.

16. The family received a copy of the draft version of the report as part of the consultation period. I am grateful to the family of the man for their

involvement in the Ombudsman's investigation and the time they have taken to consider my findings.

HMP DURHAM

17. HMP Durham is a category B prison which can hold up to 1000 prisoners, both convicted and unconvicted. On arrival at the prison, prisoners are risk assessed and given a category based on their offence and the risk they pose to the public, should they escape. Category B prisoners are those for whom the highest security conditions are not necessary but for whom escape must be made very difficult. The prison consists of nine wings including those specialising in drug treatment, segregation and healthcare.

18. Healthcare services at Durham are provided by North Darlington and Tees, Esk and Wear Valley NHS. It is nurse led, with access to general practitioners and specialists such as psychiatrists and dentists. There is also an integrated drug treatment service and some inpatient beds.

HM Inspectorate of Prisons

19. Her Majesty's Chief Inspector of Prisons carried out an unannounced follow up inspection by the then Chief Inspector in October 2009. In the introduction to the report, she commented that: " … methadone administration dominated the prison's regime, with insufficient administration points for the numbers involved." She added that: "…the arrangements for the high proportion of prisoners on IDTS were extremely unsatisfactory and potentially unsafe, and illicit drug use was very high."

Independent Monitoring Board

20. Each prison in England and Wales has an Independent Monitoring Board responsible for monitoring day-to-day life in the prison and to ensure that proper standards of care and decency are maintained. The latest report published by the IMB for December 2008 to November 2009 stated that:

> "Substance misuse, drugs and alcohol misuse, psychology, drugs testing, Detox and CARATS all seem to be working satisfactorily, being well organised and controlled. Staff are motivated and demonstrate a good level of understanding and requirements."

Buprenorphine (Subutex)

21. Buprenorphine, known by the trade name Subutex, is an opiate substitute that is used to treat addiction to stronger opiates, such as morphine, diamorphine (heroin) and methadone. Buprenorphine prevents the physical withdrawal symptoms which occur when these drugs are stopped, including physical cravings. Over time the dose of buprenorphine is gradually reduced until it can be stopped completely.

Methadone

22. Methadone is one of a number of synthetic opiates that are manufactured for medical use to treat addiction to opiates such as heroin. It is prescribed for

pain relief and prevents withdrawal symptoms. The normal prescription starts at 10ml and gradually increases to an appropriate level.

Chlordiazepoxide (Librium)

23. Chlordiazepoxide is used in the treatment of alcoholism for its sedating and anxiety-relieving effects, which help relieve the symptoms of acute alcohol withdrawal. Chlordiazpoxide is from a class of drugs known as benzodiazepines, often used to treat anxiety and help people sleep. The usual prescription in prison starts at a certain level and then decreases as the prisoner detoxifies from alcohol.

Integrated Drug Treatment System (IDTS)

24. Integrated Drug Treatment System (IDTS) is an initiative that aims to improve and increase the volume and quality of clinical treatments for substance misuse available to prisoners. Its aim is to ensure that professionals work together in the co-ordination of a prisoner's care, with particular emphasis on the first 28 days in custody. This is achieved by increasing the range of treatment options available in prison, including the prescription of drug substitutes for those with addictions to heroin and other opiates.

Listeners

25. Some prisoners are trained by the Samaritans to be Listeners. They are able to sit with other prisoners who are in a state of distress or feeling vulnerable to offer them support.

Release on licence and recall to prison

26. Once released on licence a prisoner can be recalled to prison at anytime if they breach their licence. The Parole Board will consider the details of the breach and make a recommendation to the Secretary of State on whom the final decision rests.

Counselling, Assessment, Referral, Advice and Throughcare services (CARATS)

27. Organisations specialising in the treatment of substance abuse have drug and alcohol workers based in most prisons. CARATs workers can run programmes, offer counselling, support and referral to rehabilitation centres to prisoners and on release. Access to CARATs is voluntary and by application.

Previous deaths at HMP Durham

28. The man's death was the first attributed to substance misuse at Durham in 2011. In May of that year another prisoner, who was also on a detoxification programme, died although his cause of death was not the same. Although some of the issues in the cases are similar, the specific details of his death are not the same.

