



**Investigation into the circumstances surrounding the  
death of a man in July 2011  
at HMP Hewell**

**Report by the Prisons and Probation Ombudsman  
for England and Wales**

**July 2012**

This is the report of the investigation into the death of a man who died in July 2011 at HMP Hewell. He was 33 years old. He was found unresponsive on the floor of his cell. Healthcare staff were immediately summoned but, despite cardio pulmonary resuscitation, he could not be revived. I extend my condolences to his family and friends.

An investigator carried out the investigation. A review of the man's healthcare was undertaken by a clinical reviewer. HMP Hewell cooperated fully with this investigation. I apologise that this report has been delayed.

The man had a long history of drug misuse, self-harm and physical and mental health problems. Prison staff were supportive of him especially during his times of crisis and he sometimes responded positively to this support. For example, he sought their help when he became addicted to Subutex, illicitly procured on the wing. He had a significantly damaged heart which contributed to his death but the main cause appears to have been a fatal interaction of the methadone he was prescribed to manage his addiction with other medications he was taking – some illicitly obtained.

The man posed a management challenge to prison staff as he was intent on maximising his medication and drug intake, both licit and illicit. The investigation concludes that such highly medicated individuals as him could benefit from more gradual and closely monitored prescribing regimes which take into account personal histories and risk factors. There is also a need for prisoners to be made more aware of the dangers of mixing methadone with other drugs.

Similarly, while it was not established that the Subutex used by the man was diverted from prison supplies, the investigation raises concerns about the security of the dispensation of medication and recommends that further steps are taken to minimise the chance of prisoners supplementing their prescriptions with medication diverted from other prisoners. Attention is also drawn to the failure to fully involve staff from the different relevant departments in the prison in his suicide monitoring process. This system is at its most effective when all staff involved in the care of the prisoner can participate.

This office has dealt with too many deaths arising from methadone interacting with other medications. Together with a number of Coroners, I have raised concerns about the apparent increase in such deaths, including issues regarding the prescription and administration of combinations of medication to those on methadone programmes. I am pleased that the National Offender Management Service has responded to these concerns by undertaking work to learn more about the dangers of methadone interacting with other medications.

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**

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## SUMMARY

1. The man was born in 1978. He served a number of sentences in HMP Hewell. He had been released on 30 July 2010 but was recalled to prison on 23 August, having breached the terms of his license.
2. On his return to prison, his mental health and self-harm problems were recognised and he was immediately supported by suicide prevention procedures, something that would continue throughout his time in custody. His extensive health problems and medication prescriptions were also acknowledged by the prison's healthcare staff.
3. The man was held in a section of the prison reserved for those who needed protection from other prisoners. During his time at Hewell, he cut himself on a number of occasions, sometimes requiring treatment in hospital.
4. Although there was rarely any direct evidence, staff were concerned that throughout his time at Hewell the man was involved in using medications prescribed for and obtained from other prisoners. As he was segregated from the general population for his own protection, it was difficult for the prison to relocate him to another area of the prison where he might have found it more difficult to get drugs and without risking an increase in his level of self-harm.
5. In the first few months of 2011, the man disclosed to staff that he had developed an addiction to Subutex (a heroin substitute) procured illicitly on the wing. It was agreed that he would be prescribed methadone to help him cope with the withdrawal from Subutex, but this could only be done safely once he complied with the prescription requirements including providing a Subutex free urine sample. He began methadone treatment on 22 July. Accounts from prisoners and staff differ over the issue of whether the methadone affected his demeanour, although there was some suggestion that he became more lethargic. Nursing staff never raised concerns that he was over-sedated when collecting his methadone.
6. The man collected his methadone as usual at 2.00pm a few days later and had a suicide monitoring review later that afternoon with only an officer and senior officer. The officers reported that he engaged with them well during the meeting. However, at approximately 5.00pm that afternoon he was found unresponsive by his cellmate on the floor of the cell. Sadly, despite the efforts of staff and paramedics he could not be revived and it was confirmed he had died at 5.35pm.

## THE INVESTIGATION PROCESS

7. The investigation into the man's death was opened at HMP Hewell on the 8 August 2011 by an investigator. He reviewed the man's prison files and arranged for relevant documents to be forwarded to him. Later, he met prison managers to gain an overview of the man's time at Hewell and visited his cell.
8. The Ombudsman's terms of reference and notices of investigation were sent in advance of the investigator's visit to ask staff and prisoners with relevant information to come forward. No responses were received
9. The investigator returned to Hewell on 6 October and 17 November to conduct interviews with staff. He provided feedback on the progress of the investigation to the Deputy Governor and followed it up in writing. The delay to the publication of this report was caused by the change in job role of the investigator assigned to the case.
10. A review of the man's healthcare while at Hewell was commissioned by the local Primary Care Trust (PCT). A clinical reviewer carried out that review on their behalf and submitted it to the Ombudsman's office on 21 December 2011.
11. Her Majesty's Coroner for Worcester commissioned a post-mortem examination following the man's death. The cause of death was confirmed as cardio respiratory failure due to mixed drug toxicity (when the combination of drugs in the system causes the heart and lungs to fail).
12. On 18 August, one of our family liaison officers telephoned the man's mother. He explained the process of the investigation and offered her the opportunity to raise any questions she would like the report to consider. Up to the circulation of this report, no concerns have been raised by the family.
13. Following the publication of the draft report, the office received a response from the National Offender Management Service (NOMS). The response from NOMS accepted all of the recommendations (further information is provided on pages 29 and 30).
14. The man's family received a copy of the draft version of the report as part of the consultation period. They told the family liaison officer that they found the report helpful and informative. However, they were very unhappy with what they deemed to be conflicting information provided by the interviewees.

## **HMP HEWELL**

15. HMP Hewell was created on 24 June 2008, by merging three separate prisons which were located on adjacent sites (HMP Blakenhurst, HMP Brockhill and HMP Hewell Grange). Hewell primarily serves the West Midlands, Worcestershire, and Warwickshire areas.
16. There are eight houseblocks in the prison, each divided into wings. Houseblocks one to six (the former Blakenhurst) accommodate prisoners remanded by the courts, those awaiting sentence and convicted prisoners who are awaiting transfer to other prisons.
17. There are two spurs (A and B) within houseblock two which are used for vulnerable prisoners. B spur is generally reserved for those who require separation from the general population due to the nature of their offences, usually sex offenders. C spur is mainly for those who seek protection for other reasons, such as debt or an inability to cope on a general population wing. The man was located in the latter area.
18. Healthcare is provided by the local Primary Care Trust (PCT). The unit has 24 hour nursing staff, with inpatient care on the lower floor of the unit.

