



A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP Elmley
in October 2012**

Our Vision

*'To be a leading, independent investigatory body,
a model to others, that makes a significant contribution to
safer, fairer custody and offender supervision'*

This is an investigation into the death of a man at HMP Elmley in October 2012. He took an overdose of medication that he had not been prescribed. He was 50 years old. I offer my condolences to his family and friends.

A clinical reviewer was appointed to conduct a clinical review of the man's care at Elmley. The prison cooperated fully with our enquiries.

When the man first arrived at the prison in May 2012, he was monitored under suicide and self-harm prevention procedures, but the monitoring stopped after a month when it was considered he was no longer a risk. After his death, a note was found in which he said that he found prison difficult and that no staff or prisoners were to blame for his death.

The investigation into the man's death has identified a need for improvements in a number of areas. He died of an overdose of medicine that he was not prescribed and Elmley requires much better medicines management and a robust strategy to reduce illicit trading in prescribed medication. The prison also needs to improve its suicide and self-harm monitoring procedures. Above all, the emergency response to him was chaotic and disorganisation even extended to the prison unnecessarily delaying notification to his next of kin. Elmley must learn from these mistakes.

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

November 2013

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SUMMARY

1. The man was charged with a serious sexual offence and was remanded to HMP Elmley in May 2012. He was 50 years old and it was his first time in prison.
2. At reception, a mental health nurse started suicide and self-harm prevention monitoring because the man threatened to kill himself. The next day, another nurse assessed his mental health and concluded that he needed no mental health support. His risk was reviewed regularly and, on 5 June, it was decided he no longer needed monitoring.
3. In July the man was diagnosed with sciatica and the doctor prescribed an antidepressant to manage the pain. The doctor noted that he had thought of suicide but did not think he was at risk of carrying it out. In August another doctor prescribed a different antidepressant to treat depression. He was not referred to the mental health team, but he was assessed by a mental health nurse before and after visits to court.
4. Prison staff believed the man to be happy and positive. He told officers and prisoners that he liked his job as a cleaner. However, during telephone calls to his wife he seemed very low and at risk of harming himself. The security department reported to his personal officer that, during a telephone call on 1 October, he had threatened to take his life. When an officer spoke to him, he said that he had been upset but was now fine. His assurances convinced the officer and suicide prevention measures were not started.
5. The evening before he died, the man had spent the evening watching television and sharing food with the two other prisoners in his dormitory cell. The next morning his cell mates raised the alarm when they became concerned about his breathing, which sounded very laboured. They had tried to get a response from him, but could not wake him. A member of staff who responded to the alarm called for assistance, but did not enter the cell until other staff on night duty arrived ten minutes later. Another five minutes elapsed before a nurse reached the cell. Officers attempted resuscitation, and an ambulance was called. Paramedics arrived and pronounced him dead at 1.40am. The post-mortem examination reported that he had died from an overdose of propranolol, a drug he had not been prescribed.
6. We are concerned about the operation of suicide prevention measures at Elmley, the speed and adequacy of the emergency response, and the delay in calling for an ambulance, when it was apparent there were serious concerns about the man's health. He was able to obtain a quantity of medication that he had not been prescribed and we make recommendations about risk assessments for prisoners to have medication in their possession, as the security of dispensing arrangements. Finally, family liaison arrangements after a death in custody need improvement.

THE INVESTIGATION PROCESS

7. The Ombudsman was notified of the man's death on 28 October 2012. The investigator issued notices informing staff and prisoners at Elmley of the investigation and asking anyone who had relevant information to contact her. No responses were received.
8. The investigator visited Elmley on 31 October 2012. She met the Governor and the prison's senior management team. She interviewed the two men who shared the man's cell, visited the cell, and obtained relevant documents.
9. The investigator informed the Coroner for Mid Kent and Medway about the investigation. The post-mortem report found that the man died from propranolol poisoning, a beta-blocker which he was not prescribed. The Coroner has been sent a copy of this report
10. The local PCT appointed a clinical reviewer to review the man's clinical care at Elmley. The clinical reviewer was given relevant prison and medical records. The clinical reviewer and investigator carried out joint interviews on 20 and 29 November, and the investigator carried out more interviews on 6 December. The investigator provided initial feedback to the Governor.
11. One of the Ombudsman's family liaison officers contacted the man's family to explain the purpose of the investigation and to identify relevant matters for the investigation to consider. His wife said that he had talked about suicide during telephone conversations. She said officers were aware of the conversations and wanted to know why he was not monitored. She wanted to know how her husband obtained the medication that killed him and was concerned that one of his cell mates seemed to know that he had taken his own life. (She was unaware at the time that her husband had left his cell mate a note stating this.) She was also concerned that the police had told her of her husband's death and that they had only been able to give her limited information about what had happened. No further comments were made on the draft report.