KEY EVENTS

29. The man was released from Durham on 20 December 2010 (and had also been in custody there in 2006 and 2009). He was recalled to prison on 5 January 2011, following a further offence which breached his licence conditions. The prison documentation from his last time in custody at Durham remained relevant and merged with his current prison file. Despite this, as with all prisoners entering a prison, he underwent the standard reception procedures.

30. A Cell Sharing Risk Assessment (CSRA) was undertaken to assess the level of risk the man presented to a cellmate. It identified no concerns and classed him as low risk and able to share a cell with another prisoner.

31. During reception, the man was seen by a staff nurse, a registered mental health nurse. He answered a number of standard questions and gave a urine sample which was analysed for drugs. He tested positive for buprenorphine (subutex) and benzodiazepine (diazepam or valium). He said he had a history of benzodiazepine misuse and had been prescribed mirtazapine for depression whilst in the community. He told the nurse that he did not have a psychiatric nurse or care worker in the community. He discussed his alcohol and drug problems and said he used benzodiazepines (20 to 30 tablets a day) and subutex, which he had started taking a year before. He said he also injected steroids and drank between ten and fifteen cans of lager a day. He consented to being referred to the Substance Misuse Service and also to the Specialist Alcohol Service.

32. Prison Officer A working in the CARATS team completed a Substance Misuse assessment whilst in reception. The man confirmed that he had been taking benzodiazepines and subutex and injecting steroids. The officer said during interview with the investigator that he remembered him from his previous time in custody, but in the past he had never tested positive for opiates or subutex. On this occasion, he did test positive for subutex. He told the officer that he had used subutex, as well as valium tablets and injected steroids. The officer arranged to see him the next day.

33. A doctor at Durham also saw the man and referred him to the Mental Health Team. He prescribed him zispin (an antidepressant) to manage his depression and also prescribed him eye ointment for conjunctivitis. During their discussion, it was identified that he had issues with alcohol and drugs and he agreed to undertake a detoxification regime to begin the next day. He was prescribed a seven day alcohol withdrawal programme, which consisted of 30mg of chlordiazepoxide three times a day. This was to be administered by a nurse as the tablets could not be held in his possession. However, he was permitted to keep a course of thiamine (vitamin B1, used to boost the immune system) in his possession, and told to take one 300mg tablet daily.

34. The man also began a five day Methadone stabilisation regime as part of his drug detoxification. This was to be administered by a member of healthcare.

He received ten ml of methadone for drug detoxification that night, along with 30mg of chlordiazepoxide.

35. Following these assessments, the man was located in the First Night Centre on E wing (this is where all new prisoners stay when they first come into prison, irrespective of whether it is their first time in custody at Durham). He was in a shared cell with another prisoner.

36. The man completed the usual induction procedures on the First Night Centre. He was given a smoker's pack, and issued with crockery and cutlery. He was monitored throughout the night at various intervals to check how he was coping. At 00.58am it was recorded that he was still awake and talking to his cell mate. On the other occasions that staff checked him it was noted that he was asleep. The night passed without incident.

37. The next morning at approximately 8.10am, the man received, and signed for, 10ml of methadone. The signature of the person who administered the methadone is illegible.

38. Later that day, the man was seen by a healthcare support worker (HSW) in the Substance Misuse Team. She worked through the first stage of the Integrated Drug Treatment Strategy (IDTS) care plan with him and discussed the treatment procedures. These included attending the treatment hatch for medication at the correct time and displaying acceptable behaviour towards treatment staff. He agreed to abide by these conditions and signed a form to indicate this.

39. The man also met with Officer A again. The officer said that, because they knew each other quite well they had a "good chat". He said he had no issues but did not want to work with the CARATS team, which was his decision. He did not want to discuss why he had started taking subutex. He said he was receiving sufficient help and treatment by being on the methadone programme and signed a disclaimer to this effect.

40. The HSW also assessed the man against the alcohol/benzodiazepine withdrawal monitoring scale. This involves monitoring a prisoner's pulse and checking whether they have a tremor, are perspiring, suffering from insomnia, appear agitated or anxious and whether they have any perceptual or orientation difficulties. He said he found it hard to sleep and had a pulse rate of 103, which is quite high.

41. The man received and signed for 10ml of Methadone at 3.00pm. The signature of the member of staff who administered this is illegible, and it was not witnessed by anyone else. Later that day, the records indicate that he was given 30mg of mirtazipine (an antidepressant) but on this occasion no signature was recorded, so it is unclear whether this medication was actually administered.