## **Release on licence**

19. Prisoners released on licence before the expiry of their sentence are supervised by the Probation Service. They can be recalled to custody at any point until the expiry of their licence if their behaviour gives grounds for concern.

## **Assessment, care in custody and teamwork (ACCT) procedures**

20. When a prisoner is deemed to be suicidal or at risk of harming themselves staff can use the ACCT (Assessment, Care in Custody and Teamwork) framework to monitor and protect the prisoner concerned.
21. Once placed on an ACCT, the prisoner is observed at predetermined intervals according to the perceived level of risk. Each prisoner is assessed within 24 hours and then reviewed at intervals decided on an individual basis. The ACCT guidance says that, to be effective, the review should involve the key people who know the person at risk or are involved in their care.

## **IDTS (Integrated Drug Treatment System)**

22. Integrated Drug Treatment System (IDTS) is an initiative 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 coordination 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, which includes the prescription of drug substitutes for those with addictions to heroin and other opiates (drugs with sedative effects). Other

aims include combining clinical and psychological treatments in prison into one system, and reinforcing continuity of care from community drug intervention programmes into prison, between prisons, and on a prisoner's release back into the community. IDTS began at Hewell in 2010.

### **TAB (Tackling anti-social behaviour)**

23. When a prisoner acts in an anti-social manner, the prison can react by beginning TAB procedures. This can involve a range of actions including the movement to a different location of the perpetrator, monitoring and the recording of behaviour.

### **In-possession medication**

24. When medication is prescribed to a prisoner, staff must assess whether the prisoner can keep the medication in their possession, or be provided with it each time it is needed. This risk assessment is based on both the nature of the medication, and a judgement on the prisoner.

### **Independent Monitoring Board (IMB)**

25. Each prison has an IMB, made up of members of the public appointed by the Secretary of State for Justice. Their role is to satisfy themselves that prisoners are treated humanely and justly and that there are adequate programmes for preparing prisoners for release. In the most recent annual report published by the IMB at Hewell (2009 – 10) the Chair reported:

“At the end of the last reporting year, the Board expressed concerns that further reductions in the prison's budget could have an adverse effect on any future consolidation or improvements. Reductions in budgets have continued. The prison has repeatedly met these demands with diligence. There is little indication that budget reductions are having a direct effect on offenders.”

### **HM Inspectorate of Prisons' report**

26. The last inspection of Hewell by the HM Chief Inspector of Prisons was in November 2009. The Chief Inspector said with regard to safety and security:

“The quality of TAB documents was good but monitoring entries could be improved. Bullying was an issue on houseblocks 1-6 but staff were robust in tackling it. Security procedures were proportionate and managed effectively through a single security department for all three sites. The intelligence-led department processed and analysed information effectively.”

27. The report noted that there was little evidence of multidisciplinary attendance at the majority of ACCT case reviews. Reference was also made to the lack of flexibility in detoxification processes, something returned to in this report.

### **Previous deaths at Hewell**

28. There have been five previous deaths at Hewell in the past year. None of those deaths had direct similarities to that of the man's.

## KEY EVENTS

29. The man was born in 1978. It was recorded in his prison file that he started taking heroin at the age of 13 years, as well as crack cocaine and alcohol. He left school without any qualifications and was unemployed for a long time and had received sickness benefit because of health problems.
30. According to the man's probation records, he had seen a psychiatrist who diagnosed him with ongoing depression and paranoia, possibly linked to a personality disorder. The psychiatrist noted that he had reported to him that he had cut himself and made numerous suicide attempts. He also suffered from a number of physical health problems such as hepatitis C and swollen legs for which he required regular medication and frequent treatment.
31. On the 18 May 2010, the man was released from Hewell after serving a sentence for burglary. However, on 4 July, he was recalled to Hewell at the recommendation of his offender manager from the Probation Trust for failing to comply with his licence conditions. (An offender manager is a probation officer who helps monitor prisoners released into the community under the supervision of the Probation Service.) A first reception health screen, to assess his immediate medical condition, was carried out at Hewell by a nurse. The nurse noted that he was a prolific self harmer and was addicted to illicit drugs and alcohol. The nurse wrote that the Community Drug Team (CDT) would be contacted so details of his community drug maintenance programme could be transferred to Hewell. The nurse also referred him to the CARATs team and the doctor. (CARATs is the Counselling, Assessment, Referral, Advice and Throughcare service, which provides voluntary non-clinical treatment for those with substance misuse needs.)
32. The man was next seen by a doctor and prescribed omeprazole (for acid reflux and chronic heartburn) and venlafaxine (an anti-depressant). The doctor wrote that he would wait for confirmation of his other prescribed drugs from his community doctor, before prescribing any other medication.
33. The following day, another doctor noted that she had telephoned the Drug Interventions Programme (DIP) team in the community and confirmed that the man had been prescribed diazepam (a medication used for sedation and anxiety) and methadone (a heroin substitute). The doctor wrote a prescription for him for diazepam and methadone in accordance with his community drug programme.
34. A nurse noted on 6 July that the man should be referred to mental health services and two days later he was seen by another nurse. He told the nurse of his substance misuse history and that he "feels paranoid at times". He said he would benefit from anti-psychotic medication. The nurse made an appointment for him to see a psychiatrist. A week later a psychiatrist saw him and prescribed zopiclone to help him sleep. The doctor noted that he had a mental and behavioural disorder due to substance misuse.