HMP ELMLEY

12. HMP Elmley is part of the Sheppey group of prisons, which includes HMP Standford Hill and HMP Swaleside. Elmley serves courts in Kent and holds both remanded and sentenced adult men, as well as unsentenced male young offenders (those aged 18-21 years). It can hold more than 1,200 prisoners in five houseblocks, with a mixture of single, double and triple cells.
13. The local PCT commission healthcare services at Elmley. The healthcare centre includes a 29-bed inpatient unit.

Her Majesty's Inspectorate of Prisons (HMIP)

14. The most recent inspection of Elmley was in March 2012. The Inspectorate found that incidents of self-harm were lower than in many local prisons and those in crisis received good levels of care, particularly from Listeners (prisoners trained by the Samaritans to support other prisoners). However, inspectors noted that not all night staff had the confidence to deal with emergency situations and some were unable to open the cell key pouches used in an emergency.
15. The Inspectorate found that health care provision was good, but there was too much reliance on agency staff to address staff shortages. Prisoner perception of healthcare was poor. Loose strips of tablets were found in most treatment rooms which were not properly accounted for. The Inspectorate recommended that record-keeping for medication should be improved. In relation to misuse of drugs, inspectors found that misuse of diverted prescribed medication was more of an issue than drugs coming into the prison.

Independent Monitoring Board (IMB)

16. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community who monitor day to day life in the prison to help ensure that proper standards of care and decency are maintained. The last published report by the IMB for Elmley in 2011 noted that there had been a decrease in the number of ACCT (Assessment, Care in Custody and Teamwork, self-harm monitoring documentation) which was seen as an encouraging trend. The Board was concerned that some prisoners (like the man) continued to be held in triple cells which the IMB did not regard as decent conditions.

Previous deaths at Elmley

17. We investigated two deaths at Elmley in 2011, in which we made similar recommendations as in this case about healthcare's poor record keeping. The man's death was the first of three apparently self-inflicted deaths at HMP Elmley in 2012. In these cases there were concerns about medicines management and supporting prisoners at risk of suicide and self-harm.

18. In an investigation carried out in 2010, we were concerned that staff did not have access to face masks in an emergency. We repeat this concern in this report and make a related recommendation.

KEY EVENTS

19. The man appeared at Magistrates' Court on 28 May 2012 charged with a serious sexual offence and was remanded to HMP Elmley on 28 May 2012. He was committed for trial at Crown Court. It was his first time in prison.
20. At his initial health screen the man told a nurse that he had ruined his 32 year marriage. The nurse described him as very low in mood, subdued and lethargic. He told the nurse that he would end his life if he had the opportunity. He signed an agreement to hold medication in his cell, although he was not prescribed any at this point.
21. The nurse referred the man for a mental health assessment and opened an ACCT document (Assessment, Care in Custody and Teamwork, the prison service process designed to identify and support prisoners at risk of suicide or self-harm). The nurse noted that this was his first time in custody and that he had been charged with a serious offence which could affect his family and business.
22. A Senior Officer (SO) agreed that the man should be allocated a cell on the vulnerable prisoners' unit as he might be at risk from other prisoners because of the nature of his alleged offence, and that he should not be allowed to hold any medication in his possession until his risk had been more thoroughly assessed.
23. On 29 May, the man told a doctor that he had no physical health problems, but he felt low. The doctor noted that he was due to be assessed by the prison's mental health team and that a decision about any medication would be made after that assessment. He told the doctor that he had never self-harmed, taken an overdose or tried to kill himself. He asked for some paracetamol for occasional headaches. The doctor prescribed him 36 paracetamol tablets to be dispensed individually from the wing's treatment hatch when he needed them.
24. An officer assessed the man's risk of self-harm later that morning. He told the officer that he would not harm himself, but would kill himself if he got "that feeling again". (It is not entirely clear from the record what he meant.) He was worried that his family would disown him because of the charges against him. The officer explained the support available to him in prison.
25. At the first ACCT case review that afternoon, the man was tearful and spoke about the impact his situation had on his family and his business. He told the wing officer and chaplain at the review that the prison did not make it easy for prisoners to kill themselves, that he liked his cell mates and appreciated the support he had been given so far in custody. He identified things he needed to do in the future to keep his family, but these were not recorded. During this review, he was assessed as low risk.