42. Another HSW went onto the wing at approximately 8.30am the following morning. She recalled the man because he suffered from conjunctivitis and

she remembered his sore eyes. He seemed pleasant and chatty and she had no concerns about him. She monitored his drug and alcohol withdrawal and what effect it had on him. His sleep seemed to be interrupted and he complained of stomach pains, but that was not unusual with prisoners withdrawing from substances. He had no other problems and was compliant when taking his medication. He was given 15ml of Methadone and 20mg of chlordiazepoxide.

43. Approximately an hour later, the man underwent an opiate withdrawal observation with the HSW. His pulse rate was lower than the day before, but he complained of stomach cramps. He also said he had some joint pain, but there were no major concerns about any of his withdrawal symptoms. She then carried out the alcohol /benodiazepine withdrawal monitoring scale. On this occasion, he complained of insomnia and appeared to be suffering from mild withdrawal symptoms. Later that day he received 15ml of methadone and 30mg of mirtazipine.

44. On the morning of 8 January, the man received further doses of methadone and chlordiazepoxide. Later that day, he was seen by a nurse, to carry out the opiate and alcohol withdrawal assessment. She noted that the only symptom he had from the opiate withdrawal was mild stomach cramps. On this occasion, no readings of blood pressure or pulse were recorded. At 3.30pm, he received another dose of methadone, and later that evening was given mirtazipine.

45. That night, the man told his cell mate that he had acquired small tablets which he described as “DF’s” (dihydrocodeine, a painkiller). He offered one to him, who refused. (He was also prescribed methadone and did not want to mix it with the medication.) He said he had two 240ml tablets which he had got from someone on the wing. He took both pills at about 4.30pm and, as he said he felt very sleepy, he went to bed at approximately 6.30pm.

46. The man’s cell mate recalled that the man snored heavily during the night and, as he had snored the previous nights as well, believed him to be fine. He also remembered that at some point during the night the man jumped down from his bed (the top bunk) and switched the television off.

47. The next morning the man did not get up for his breakfast, but his cell mate assumed it was just because he was still tired. The cell mate went to get his breakfast and made a cup of tea for himself and for the man, as he was due to get up soon to take his medication. He also noticed that the man had been sick as there were signs around the toilet bowl, which he said he was going to ask him to clean up when he got up.

48. Just before 9.00am, the cell was unlocked by an officer for the prisoners to go to the treatment room to be given their medication. He saw from the doorway that the man was still in bed, and asked his cell mate to rouse him. He shouted to him to ask whether he was getting up for his medication. He got no response so he walked over to him and called him again. As he again received no response he pushed him, but he did not move.

49. The officer entered the cell and pulled down the man's bed covers. He saw immediately that something was wrong and pulled the covers back up. He said that he could tell by the feel of him, the fact that he was rigid and the colour of his skin, that he had been dead for some time. He asked the cell mate to leave the cell and called the communications room by radio to inform them that there was an emergency. He used the "code black" radio code. (A code black means a prisoner is unconscious and unresponsive.) He called out to another officer to take the cell mate to another cell, but he had already made his way to the treatment room for his methadone. (Subsequently, he was located in another cell, on another wing, with two Listeners.)

50. A Senior Officer (SO), who was in charge on the wing that weekend, heard the emergency call over the radio and immediately went to the man's cell. Within seconds of her arriving, members of healthcare staff had also arrived.

51. Nurse A responded to the call over the radio, accompanied by Nurse B. Nurse B said at interview that another member of healthcare picked up the emergency bag and defibrillator, which they took to the cell. She recalled at interview that the man was lying in bed, on his left side and looked as if he were asleep. Nurse A checked for signs of life, but found none. He noted that rigor mortis was present.

52. A Principal Officer (PO), a security manager, also heard the radio call and went to the cell. He recalled one of the healthcare staff asking if an ambulance had been called. He contacted the communications room to check this was the case, and was told that they were waiting for confirmation that one was required. He confirmed that it was (and should have been requested immediately a Code Black was called).

53. In the meantime, while the HSW administered methadone to the cell mate, he mentioned to her what had happened to the man. He told her "I think he's died". She immediately made her way to the cell. When she got there she saw him lying on his left side, looking as if he were asleep. Healthcare staff had already arrived and were assessing him. (As healthcare staff were managing the situation, she left the cell).