35. The man was released from Hewell on 30 July. (He was given 40ml of methadone before his release in accordance with his maintenance prescription.) However, he was recalled to prison on 23 August, having breached the terms of his licence. He underwent another reception healthscreen where his medical condition was assessed. He was noted to have been prescribed gabapentin (a pain-killer), methadone, diazepam, olanzapine (an anti-psychotic) and venlafaxine, and was prescribed a continuation of his medication.
36. Assessment, Care-in-Custody and Teamwork (ACCT) procedures were begun on the same day to provide support to the man due to his history of mental health problems and self-harming behaviour. He told staff that he often cut himself and felt unsettled having missed his methadone administration for a few days. He was located in Houseblock 2, B spur for his own protection due to the circumstances of a previous offence.
37. Throughout September, staff noted that he spent a lot of time in bed. He was provided with further pain relief for an injury to his leg. A doctor noted in September that, because his release date was not until July 2011, his methadone prescription would need to be gradually reduced until it ended.
38. At the start of October, the man saw a mental health nurse as he had suicidal thoughts. He was prescribed zopiclone (sleeping tablets) by a doctor until he could see a psychiatrist. He told her that he wanted to come off methadone because "it has caused me nothing but trouble since being on it". Three days later he saw the psychiatrist who prescribed quetiapine (an anti-psychotic medication).
39. The man finished his methadone detoxification regime in mid-November, but this coincided with a number of instances of cutting himself. Staff thought that it might be connected to him no longer taking methadone and his ACCT observations were increased, as was his prescription of diazepam.
40. On 2 December, the man was taken to hospital having made a deep cut to his arm. He was also subject to TAB measures at this time as there were concerns that he was bullying other prisoners for their medication. As a result, he was observed when receiving his medication, and staff witnessed him asking other prisoners for items. His TAB observations were raised when he encouraged another prisoner to harm himself, but they were lowered again in February 2011. The TAB procedures were closed on 19 February. Although staff had concerns that he was procuring medications from other prisoners, the observations did not reveal any direct evidence of it.
41. Throughout December, his medications were increased and reduced according to his level of anxiety. On 30 December, he was taken to hospital in an ambulance, having said that he had taken a paracetamol overdose. He returned to Hewell the following day as tests had proved negative for paracetamol and his electrocardiogram (a test which measures the electric activity of the heart) reading was normal.

42. A number of tablets were removed from the man's cell on 3 January 2011. Neither he nor his cellmate were authorised to have in-possession medication, which meant that it belonged to another prisoner. He received a behavioural warning for insulting an officer during this search.
43. He asked for extra support on 13 January, as the following day was his daughter's birthday. His observations were increased. It was noted in a multi-disciplinary team meeting that any bullying for medication would result in disciplinary procedures and could affect his prescriptions. According to the mental health nurse, he told her that he occasionally procured medication from other prisoners. A Senior Officer (SO) said:

“Although I never saw him doing anything like that personally, a lot of prisoners would tell us of their concerns over a length of time ... he admitted to myself at times you know I've been given extra medication by other prisoners and he was quite often quite honest and open about it. So yes I suppose we all knew and you know we would say look it's very dangerous, you know you shouldn't be doing it you should be going you know taking your own medication. But he, he would more or less say if the opportunity was there he would take that opportunity...”

44. As a matter of safety and security, the prison has a responsibility to prevent prescribed medication being diverted to other prisoners. Staff monitor prisoners, search cells and use TAB procedures. In serious cases, prisoners can be moved to ensure the safety of everyone on the wing. It is also standard practice for prisoners to be observed while they receive their medication. The SO explained this to the investigators:

“ ... there's always a member of staff stood by the nurse's hatch and the nurse will ask them to open their mouths and if we've looked then a member of staff as a discipline officer would step in and say come on the nurse's said to open your mouth so they can check if, they've got anything and quite often he was asked that because that the staff knew that he had that potential to keep medication or have it off others.”

45. A nurse explained to the investigator what the nurses check for when they dispense medication:

“ ... if we feel someone's over sedated we can actually sort of omit their medication the doctors are quite happy for that. And you do learn to assess people for ill health and obviously if anyone comes to the hatch and they are not well I would sort of make efforts to get them seen by a doctor as soon as possible.”

46. An enhanced ACCT case review was held on 14 February involving a representative from the IMB, a nurse, a Governor and a SO. The man agreed to his mental health care plan, which was incorporated into his ACCT care plan. It was decided that he would continue to have regular meetings with mental health staff, and with the psychiatrist to discuss his prescriptions. It was also agreed that any bullying of other prisoners for medication would

result in an immediate review of his prescribed medication and possible disciplinary action.

47. The man met the psychiatrist on 17 February when he told her of his addiction to Subutex, which he had illicitly procured on the wing. (The source of this Subutex is unclear.) He was reluctant to provide a urine test as he feared it would result in a period in the segregation unit which he felt unable to cope with. (A segregation unit is an area of the prison used to separate prisoners from the general population for a number of reasons, including poor behaviour and for their own safety.) She increased his dosages of zopiclone and diazepam for the week.
48. Another ACCT review was held in early March. He said he had no thoughts of harming himself at that time. During April, he continued to mention his withdrawal from Subutex.
49. The man was taken to hospital in mid-April as he complained of feeling very unwell. He said that he was cutting himself and then waiting before contacting staff, and acknowledged that this was risky behaviour. While at hospital he said that he was sick of the pain and wished that God would let him die. However, staff reported that he appeared more content once a catheter was inserted and he was provided with morphine for the pain. (A catheter is a tube to allow fluid to be drained from the body.) He returned to Hewell early the next morning, but returned to hospital the following day for a new catheter to be inserted.
50. On 6 May, during an ACCT review, the man told a SO and an officer that he had been told that he might only have a few years to live. He said he was determined to spend as much time as he could with his daughter. He told the mental health nurse that he had continued to use Subutex on and off on the wing, and suffered periods of withdrawal when he was unable to get any drugs. The nurse said she would talk to IDTS and CARATs to discuss a possible detoxification from Subutex. He said he would be happy to do this.
51. A SO recorded in the man's notes on 23 May that she was very worried about his physical and mental health. She noted an increase in his self-harm and wrote that she felt he needed a period in the healthcare unit to be appropriately cared for. However, three days later he was recorded as feeling better after having a chat with staff during an ACCT review. The psychiatrist increased his dosages of diazepam and zopiclone for the week on 31 May. He was reported to be struggling with concerns about his level of debt to other prisoners.
52. The man cut his arm in early June. He told staff that this was because he was addicted to Subutex but, as he was not selling any medication, he had no money and was in debt. He said he had started to withdraw from Subutex and agreed that he needed help to manage it. He told an officer a day later that he was really struggling with his withdrawal now that prisoners were not giving him any more Subutex. (Security intelligence in his records, suggested he was supplied drugs by other prisoners, and acted as an 'enforcer' for those

involved in drug dealing.) He said he was unhappy, and threatened to slit his throat rather than go through withdrawal. She told him that she had sought advice from nursing and CARATs staff regarding the Subutex addiction. A nurse described this pattern of behaviour to the investigators during interview:

“ ... there was quite an issue around Subutex on the wing and him obtaining Subutex he openly told me that he was using Subutex on the wing. And when he couldn't get the Subutex he'd start having withdrawal symptoms which would then link into his self-harm.”