26. An officer completed the caremap, which should set out actions designed to support the man and reduce his risk. The only action noted was that he was waiting for a phone account and had had not spoken to his solicitor. Apparently, this was resolved at 3.00pm that afternoon. There were no other actions in the caremap such as how he would maintain his family ties which he had said were important to him.
27. After the case review on 29 May, a member of the mental health team assessed the man's mental health. He said that he had had no previous contact with any mental health services. He was mainly concerned about the impact of the charges he was facing on his reputation. He said that he occasionally thought about self-harm and suicide, but he did not intend to act on these thoughts, as he was trying to stay positive. She concluded that he did not need support from the mental health team at that time, because there was no evidence to indicate any underlying mental health issues.
28. On 1 June, the man attended court. He was assessed by a nurse before he left the prison and she noted no physical or mental health issues. He was further remanded into custody until 29 June and returned from court at 1.30pm. Later that afternoon, he told an officer that he felt fine after his court appearance.
29. At the ACCT case review on 5 June, it was agreed that the man's risk of self-harm was low and he told staff he was feeling a lot better and wanted to move on from where he was when the ACCT was opened. The SO who chaired the review said he remembered that he had seemed really positive, maintained good eye contact throughout the meeting and gave the impression that he was able to cope. The SO, an officer and the man agreed to close the ACCT.
30. A SO chaired the post closure review on 12 June, which the man and an officer attended. The SO wrote:

"He is really settled now and appreciates the concern shown to sort him out. He now feels he is accustomed to prison life and is just getting his head down and getting on with it. No suicidal thoughts shown or expressed."
31. The man was given a job as wing cleaner, which he seemed to enjoy. He was subsequently put in charge of the cleaning materials for three spurs of the wing.
32. On 2 July, the man told a doctor that he had a bad back and sciatica in his left leg. The doctor also noted low moods, anhedonia (an inability to experience pleasure), suicidal ideations and insomnia. The doctor prescribed 25 milligrams (mg) nortriptyline (an antidepressant) to help manage the sciatic pain rather than for his mood. The doctor prescribed the tablets to be collected 28 tablets at a time, for him to keep in his cell. The doctor did not consider him at risk of suicide or self-harm.

33. The man continued to complain of back pain. On 16 July, a doctor confirmed that he had sciatica and planned physiotherapy, although there is no record that this took place. The doctor prescribed him diclofenac (an anti-inflammatory and painkiller) and misoprostol (an anti-inflammatory). Once again, he kept this medication in his cell.
34. For the next month the man took medication for sciatica and was prescribed more nortriptyline to be kept in his possession. He shared a triple cell with two other prisoners. Prisoner A told the investigator that the three cell mates got on very well together. On 3 August, the man's personal officer wrote in his record that he was having no problems, was getting on well with his cell mates, but would prefer a single cell if one became available. (Personal officers are assigned to prisoners to support them and be their first point of contact for questions of concerns.)
35. At a medical appointment in healthcare on 13 August, the doctor told the doctor that he had pain in his knee and had arthritis. He did not want a blood test, or a knee X-ray, as he was nervous about visiting both the prison's healthcare centre and outside hospital. The doctor recorded that he had a history of depression, was not sleeping properly and was preoccupied with his court case in October. The doctor noted that he had suffered from depression eight years earlier and had been prescribed fluoxetine (prozac) for three months. He said he had no suicidal thoughts and had never deliberately taken an overdose. The doctor prescribed 20 mg fluoxetine, ibuprofen and paracetamol for his knee pain. He noted that he should be reviewed four weeks later.
36. Prisoner A told the investigator that he had seen the man on a number of occasions take more than the prescribed dose of antidepressants at one time. He said that he did not tell officers about this.
37. On 5 September, the man spent the day in police custody assisting with their enquiries. Prisoner A recalled that he was tearful when he returned and needed comforting. He spoke about how he had messed up his life and that of his wife and children.
38. Two days later, on 7 September, a note on his medical record indicated that the man was prescribed nortriptyline, fluoxetine, ibuprofen and paracetamol, all to be kept in his cell.
39. The man received a letter from his solicitor dated 28 September (although it is unclear what date the letter was passed to him). The letter gave further information about the charges against him and his court case. His next court appearance was scheduled for 18 October and his trial was due to begin on 29 October at Crown Court.
40. On 1 October, the man told a locum prison doctor that he wanted more fluoxetine and medication to help him sleep. The doctor described him as a well-adjusted, normal man, with no symptoms of clinical depression. However, the doctor noted that he had a depressive disorder and increased