54. The paramedics arrived approximately ten minutes later. They carried out a number of checks on the man and confirmed that he had died at 9.27am.

55. The duty manager also heard the emergency call over the radio and went to the cell. Once the man's death had been confirmed, the cell was sealed and a log keeper assigned to note who entered and left the cell. He then attended the command suite with another manager to instigate contingency plans for a death in custody. This includes informing relevant departments about the death, appointing a family liaison officer and arranging for the man's family to be notified of his death.

56. A hot debrief was held at 12.30pm and was chaired by the Governor. The security manager raised the issue of the ambulance not being called when the

code black emergency call was made. An action point was noted for use in future emergency situations:

> " .. that an ambulance must be summoned immediately a Code Black alarm is raised and not wait until confirmation from HCC staff once at the incident scene."

57. Another issue raised at the debrief was that there seemed to be some confusion over who was the duty care team member and how staff could contact them. (The staff care team are available to any member of staff who feels in need of further support and wishes to talk in confidence about how they are feeling.) However, this did not seem to have an adverse effect on the staff on duty that day, and the situation was remedied the next day.

Liaison with the man's family

58. The SO was appointed as the prison's family liaison officer and asked a chaplain to assist her in her duties. She collated information regarding the man's next of kin. They found that his bother was also on another wing in Durham. They went to see the man's brother to inform him of what had happened. He also gave them the next of kin details but explained that, as his mother was very poorly, his aunt should be contacted instead.

59. Staff on the wing were made aware of the man's brother's bereavement and were asked to keep a close eye on him. He spoke to the investigator on 9 March. He said he had been offered the services of Listeners and the Samaritans. He also said he was awaiting a referral to the mental health team. The investigator spoke to staff who arranged for an urgent referral to be undertaken, as well as a family visit be granted to provide further support.

60. The SO and chaplain arrived at the family's address at approximately 2pm and broke the news of the man's death. They explained their role and the support that was available to them and told them what they could of the circumstances surrounding his death. They arranged to return his belongings and to assist with funeral costs. The funeral was held on 2 February 2011, and the family declined the SO's offer to attend.

Support for prisoners

61. After the man's death, a notice was issued to all prisoners, informing them what had happened and who they could speak to if they felt affected by his death. Also, all prisoners who were subject to suicide monitoring procedures were reviewed to ensure they were not adversely affected by his death.

Support for staff

62. A critical incident debrief was held approximately two weeks after the man's death, although the staff the investigator interviewed could not remember the exact date. All those staff who knew him and were involved in the discovery of him were invited to attend.

Post mortem

63. A post mortem was held on 10 January 2011. The examination was unable to find an anatomical cause of death. Tissue samples sent for a toxicology examination indicated: “therapeutic concentrations of mirtazapine, diazepam, chlordiazepoxide and paracetamol, together with a concentration of methadone”. The report added that: “methadone use is associated with a depressant effect on the central nervous system and such effects can be exacerbated by diazepam, dihydrocodeine and chlordiazepoxide even if present only in therapeutic doses. In view of this, the opinion of the toxicologist and the lack of a competing cause of death at post mortem it is my opinion that the cause of death is more likely than not due to methadone toxicity in the presence of diazepam, dihydrocodeine and chlordiazepoxide”.

Security issue

64. A Security Information report (SIR) was submitted by an officer regarding a prisoner dealing medication on E wing after the man had died. The officer raised the issue because he had concerns that a prisoner may have been selling or handing out medication. When the officer heard that the man had taken some “DFs”, this raised his suspicions further as he knew the prisoner he suspected had been prescribed dihydrocodeine. The officer made further investigations and found that some of the prisoner’s medication was missing. However, the prisoner was transferred to another prison before a full investigation could take place. The officer reiterated that he did not have any firm evidence at that time and further enquiries would have been necessary reach any conclusions. (This was an on-going issue when the man died.)

ISSUES

Clinical care

65. The clinical reviewer finds that, during the time that the man was in custody at Durham he received a high standard of care, equal to that of a National Health Service patient in the community. The prison's detoxification team were able to prescribe and administer to him split doses of methadone, allowing him to be monitored throughout the day before giving him his remaining dose, which is good practice.