53. On 9 June, the man severely cut his arm and was taken to hospital for treatment. In the next week, he told staff he was going to struggle now that his main supplier had gone. He had his diazepam and zopiclone increased at the end of June, as he was not deemed to be coping well. He complained of feeling unwell on several occasions at the end of the month, but staff thought that he was trying to engineer a transfer to hospital, where he would try to obtain further illicit drugs. (Staff believed that he had done this in the past to have drugs left for him at hospital by associates outside prison.)

54. He met the psychiatrist on 20 June where he acknowledged that he might need to be 'retaxed' onto methadone given his ongoing struggle with Subutex misuse. He was waiting for a meeting with IDTS staff. A nurse recorded in his medical record on 3 July that he seemed over-sedated. The nurse explained to the investigators that his voice was slurred and, although he knew that his voice was often slurred, it made him consider the possibility that he was taking extra medication.

55. The man was told on 12 July that the doctor would consider putting him on a methadone maintenance prescription to enable him to cope with his withdrawal from Subutex. A nurse explained the reasoning for this:

“ ... the idea was to try and get him re-toxed .... earlier on to try and manage the substance misuse he was engaged with in the wing.”

56. He was later told that this would start on 18 July. On that day, the psychiatrist noted the reasons for prescribing him methadone:

“ .the thinking behind this is to limit his risk in the prison of issues such as debts, self harm and diverting other prisoners' medication, the self harm is deep muscle cutting (he cuts when detoxing from meds) and community risks as above and overdose and crime:

1. get him onto a regular dose of opiate not illicit Subutex
2. let him decrease his debt on the wing
3. enable aftercare planning.”

57. However, the methadone programme was not begun as the man tested positive for Subutex. A nurse told the investigators: “we asked him for, to prove to us that he could have that just a couple of days of not taking it so then we could safely start him on the methadone ... maintenance”. He cut his arm

later that day and was taken to hospital. When he got back, he was spoken to by staff as he was walking around the wing with his wound uncovered which disturbed other prisoners. He also admitted that he was in debt and had been trying to detoxify by himself. He was told that staff would hold a meeting on Thursday with a number of different departments to try to organise the best way forward. He said that he would do his best not to harm himself and not take any more Subutex.

58. On 21 July, a nurse recorded that the man provided a negative urine sample for all medication which was surprising given that he had taken his dosage of diazepam shortly before. Staff suspected that he had given someone else's urine, so he was told that he would not be prescribed methadone until he could provide a genuine sample. He provided another sample which tested positive for his prescribed medication but also Subutex. He was again told that he could not be prescribed methadone until he provided a sample which was positive for the medication he was prescribed, and negative for Subutex. He did so the following day, and he began the methadone treatment. The clinical reviewer writes in his clinical review the structure of the treatment:

“The man's initial prescription chart suggested an initial dose of 10mg with daily increments of 10mg until reaching 40mg maintenance. He was in fact initially commenced at 20mg ... “

59. During an interview with the police following the man's death his cellmate said that he had frequently found him on the floor of the cell after he began his methadone treatment. He said that this had never happened before he was prescribed methadone. A SO told the investigators that she had no recollection of the cellmate ever raising this concern with her. An officer said that the cellmate told her, when the man died, that, in the days preceding his death, he had regurgitated his methadone to enable other prisoners to take it.

60. A nurse told the investigators she saw the man on 27 July on the wing:

“There were times when he said he was tired. The day he died I saw him I was due to see him that afternoon ... I agreed to see him the Friday afterwards. At that point he did, he looked a bit dozy and I said to him you know, he said I'm just tired. And there were other times when yes he did appear dozy but at the same time when you questioned him about it he just said I'm not sleeping very well at the moment you know ... But obviously us being aware of him abusing other medication and that was what we were trying to get him away from by looking at the methadone, was trying to get him away from abusing other people's medication. He could have taken anything; he could have been taking all sorts of stuff that we didn't know about.”

61. An officer also felt that: “in that last few months yes he [the man] did actually get to be a bit sluggish, more than usual in my opinion.” However, a SO, when asked if she noticed him particularly sleepy in the time preceding his death, told the investigators:

“No, I never particularly noticed it sort of the last week or so. He did to my knowledge he was very open and he would say he had lots of medications, he was onto various medication. So a lot of that would make him groggy anyway ... I suppose when he'd come back from his methadone he would probably be a bit more relaxed then he'd probably be during the morning prior to it so yes I suppose he would be a little bit groggy but no more than he usually was.”

62. An officer unlocked the man from his cell at approximately 2.00pm on 27 July in order to get his methadone. He was escorted through the prison to the healthcare department to receive the medication. The officer recorded in her statement that he seemed fine. However, a friend of the man's wrote in his police statement that he told him he felt weak just before he went to collect his methadone from the healthcare centre. He later complained of feeling “groggy” while they waited for the methadone. The friend described him as a “bit spaced out” but said this was not unusual given his medication. Following the taking of his methadone, the officer locked him back in his cell and said she did not notice anything out of the ordinary. However, the friend told the police that he was slurring his words and appeared to be “nodding off” as he sat on his bed.
63. The officer returned to the man's cell at 3.20pm to collect him for an ACCT review with her and a SO. He engaged well with them during the review and said he felt better having begun his methadone treatment. He offered to tidy his cell which was noted by the officer to be a positive move, as his cell was generally very untidy. During interview with the investigator, both the SO and the officer felt that the review went well. However, in her statement, she noted that: “He did say that he felt a bit groggy and he put this down to water retention and other health problems that he has got”. The SO told the investigator that she noted that she would speak to healthcare colleagues about this. There was no healthcare worker or drugs worker at the review. The officer told the investigators that he had alleged another prisoner had tried to make him take drugs. She thought he meant he had not taken any and would continue to resist. The SO also recalled the conversation, but thought that it happened outside the ACCT review.
64. The officer locked him back into his cell at 3.50pm. She recalled that his cellmate was in the cell and the man appeared fine. She said that he had a joke with his cellmate about cleaning the cell. She said to the investigators that his presentation on 27 July: “ ... was probably one of the better days I've seen him”.
65. The officer and her colleague began unlocking the cells on the wing for prisoners to collect their evening meal at 4.45pm. She recalled that, as she had seen him recently, she did not pay any particular attention to his cell when she unlocked it and continued opening the other cells.
66. The cellmate said that he woke up when the cell door was open and found the man apparently asleep on the floor. He said that he had heard him make retching noises over the last few days. He said that he was snoring and he

was unable to wake him. He became worried about his colour and called for help from another prisoner. The prisoner said that he was waiting downstairs when the cellmate called for him to come up to his cell. When he got there, he saw the man on the floor. He felt a pulse in his neck and thought he was breathing. However, shortly afterwards the colour in his face changed and the skin by his ear went blue. He went to summon help.