the dose of fluoxetine to 30 mg, to be increased up to 40 mg if necessary. He was given this medication in his possession. The doctor did not record the reason for this increase or refer him to the mental health team for ongoing support.

41. Also on 1 October, the security department contacted the man's personal officer because routine monitoring of a telephone call he had made to his wife that day indicated that he had said he was going to kill himself. She spoke to him about this and he said he had been upset after his court appearance, but he was okay now. She recorded in the case notes that there was nothing to be concerned about and she did not open an ACCT.
42. On 9 October, the man's personal officer recorded that he told her that he had felt very down at the beginning of the month but was fine now.
43. The investigator listened to recordings of the man's telephone calls between 14 and 27 October. On 14 October, he spoke to his wife twice and in another call to a friend said that he liked his cell mates very much and enjoyed his job as a cleaner.
44. On 17 October, the man telephoned his wife. He told her he did not want anyone to attend court, but said he needed her help, love and support so they could start afresh. He spoke about renewing their wedding vows in the future.
45. The man last attended court on 18 October. A nurse assessed him as he left the prison and recorded that there were no physical or mental health concerns. He returned to the prison later that evening when another nurse saw him and did not note any concerns, but wrote that he was due to attend court again on 29 October.
46. During a telephone conversation with his wife on 20 October, the man spoke about "doing himself in", that there were ways of harming yourself in prison and that he was feeling down. He changed the subject and said he thought he was not worth bothering with, but he realised he had things to look forward to. He again suggested renewing their wedding vows.
47. The man was upset during two telephone conversations to his wife the next day. He said he was taking tablets to help him sleep. He said he was sorry for what had happened and he needed encouragement and support.
48. In a telephone call to his brother on 24 October, the man said he was considering entering a guilty plea to get a shorter sentence. He said that he was getting on well in prison, had made friends and staff got on well with him. In a call to his wife later that day, he asked if she would wait for him because he needed something to live for.
49. On 25 October, the man appeared less positive in a telephone call to a friend. He said he did not know when the trial was to be held and said that he would plead guilty. He said he was concerned about his family and had no energy left.

50. The next day the man made a number of calls to family and friends. He said that he had lovely memories that he was proud of his son and that he loved him, that he was in court the following Monday but did not want anyone to attend. He described his cell mate, Prisoner A, as a 'dear friend' and said he was happy with his cleaning job. He continually spoke about what would happen after his release and asked his wife if she would be there for him. At one point he threatened to take his own life, but appeared calmer when his wife said she would stand by him.
51. Also on 26 October, the man's personal officer noted that the man had been spoken to about his behaviour and inappropriate comments he had made to staff about their appearance and marital status.