In possession medication

66. It is Durham's policy to allow prisoners to be responsible for their medication unless there are clearly identified factors that this should not be the case. Some medication is not suitable to be kept 'in-possession' such as methadone (therefore the man did not keep his medication in his possession, aside from the vitamin tablets). Sometimes it is the suitability of the individual prisoner that informs the decision not to permit the medication to be held by them.

67. According to the prison's 'Medication in possession policy', a formal risk assessment is not necessarily made about every prisoner, but the prescriber will review the risk every time the medication is prescribed.

68. Prison staff who suspect that in possession medication is being sold or shared with other prisoners should complete a Security Information Report (SIR) highlighting the suspected misuse. Two SIRs were completed following reports that a prisoner was selling or sharing dihydrocodeine medication at the time of the man's death. This was one of the medications found in his body at the post mortem. However, although he was not prescribed dihydrocodeine by a doctor, it is not clear that he obtained the drugs from that source.

69. The investigation found that Durham followed the in-possession policy as directed. It appears that it was the actions of the man that led to his death by illicitly obtaining and taking medication from (presumably) another prisoner. The clinical reviewer takes the view that it would be desirable for prisoners on detoxification programmes to have the message of the danger of mixing drugs emphasised.

    The Head of Healthcare should ensure that patients receiving methadone are advised and educated regarding its use and the need to comply strictly with its prescription, as non-compliance could be fatal.

70. The clinical reviewer also suggests that consideration should be given to the use of alerts on the clinical computer system, to identify if a prisoner has misused in-possession medication. It is unclear how actionable this suggestion is given the software involved, but it is brought it to the attention of the Head of Healthcare for their consideration. Certainly relevant information

regarding the misuse of medication should be recorded wherever relevant, regardless of whether it is achievable by means of an alert.

Standard of clinical record keeping

71. The clinical reviewer identifies that, throughout the administration of the man's medication, staff repeatedly failed to document and sign the paperwork regarding the methadone dispensation. Neither was a second member of staff present to witness that the methadone had been administered. For that reason the clinical reviewer's recommendation is endorsed:

The Head of Healthcare should ensure that all clinical staff document and sign paperwork when administering methadone and ensure that a second member of staff is present to witness this.

Requesting an ambulance

72. There appeared to be a breakdown in communications between the staff attending to the man and the communications room on 9 January. It was thought that using a code black radio code would automatically trigger a request for an ambulance. However, staff in the communications room awaited confirmation from a member of healthcare staff before doing so. There is no suggestion that an earlier request for an ambulance could have changed the outcome for him, but that would not be so in every case.

The Governor should ensure that staff in the communications room follow the procedures for automatically calling an ambulance following an emergency call.

CONCLUSION

73. Recommendations are made by the clinical reviewer regarding reducing the risk of methadone toxicity. However, when the man entered the detoxification programme at Durham he agreed that he would not take any illicit drugs whilst he was receiving treatment. Unfortunately he did not adhere to this agreement and the post mortem found that he had taken dihydrocodeine, diazepam and paracetamol in addition to his prescribed medication.

74. However, it is recommended that the prison reinforce to prisoners the dangers of taking other drugs whilst on the methadone and alcohol programme. It is also recommended that healthcare staff take greater care and accuracy when recording clinical notes.

75. We recognise that Durham makes great efforts to alleviate the problem of prisoners selling their prescription drugs, sharing their medication with other prisoners or abusing the use of their medication. The prison has an in-possession drugs policy which assesses the risk of a prisoner being permitted to hold their own medication; they also conduct cell searches and use prison intelligence to try to resolve this problem. However, Durham, like most other prisons, faces an enormous challenge to eliminate this risk.

RECOMMENDATIONS

To the Head of Healthcare:

1. The Head of Healthcare should ensure that patients receiving methadone are advised and educated regarding its use and the need to comply strictly with its prescription, as non-compliance could be fatal.
   The prison accepted this recommendation and is now in place.

2. The Head of Healthcare should ensure that all clinical staff document and sign paperwork when administering methadone and ensure that a second member of staff is present to witness this.
   The prison accepted this recommendation and is now in place.

To the Governor:

1. The Governor should ensure that staff in the Communications Room are aware of the procedures for calling an ambulance following an emergency call.
   The prison accepted this recommendation and is now in place.