67. After about five minutes of unlocking cells, an officer became aware of other prisoners (including the first prisoner) calling for her to help the man. She headed back to his cell, with another officer following, and found him lying on his side on the floor in his cell with his head towards the door. She wrote in her statement that she was back within “seconds”.
68. She called a code blue on her radio at approximately 4.55pm and tried to get a response from the man. (A code blue is a radio code used to alert colleagues and healthcare staff that someone is not breathing. The use of codes helps ensure staff bring the right medical equipment to the scene.)
69. The officer thought she got a slight response when she pinched his ear. In the meantime, the other officer asked the other prisoners to leave the cell. A SO arrived from the servery and also believed she got a small response when she lifted his eyelid. Two more SOs arrived and, having noticed that he appeared to be turning blue, suggested moving some of the furniture out of the cell.
70. About three minutes after the code blue radio call, a nurse arrived at the cell. He described his actions to the investigation once he heard the code blue alarm:

“I think we were dispensing in possession medication in upper medical and as soon as the code blue was called I sort of vacated medical with the response bag and the defibrillator.”

71. He asked for help putting the man onto his back. He asked the SO to call the healthcare department for further support and request an ambulance at approximately 5.00pm. He told the investigator that he could tell that he was in a serious condition, as he had turned blue. The SO went to the central office and telephoned the healthcare unit, asking for further equipment to be brought. The nurse said that he found no pulse, so he began cardio pulmonary resuscitation (CPR). CPR involves chest compressions and rescue breaths administered at a ratio of 30:2.
72. Two other nurses arrived at approximately 5.02pm and assisted the first nurse with the CPR. The defibrillator was attached to the man and the nurse inserted a guedal airway (a medical device used to open up his airway). An ambu-bag was applied to him to provide oxygen. (An ambu-bag is a hand-held device to enable oxygen to be administered to a patient.) The defibrillator indicated that there was no shockable rhythm in his heart, so CPR should be continued. The guedal airway was removed and an I-gel airway inserted (used to go further in to the airway and is connected to an oxygen cylinder).

The nurse wrote in her statement that she double-checked that an ambulance had been requested.

73. A doctor arrived between 5.10pm and 5.15pm and inserted a cannula (a small tube) into the man to administer resuscitation drugs (adrenaline, naxolone and atropine). A nurse described the arrival of the ambulance to the investigator: "... the ambulance was there very quickly because very shortly after the doctor had administered the first adrenaline the paramedic arrived, and once the paramedics arrived they took over the resuscitation attempts working with the doctor".
74. Two paramedics arrived at approximately 5.15pm and were briefed by the healthcare staff. Further drugs were administered by the paramedics and a senior paramedic arrived. After 35 minutes, the doctor and the senior paramedic agreed that nothing further could be done for the man and CPR was ended at 5.35pm.

### **Liaison with the man's family**

75. A prison family liaison officer was appointed. She and a governor left the prison at 6.30pm to break the news to the man's nominated next of kin, his mother. However, the address that he had provided for his mother was no longer accurate, and they were unable to find the correct house. The prison tried a number of methods, including asking some of his friends if they knew where his mother lived. Despite these efforts, they were unable to locate his mother and decided to ask the police for help in finding her address. The prison subsequently found out that the police had informed his mother of his death late that night.
76. The family liaison officer, in view of the late visit from the police, decided to contact the man's mother after lunch the next day and telephoned her at 2.20pm. She explained her role as family liaison officer and expressed her condolences. She and a prison chaplain visited the man's mother on 1 August and returned some of his property. They offered the family a chance to visit the prison, but they declined. The prison contributed to the cost of the funeral, and she and the chaplain attended the funeral on behalf of the prison.

### **Support for prisoners**

77. After the man's death, his cellmate was moved into a different cell with another prisoner to support him. The SO told the investigator that approximately twelve Listeners were brought onto the wing to help support any prisoners who needed it. (Listeners are prisoners trained by the Samaritans to provide emotional support to other prisoners.) Prisoners subject to ACCT monitoring procedures were reviewed and support was also available to all the prisoners from the chaplaincy.

## **Support for staff**

78. A hot debrief was held shortly afterwards with the staff involved in the man's attempted resuscitation. (This meeting offered the staff an opportunity to express their initial feelings and seek support should they require it.) The care and support team were informed and available to all staff that needed further support.
79. Staff involved in the attempted resuscitation of the man were involved in the debrief and felt appropriately supported but some other staff who had known him well for a number of years and naturally felt a degree of shock at his sudden death were not included. They told the investigator that they would have welcomed the opportunity to participate. The purpose of the hot debrief is to deal with the immediate incident and we are satisfied that there were appropriate support arrangements in the prison for other staff affected by his death.

## ISSUES

### Clinical care

#### *Overall care*

80. The clinical reviewer writes of the challenge the man presented to healthcare and prison staff:

“He was an individual with complex physical and mental health illnesses and needs. He was reliant on prescribed medication and illicit medication. The records suggest that he exhibited manipulative behaviour to obtain this medication and had inappropriate and dysfunctional coping behaviours in response to stress and anxiety which resulted in recurrent episodes of self harm ... “

81. Despite this, he writes of the overall level of care provided to him:

“There were many areas of good practice demonstrated by staff at HMP Hewell in the care of him. I felt that the prompt multi-disciplinary assessments, reviews and treatments exceeded the care that he would normally expect to have received in the community. The decisions appeared to have been appropriate with his mental and physical health paramount.”

#### *Medication*

82. Although the clinical reviewer considers Hewell to have, in the main, managed the man well, he raises a number of concerns regarding the amount of medication that he was prescribed throughout his time in custody:

“These documented side effects of the individual medications are potentially magnified when the drugs are used in combination. He was taking three medications, Venlafaxine, Pregabalin and Quetiapine, all with warnings regarding possible potential towards cardiac arrhythmia, increased in conjunction with Methadone.”