27/28 October 2012

52. In a number of calls on 27 October, the man told his wife he loved her and missed her, that he felt very guilty and that when the case went to court it could be embarrassing for his family. He thanked his friend for his friendship and recalled happy memories. He told his mother that he loved her and then became tearful. He told his brother he was proud to have him as a brother and thanked him for all he had done.
53. A SO gave the man an Incentive and Earned Privileges (IEP) warning because he had made inappropriate comments twice the day before. The SO explained to him how his comments and behaviour were perceived. He was described as very apologetic and accepted that he needed to stop.
54. At 4.45pm, the man spoke to his wife and son on the telephone. Prisoner A recalled that he was crying when he got back to the cell, but he would not say why he was upset.
55. The evening before the incident, Prisoner A recalled that he, the man and Prisoner B were locked in their cell at 8.30pm. He said that the man had seemed in good spirits and they had bought chocolate puddings, custard and pears. They shared the food while watching a film on television. After the film, he began watching another film while Prisoner A went to bed at about 11.00pm and fell asleep.
56. Some time later Prisoner B switched a light on to use the toilet. He noticed that the man's breathing was laboured, so he woke Prisoner A. Because of the noises he was making, Prisoner A thought the man was just dreaming and went back to sleep. A few minutes later, Prisoner A was woken up by a banging noise and Prisoner B turned the light on again. Prisoner A saw that the man's arm and leg were hanging over the bed and he had saliva around his face.
57. Prisoner A said he immediately got out of bed. He established that Prisoner B had pressed the cell emergency bell and he then checked the man's pulse. He said he noticed his wrist felt cold but his head felt warm and clammy and

he was staring straight ahead. He remembered that he appeared to be in a deep sleep, but his snoring sounded different. He shouted his name but he did not respond. The cell bell record showed that the bell was pressed at 1.47am, although the clocks were one hour ahead, so it was actually 12.47am.

58. The Operational Support Grade (OSG) who was on night duty on houseblock one, said he arrived at the cell within a minute of the call. Prisoner A told him that there was an emergency. The OSG tried to get a response from the man and then radioed an emergency code blue (that a prisoner has breathing difficulties or is unresponsive), and asked for the emergency healthcare response. Although he said he responded immediately this was logged in the prison's incident log at 12.55am, eight minutes later. Local prison night operating instructions advise a member of staff to enter a cell in an emergency if assessed that it is safe to do so. As the OSG was alone, and the man was in a shared cell, he decided to wait for assistance from other staff rather than go into the cell on his own. While he was waiting the OSG said he continued to try to get a response from him by banging on the door and calling his name. The cell mates also continued to try to get a response. Prisoner A passed a note written by the man under the cell door to the OSG. He said that he could see that the man was sweating heavily and his stomach was rising and falling very quickly.
59. A Senior Officer (SO) was in charge of the prison that night and, when he heard the alarm, he sent an officer to collect the nurse from healthcare, while he went directly to the houseblock. (Nurses do not carry keys at night.) The SO arrived at 1.05am. The OSG passed the note Prisoner A had given him to the SO. The officer told the investigator that he had gone straight to the healthcare centre to collect the nurse, and they went to the houseblock together. The officer estimated that this took them ten minutes, although the incident log noted that they arrived at 1.10am, 15 minutes after the code blue emergency was called.
60. Two officers, who were both on houseblock two when they heard the emergency call, said they arrived at the cell about two to four minutes after the code blue was called, but according to the incident log it was ten minutes. They looked through the observation panel and could see that the man was unresponsive and sweating profusely. His cell mates were still trying to rouse him. The officers opened the cell using the key from the OSG's sealed pouch as he had it ready (at night staff carry a sealed pouch containing a cell key to be used in emergencies). They said the SO arrived a few seconds afterwards, followed by an officer who had been in the Administration Department and heard the call over his radio.
61. The SO asked both cell mates to wait outside the cell. He said that the man looked very grey and felt extremely clammy. He was lying on his back on the bed. He was not moving, but appeared to be breathing. The SO was unable to get a response from him and asked an officer to radio for an ambulance at 1.07am. The officer, who was first aid trained, tried to find a pulse, and eventually thought she felt one on his neck. She could see that his pupils had

not dilated. She said she was fairly certain that he was still alive. The SO heard a rattling sound from his throat and tapped his face to try to get a response. The SO and officer started to attempt cardiopulmonary resuscitation (CPR) and the SO asked two officers to wait for the ambulance at the prison gate.

62. At this point the officer arrived with a nurse. There are conflicting accounts of the nurse's actions once he arrived. Officer A and the OSG did not recall the nurse checking the man at all, although Officer B, who was at the scene, said that the nurse went into the cell and tried to get a response from him and checked his pupils. The SO said that when the nurse arrived he stood there for a while, before attaching an oximeter to the man's finger (to check the blood's oxygen level) while resuscitation continued. The nurse got a towel and placed it over his mouth before beginning to administer rescue breaths. The SO said the nurse gave two breaths before he stopped. Officer A suggested putting him on the floor to carry out the CPR more effectively, but the nurse said this was not necessary. The nurse said at interview that the bed was firm enough to allow effective compressions.
63. Officer B took over from Officer A and together with the SO they continued CPR without a face mask. The nurse took over chest compressions briefly, but the SO resumed these, relieved by Officer B when he became tired. Officer B asked the nurse whether he had a defibrillator with him, and the nurse attached it to the man. The machine's reading said that a shock was not advised and to continue with CPR.
64. Officer B recalled that the nurse left the cell to go to the treatment room on the houseblock to check the man's medical records. The SO and both officers continued with CPR for about five minutes until the paramedics arrived, which would have been at 1.30. They said that the nurse had advised them to stop at that point as the man had died.
65. The nurse said when he arrived at the cell two officers had already begun CPR. He said he examined the man and noted that he had urinated on the bed. He said he checked for a pulse but found none. Also, his pupils were becoming dilated. The nurse attributed the rise and fall and noises coming from him as agonal breathing (final breaths, often described as a death rattle). He used the oximeter to determine whether there was any oxygen in his blood, and a defibrillator to determine whether he could detect a heart rhythm, but found no signs of life. He said that he did not leave the cell and continued CPR until the paramedics arrived.
66. The paramedics arrived at the prison at 1.28am but it took them until 1.35am, seven minutes later, to reach the cell. They noted that the man was cyanosed (blue) and they thought he was dead when they arrived. They pronounced him dead at 1.40am.
67. Although the paramedics had already confirmed that the man had died, a duty doctor was telephone at 2.25am to certify his death. The duty doctor had a

number of emergency calls to make, so a prison doctor certified his death when she arrived at the prison at 9.30am.

68. The man left six notes in his cell. One was to Prisoner A, in which he wrote he wanted to die. Another was addressed to “The Authorities”, in which he said that officers could not have prevented his death, and that the finest search would not have discovered the pills. The third letter was addressed to “Officers”, and asked them to give most of his belongings to Prisoner A. Another note had contact details for a number of family and friends, with instructions about contacting them. There were another two brief notes, one to nurses and another to his brother.

Staff support

69. A debrief was held the next morning before staff went off duty. No concerns were identified about what had happened or how the emergency incident had been managed. A member of the prison’s care team also spoke to staff the next morning. He said that all of the staff who had been involved seemed to be coping well.

Family liaison

70. A chaplain was told of the man’s death when he arrived at the prison the next morning and was appointed as the prison’s family liaison officer. He gathered the man’s family’s details and was about to leave to break the news of his death to them when the Governor told him that the police had already done it. This had been done without the knowledge of the prison and was not in line with the agreed procedures between the prison and the police.
71. The chaplain visited the man’s family that morning, with the deputy Governor. They explained what would happen next, and that the prison would contribute to funeral expenses. The chaplain left his contact details and agreed to keep in touch with the family.
72. The funeral was held on 19 November. The chaplain conducted the service.

Prisoner support

73. Once officers arrived, they asked both cell mates to leave the cell and quickly moved them to another cell. They were given the opportunity to speak to Samaritans or Listeners and given a drink, something to eat and a change of clothes, and were seen by a doctor. An ACCT was opened for both prisoners to support them.
74. The Governor issued a notice to prisoners about the man’s death, reminding them of the support available in the prison. All prisoners being monitored as at risk of suicide and self-harm were reviewed in case they had been adversely affected by his death. A memorial service was held on 29 October, to which the prisoners on his houseblock were invited.

Post-mortem examination

75. A post-mortem examination was carried out on 31 October. The pathologist concluded that the man died from propranolol poisoning. A toxicology examination detected that he had nortriptyline in his blood, along with propranolol, a drug which he had not been prescribed. Propranolol is a beta blocker and used in the treatment of high blood pressure, angina, heart attacks and heart failure.