83. He notes that it is to Hewell’s credit that they made attempts to limit increases in the man’s amount of medications, although in fact his prescriptions increased. He makes the following recommendation which we endorse, with the aim of ensuring that prisoners with a lot of medications are regularly reviewed to limit the risk of toxification:

**The Head of Healthcare should ensure that all patients with complex repeat medication regimes have regular recorded medication reviews with individual prescribers, particularly prior to increasing doses of existing medications or to commencing new medications.**

84. The clinical reviewer is also concerned about the level of knowledge prisoners have of the risks associated with methadone. He notes that the man signed a

contract promising not to take any illicit drugs while taking methadone, but the toxicological tests after his death indicate that he did not abide by this. In a recent investigation undertaken by this office, the issue of educating prisoners about the risks of methadone was also raised. The recommendation is repeated below:

**The Head of Healthcare should ensure that patients are reminded that methadone is unlike other opioid medications and compliance with the medication is essential, as non-compliance could be fatal.**

*Cause of death*

85. The clinical reviewer also explains the conditions that led to the man's death:

"At post mortem he was found to have a very tight narrowing in one of the main arteries supplying blood to his heart. Whilst there were no histological features of myocardial fibrosis [damage to heart valves] to indicate previous heart muscle damage attributable to this, such a degree of stenosis [narrowing of an artery] would put him at risk of an abnormal heart rhythm, developing particularly if his blood was inadequately oxygenated."

86. He writes that there was an opportunity to find out more of the narrowing of the man's arteries, but he declined to pursue it:

"He had been referred for assessment and investigation to a cardiologist but signed a witnessed disclaimer/refusal to attend and thus a potential opportunity to diagnose this underlying medical problem was missed."

87. With regard to the cause of death, the clinical reviewer comments:

"The pathologist who performed the post mortem stated: *The combined effects of the medication he had taken caused a degree of respiratory depression, resulting in lowering of his blood oxygen and rendering his heart muscle vulnerable to developing an arrhythmia in the face of the tight coronary artery stenosis.* I would also add that Methadone in conjunction with Pregabalin, Quetiapine and Venlafaxine are also recorded in the BNF [British National Formulary] as potentially incurring an increased risk of cardiac arrhythmia."

88. He notes that not all of the medication prescribed to the man was found in his body after his death, but traces of mirtazapine (a sedative antidepressant) (which was not prescribed to him) was found in the toxicological tests. These findings suggest that he was not accurately taking the medication prescribed for him, supplementing it illicitly and possibly diverting some of his own prescribed medication.

## **Methadone prescription**

### *The decision to prescribe methadone to the man*

89. The man was prescribed methadone to enable him to cope with the withdrawal symptoms he faced from the Subutex he had illicitly taken on the wing. The reviewer writes that the decision to do so “... seem[s] entirely appropriate and decisions were made in the best interests of his physical and mental health.”

### *The level of the man’s methadone prescription*

90. However, the clinical reviewer is concerned that the prison initially started the man on 20 milligrams (mg) rather than the usual initial dose of 10mg, and then gradually increased the dose to 40mg. He asks whether a more individual plan should have been developed for him, given the varied medication prescribed to him:

“He was clearly an individual at risk from toxicity due to the multiple prescribed medications he was already taking and due to the recorded and noted concerns detailing aspects of his physical health. Such an individual with complex issues and polypharmacy should be given greater consideration regarding a more personal titration regime. There appeared to be no need or urgency for him to be given what was effectively a maximum recommended titration. Smaller increments at more prolonged intervals would have seemed to be more appropriate.”

91. Methadone titration prescriptions can be modified to fit the specific circumstances of the prisoner concerned and, given the man’s level of medication (licit and illicit) further thought could have been given to a more gradual titration. The clinical reviewer makes a recommendation concerning this which is included in an amended format. The recommendation is similar to the recommendation made at paragraph 3.91 of the most recent HMCIP report of 2009 which identified the need for prescribing regimes to be based on individual need:

**The Head of Healthcare should ensure that a smaller initial methadone dosage and smaller incremental increases at more prolonged intervals are considered for prisoners at a higher risk of mixed-drug toxicity.**

### *The monitoring of the man’s methadone prescription*

92. Prisoners on the man’s wing attend the treatment hatch in the healthcare centre to receive their dose of methadone, usually in the early afternoon. Nursing staff ensure that the correct amount of methadone is dispensed, and check that each prisoner does not appear over-sedated. Any concerns about prisoners would be raised with the specialist substance misuse nurses. The clinical reviewer comments on the level to which he was monitored outside of his visits to the medication hatch: “there needs to be formal processes for review and enhanced observation of high risk individuals, especially in the first five days of methadone induction”. The reviewer discusses the possibility of

fatalities from methadone at dosages as low as 20mg and because: “He was clearly at risk of toxicity due to his prescription drugs ... ” makes the following recommendation which we endorse:

**The Head of Healthcare should ensure that prisoners considered at high risk of toxicity are observed and monitored by healthcare staff in addition to the regular medication dispensation times.**

### **The security of prescription medication**

93. There were concerns that the man was taking medication not prescribed to him. An officer explained the staff’s suspicions:

“... he’d hinted at it, not with other prescribed meds, he admitted the Subutex use to me and another prisoner said ‘oh, this is his sweet shop this spur is, it’s a sweet shop to him’, and I said what do you mean? He said ‘well, everyone else’s meds’, and we kind of knew but we could never prove it because he was on so much medication and symptoms of that medication and every time we did a cell search we never found anything.”

94. Prescribed medication can be procured in a number of ways in prison. It can be secreted when dispensed at the medication hatch and then traded later. It can also be smuggled into the prison, or prisoners allowed medication in their possession can trade it or be bullied for it. The safety and security of a wing can be affected by prisoners trading medication. Given the number of medications the man was prescribed and his continuing health problems, his involvement in such activities could have had a serious impact on his physical health.

### *Methadone dispensation*

95. The man was given his methadone daily in the healthcare department. While the nurses measure and hand out the methadone, officers observe the prisoners to ensure that they take it correctly. The officer explained this role to the investigator:

“ ... what I do usually is being liquid you can sort of see that, you know, if that doesn’t move then to me they haven’t swallowed, but then I have a conversation with them. If they’ve got a mouth full of methadone they’re not going to be able to have a chat with you.”

96. At Hewell, the prisoners approach the counter and are given their methadone in a cup. They are then asked to drink a cup of water afterwards in order to show that they have swallowed all of the methadone. Nursing staff and officers work together well to try to ensure that no methadone is deliberately diverted.