ISSUES

Response to the Code Blue

76. A Local Notice to Staff 149-12, issued in July 2012 said:
- “Following recent recommendations from the Prisons and Probation Ombudsman, all staff are reminded of the importance of an immediate and swift response should they discover a prisoner who is either hanging or seriously ill.”
77. When he got to the man’s cell, operational support grade radioed an emergency code blue call for assistance. The cell bell record records that the bell was pressed at 1.47am (actually 12.47am as the clocks had not yet been put back). The cell bell was reset at 1.48am. The incident log notes that the OSG arrived at the cell at 00.55am, a delay of eight minutes.
78. As the man was in a cell with two other prisoners, the OSG judged that he should wait for assistance before going into the cell. While he was waiting for help he gathered as much information as he also tried to get a response from him by banging on the door.
79. The prison log shows that the code blue emergency call went out at 12.55am, but first officers did not arrive until 1.05am, a delay of ten minutes. To walk the route from the orderly office, where the SO was based, to the wing should have taken no longer than three minutes, and it is about the same distance between the wing and the healthcare centre. It took fifteen minutes before a member of healthcare staff arrived.
80. One officer said that it took him two minutes to reach healthcare and collect the nurse, and it then took a further ten minutes for them to arrive at the man’s cell as he said the nurse had to gather the emergency equipment. Another officer said it took him between two and five minutes. All the staff statements written shortly after the man had died said that they responded straight away to the emergency call at 00.55am.
81. The control room started an incident log at 00.55am, at the same time a note taker at the cell logged events. Both logs record that a code blue was called at 00.55am. The control room log records that an ambulance was telephoned at 1.05am, the other log notes it being called at 1.10am. The note taker recorded that officers arrived at the cell at 1.05am and the SO, nurse and an officer arrived at 1.10am.
82. There is no apparent explanation for the delays. The operational support grade on the houseblock should have responded to the cell bell more quickly and once the emergency radio call had been made officers and nurses should have gone to the OSG’s assistance without delay. It is vital that prison staff respond to all emergency calls as a matter of urgency.

The Governor should ensure that staff respond to emergency calls without delay.

Calling an ambulance

83. The OSG did not request an ambulance as soon as he radioed the code blue and the control room staff did not call one, yet the Governor's notice to staff in July instructed staff that an ambulance should be requested automatically in a code blue emergency. The notice specifically states that staff should not wait for a manager to approve an ambulance if a prisoner is seriously ill.
84. The code blue was called at 12.55am and an ambulance was not called until 1.10am, when the SO radioed to request one. Any delay in calling an ambulance can have a significant effect on a person's chance of survival in an emergency. National guidance issued to all prisons in February 2011 highlighted the importance of calling an ambulance as soon as possible in an emergency. We make the following recommendation, which was made previously in investigations at Elmley, most recently in December 2012:

The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately when a prisoner appears seriously ill.

Resuscitation

85. The only officer who responded to the call, and who was first aid trained, was Officer A. He did not have a face mask, but administered rescue breaths, along with the SO, Officer B and the nurse, who used a towel. The clinical reviewer is concerned that staff did not use a face mask. After a death in at Elmley in 2010, we reminded the Governor that staff should be issued with face masks. Face masks should be easily accessible on wings and also kept with emergency equipment, so that staff can readily access them when cardiopulmonary resuscitation is needed.

The Governor should ensure that face masks for administering rescue breaths are easily accessible for use in an emergency.

86. During his interview with the investigator, the nurse said he thought that the man had already died when he arrived at the cell even though his pupils had not dilated, which can be a sign that the brain is still active. The nurse said that CPR continued until the paramedics arrived. Officers said that the nurse briefly assisted with chest compressions and rescue breaths, applied the defibrillator when prompted by officers and then decided that resuscitation was futile. Officers said that the nurse told them that the man had died, so they stopped trying to resuscitate him five minutes before the paramedics arrived.
87. The investigator asked the prison and the PCT for their emergency resuscitation guidelines which was forwarded to the PPO on 7 February 2013. The Resuscitation Council (UK) says that resuscitation should be carried out

until qualified help arrives, either a doctor or a paramedic, unless resuscitation is impossible because there are clear signs of rigor mortis. Therefore, unless a prisoner has clearly died (for example they are cyanosed or rigor mortis is present) resuscitation should be attempted and continued until paramedics or a doctor arrives and takes over responsibility for the prisoner.