### *Medication dispensation on houseblock 2*

97. It is only methadone that must be collected from the healthcare centre by B spur prisoners, and all other medications are collected from a medication hatch on houseblock 2. Similar arrangements to those for methadone dispensation apply: nurses dispense medication, and officers supervise the queue. Water is available to help prisoners 'wash the pills down' but it is not mandatory for them to do so. The nurses have a responsibility to ensure, to the best of their ability, that the prisoners swallow the medication, and the officers are there to ensure the environment is secure and prevent any prisoners acting inappropriately.
98. Healthcare staff expressed concern to the investigator about the level of support from officers during medication dispensation on houseblock 2. It was felt that officers were not sufficiently supportive of nurses in managing and supervising the queue and assisting with the integrity of the medication dispensation. This problem was considered to be particular to houseblock 2, rather than the wider prison.
99. Officers were also concerned about the arrangements for dispensing medication on houseblock 2. A SO explained:
- “... there'd be prisoners concealing stuff while they're up there and there wasn't much really from the nursing staff in terms of checking mouths. In my opinion it shouldn't be the officers checking their mouths because we don't really know what we're looking for. There needs to be a concealing policy in place from the nursing staff. They can check. I've not seen a nurse check whether somebody's taken their meds or not so it's quite difficult. ... To me at this prison there doesn't seem to be a procedure in place.”
100. It is clear that there is some misunderstanding regarding the responsibilities of officers and nurses during the dispensation of medication. The responsibility for the safe dispensation of medication must be shared, and both nurses and officers should be clear about their roles. When asked if there is a policy covering this matter the SO responded: “I'm not aware of one. I have asked other staff if they have heard of such a policy and they've said no. Whether there is one I don't know”. The investigator was provided with a copy of 'Medicines Policy – Policy and Procedure for the Prescribing, Requisition, Storage, Administration and Control of Medicinal Products 2009/10'. This policy covers all staff responsible for the above within the PCT (including prison healthcare) and states:
- “Responsibility for the process and procedures for administration of medicinal products in the hospitals, community units, prisons and clinics lies with the appointed registered health care professional in charge and the assigned registered health care professional in charge on any particular day or shift.”

101. While this may be so, it is clear that the effective and secure dispensation cannot be ensured without co-operation from prison officers. The investigator raised this matter with the Deputy Governor and was assured that it is being looked into. To that end we make the following recommendation:

**The Governor and Head of Healthcare put in place effective systems to ensure the security of all medication dispensed in the prison.**

*Coping with the man's ability to procure medication*

102. There is substantial anecdotal evidence, and reports from the man himself, that he used to supplement his prescribed medication with illicitly sourced medication. The SO explained to the investigator why it was a difficult problem for prison staff to tackle:

“We do the cell searches and obviously if there's something found on that we can take action with it. We can submit SIRs [security information reports] to security to get people MDT'd [mandatory drug tested] to get them drug tested to see if there is anything in their system. It's quite a common thing people keeping their meds back holding them in their mouths to then deal on C spur in particular I think. A lot of staff are checking the mouths of the prisoners to try and reduce the amount that they can get back to the spur to sell. It's a difficult thing to manage to be honest.”

103. Another problem was that, on a normal population wing, prisoners suspected of such behaviour could be relocated to remove them from their supply of illicit medication and potential customers. This was hard to achieve with the man. As he was an own protection prisoner, the investigator was told that the prison could not place him back with the general population unless he signed a disclaimer to that effect. Naturally he was unwilling to do this and it would be inappropriate for prisons to ask prisoners to put themselves at risk. Another option would have been to move him to B spur, which contained the vulnerable prisoner population separated due to the nature of their offences. However, owing to his personal history he was very resistant to going to B spur and staff said they were concerned about risking his wellbeing in other ways if they enforced this decision. An officer explained this dilemma:

“He was located on 5 (B Spur) for a period of time and his mental health deteriorated a lot. He was self-harming through the roof because he was surrounded by sex offenders, so C spur, seg [the segregation unit] or medical were the only places.”

104. The man was not sufficiently unwell to be located for a long time in the healthcare unit and the segregation unit was not an appropriate alternative particularly because of safer custody concerns, his history of self-harm and the restricted regime in the unit. It was a difficult problem for Hewell to manage, especially as they rarely uncovered clear proof of his wrongdoing. When he came to the officer to admit to his problem with illicitly using Subutex, she explained to the investigator that such a disclosure is hard to treat as a

discipline issue as it could threaten the chance of prisoners talking confidentially to staff in the future about such matters and getting appropriate treatment. We agree with this approach.

105. His particular circumstances and the lack of direct proof made this a difficult challenge for Hewell. This was further complicated by the wish to encourage prisoners such as him to feel confident that they will be supported if they seek help with addiction problems (something that was well-managed when he reported his addiction to Subutex). A more discipline focussed approach could have resulted in him concealing his addiction, using more dangerous substances and escalating his self-harm. All prisons face the challenge of prisoners diverting and taking medication not meant for them and using other illegal drugs. It is unfortunate that he took the choices he did and, in the circumstances, the prison adopted a reasonable approach. .

*Was the man noticeably over-sedated?*

106. There are conflicting accounts from staff and prisoners regarding the degree and consistency of the man's lethargy and sedation in the days before his death. He was described as someone who frequently stayed in bed and habitually slurred his words throughout his time in custody. However, it is not clear the extent to which this increased towards the end of his life.

107. An officer explained to the investigator that the man did appear very lethargic at times:

“he could be very lethargic, very dopey, ... and especially towards his death there was concerns that I put in his ACCT form how he's behaving today very lethargic, very dopey, slurred speech, things like that, so there were concerns ... he became a lot in my opinion became a lot worse in the last couple of months before his death. His weight ballooned. He gained a lot of weight.”

108. An officer also commented “he did actually get to be a bit sluggish more than usual in my opinion so yes”. The SO did not feel there was a great change in his behaviour, and none of the nursing staff raised concerns that he was over-sedated when he collected his medication. The clinical reviewer writes of the matter:

“... he was described as lethargic and would often lie in bed most of the day if he could. He appeared to have put on a considerable amount of weight, was described as having a bloated appearance, and at times was noted to be breathless on minimal exertion and on occasion to slur his words. There were concerns expressed from various sources regarding deterioration in his physical health and possible over-sedation, but at other times he was recorded as seeming much better and brighter.”

109. It is difficult for officers to assess changes in prisoners when they are not aware of the medication they are on. The man's condition was never

assessed as sufficiently concerning for his medication to be reassessed or stopped. During a meeting with senior healthcare staff, the investigator was told that nurses are required to look for evidence of over-sedation each time they dispensed methadone. There is a clear policy outlining what they should look for. The policy explains that if they believe someone is over-sedated, the nurses should tell a specialist substance misuse nurse who would see the prisoner as soon as possible. An assessment would then be made and the prisoner might have their prescription reassessed by a doctor.

110. Without any incontrovertible evidence, it is not possible to declare that the man was over-sedated in the days leading up to his death. Owing to his variable presentation different members of staff recall his behaviour and appearance differently. The level of medication that he was on and his continuing health problems made such accurate assessments hard. However, it is notable that the nursing staff never considered his behaviour at dispensation times to be of such concern that his medication was refused.

### **Assessment, Care-in-custody and Teamwork procedures**

111. The man was made subject to ACCT procedures when he first returned to Hewell on 23 August 2010. He had a long history of harming himself which largely involved, although was not limited to, cutting himself. Staff identified a number of potential triggers for this behaviour including a lack of tobacco and sugar, and changes to his medication. His initial CAREMAP outlines the areas that the ACCT process needed to try to resolve to reduce the risk of him harming himself further. It included goals to include physical and mental healthcare staff in his ongoing care. This CAREMAP was replaced by a more detailed one created by a SO in early 2011. This CAREMAP formalised the meetings with healthcare staff and included the timing of their meetings.
112. Although he had regular contact with staff from healthcare (in particular a nurse), it is noticeable that the ACCT process was largely devoid of healthcare input. The SO was involved in the majority of case reviews but, while this consistency is encouraging, the only other staff usually involved were prison officers. Prison Service Order 2700 (Suicide prevention and self-harm management) states that for all case reviews,

“One of the attendees must be the named Case Manager (and failing that, the Manager responsible for the prisoner’s location), one a residential officer who works in the area where the prisoner is located and the other an appropriate member of non-discipline staff.”

113. This was the mandatory baseline requirement and particularly necessary for someone such as the man with such health and substance use concerns. At his final case review, the only members of staff involved were an officer and senior officer. At this meeting he complained of feeling ‘groggy’ and, although the SO said that she would speak to healthcare staff about this, the conversation could have happened then if someone from healthcare had been present. The combined expertise from different departments could only have

benefited the review. The nurse who had a lot of contact with him regarding his mental health, stated that her involvement in the ACCT process was:

“not as often as I would have liked to. I think there were times when ACCT reviews would be done and I wasn’t aware of the ACCT reviews being done. I didn’t get involved as often as I would have liked to have been. ... There is a need to build stronger links with Safer Custody.”

114. We have found in other investigations that knowledgeable staff from different working areas who know the prisoner are vitally important for the ACCT process to work effectively. The Inspectorate’s last inspection in 2009 also raised concerns about the lack of multidisciplinary reviews, and recommended that this should change. While we acknowledge that cross-departmental staff were involved in different meetings regarding the man, the ACCT process works most effectively when all relevant staff are involved. This was particularly true of him, whose needs crossed between discipline and healthcare staff.

**The Governor should ensure that specialist staff, and those already involved in the care of a prisoner, should attend ACCT case reviews**

### **Resuscitation**

115. When the man was found by his cellmate, the alarm was quickly raised but staff were unable to save him. The clinical reviewer writes of the resuscitation attempt:

“The emergency procedures and the resuscitation procedures employed after the alarm was raised including the sending and the arrival of the ambulance service all appear to be timely and appropriate.”

## CONCLUSION

116. The man was a physically unwell man who also took a significant amount of medication, both prescribed and illicit. While Hewell had, and has, a responsibility to limit the ability of prisoners to illicitly supplement their prescribed medication, it is a difficult and ongoing challenge. He presented an extreme example of this, due to the difficulty in moving him to another part of the prison and his readiness to respond to changes in his medication with bouts of self-harm.
117. Despite these obstacles, there are areas that Hewell can improve on. When dealing with such highly medicated people as the man, further consideration should be given to providing them with a personalised methadone titration prescription. While it is clear that he had a lot of interactions with relevant staff, it is disappointing that these were not brought together regularly at ACCT reviews. In addition, it was concerning to learn of the lack of partnership working on houseblock 2 between nursing staff and prison officers to help ensure the safe and effective dispensation of medication.

## RECOMMENDATIONS

1. The Head of Healthcare should ensure that all patients with complex repeat medication regimes have regular recorded medication reviews with individual prescribers, particularly prior to increasing doses of existing medications or to commencing new medications.

**Accepted** - *The Substance misuse team will review all patients prescribed multiple medications in formal review meetings. A medication review template will be designed and added to "system 1". The Substance Misuse Policy will be amended to reflect this recommendation.*

2. The Head of Healthcare should ensure that patients are reminded that methadone is unlike other opioid medications and compliance with the medication is essential, as non-compliance could be fatal.

**Accepted** - *The Substance misuse team do this as part of their regular consultations with patients. The Substance misuse team will develop leaflets and posters to advise patients that compliance with their medication regime is essential. All nurses will be advised not to dispense methadone if the prisoner appears over sedated.*

3. The Head of Healthcare should ensure that a smaller initial methadone dosage and smaller incremental increases at more prolonged intervals are considered for prisoners at a higher risk of mixed-drug toxicity.

**Accepted** - *Prisoners who are identified in Reception in need of opioid medication will be prescribed in line with their current prescription (where this has been validated). Other prisoners will be commenced on 5-10ml of Methadone and titrated up to 40ml. Smaller incremental increases over a longer interval will be considered for those patients who are at risk of mixed drug toxicity. The Substance Misuse Policy will be adjusted to reflect this.*

4. The Head of Healthcare should ensure that prisoners considered at high risk of toxicity are observed and monitored by healthcare staff in addition to the regular medication dispensation times.

**Accepted** - *Prisoners at risk of toxicity will be observed and monitored by Healthcare staff at regular medication dispensation times and at other times. During the week the service will offer a daily stabilisation clinic, where the nurse will see every prisoner undergoing titration/stabilisation. Their treatment will be adjusted accordingly. This recommendation will be reflected in the Substance Misuse Policy.*

5. The Governor and Head of Healthcare put in place effective systems to ensure the security of all medication dispensed in the prison.

**Accepted** - *A Security Policy document will be produced that will outline the requirements for storage transportation and issue of all medication in the*

*prison, this document will have a signed agreement from the Head of Healthcare and the Governor.*

6. The Governor should ensure that specialist staff, and those already involved in the care of a prisoner, should attend ACCT case reviews

**Accepted** - *HMP Hewell's Safer Custody Policy will reflect this requirement. This will be supported by a schedule of management checks up to and including senior managers to be included in the Policy.*