88. In initial feedback, because of the varying accounts, the investigator suggested that the Governor might wish to conduct an internal investigation into the emergency response, the conclusion of which was forwarded to this office on 1 February. The internal investigation concluded that resuscitation continued until paramedics arrived and that the nurse acted in line with Resuscitation Council guidelines. These findings do not correspond with the evidence from the officers we obtained during this investigation, including the interviews with the staff involved. These indicated that the actions of staff were not in line with the guidance of the Resuscitation Council, that resuscitation should continue unless there are clear signs of death.

The Governor and Head of Healthcare should ensure that staff have clear guidance that in an emergency incident, unless there are clear signs of death, resuscitation attempts should continue until paramedics arrive.

Medication

89. Prison staff should assess prisoners to determine whether it is safe for them to keep medication in their cells, taking into account the risk a prisoner poses from not taking the doses as prescribed, over-medicating or passing on medication to other prisoners. While the man was subject to ACCT monitoring procedures he was assessed as a risk, and not given medication to keep in his cell. When the ACCT was closed, the investigator was told his risk was reassessed and he was subsequently allowed to keep his medication. During interviews, prison doctors seemed unsure of the process for prescribing medication in-possession and said they usually followed nurses' advice because they knew prisoners better. We agree with the clinical reviewer's view that:

“steps must be put in place to ensure that the reason a drug is changed from possession to non-possession must be clearly recorded in the notes.”

90. Prisoner A, the man's cell mate said that the man often took more than the prescribed dose of medication, but he continued to have this given to him in-possession. Prescription charts also show that while he was prescribed fluoxetine in-possession, there are also records that he collected the same medication at the nurses' hatch. The Head of Healthcare said that this would not happen, but could not account for the double recording of the dispensing of the drug. The clinical reviewer suggests that taking a double dose of this medication could create confusion, euphoria and raised blood pressure. Whichever was the case, this is an indicator of poor medicines management.

91. The prison had no policy to manage in-possession medication. Doctors had no clear view about their role in risk assessment and the man's records were unclear. We are concerned that his medication was not well managed and poor management in other cases would allow medication to be traded easily. We make the following recommendation:

The Head of Healthcare should ensure that doctors and nurses safely prescribe, record and dispense medication, and that there are clear procedures to assess the risk of a prisoner holding medication in possession.

92. The post-mortem report found that the man died from an overdose of propranolol, a drug which he had not been prescribed. The investigator asked the prison to examine how he was able to obtain this medication. The prison's investigation, forwarded to this office on 1 February, found:

“In conclusion I can find no specific evidence that suggests that medication was passed on to the man by prisoners who were prescribed propranolol at the time of his death. It goes without saying that this investigation relies solely on information provided by the prisoners interviewed and this can sometimes be an unreliable source of information.

There is some intelligence which indicates that prisoners B and F may have been involved in passing medication to others – in some cases under duress – however this relates to others and not the man.”

93. We were told that there were eight prisoners who were prescribed propranolol at the time the man died but they were not on his spur, and the prison's investigation could find no evidence that any of these prisoners came into contact with him. Despite the prison's view, we consider the most likely source was another prisoner. It is a concern that he obtained medication which was not prescribed for him in a quantity large enough for him to overdose. We make the following recommendation:

The Governor and Head of Healthcare should ensure there is an effective drug strategy to help reduce trading of prescribed medication.

Mental health assessment

94. The clinical reviewer considered whether the man should have been referred to the mental health team again, once he was prescribed antidepressants. He was satisfied that he was assessed by a mental health nurse before and after every court appearance and police production. The nurse who originally opened the ACCT in May was one of the nurses who carried out these assessments. His last assessment was on 18 October. No concerns were raised at any point.
95. The clinical reviewer is satisfied that the man continued to be assessed and that the decision not to refer him again to the mental health team was reasonable.

Risk of suicide

96. The man's ACCT documentation was not well completed. Section eight of the assessment, ideas to support the prisoner, was not completed. The two case reviews were chaired by two different senior officers, attended by any officer on duty and without input from the healthcare department. A chaplain should have been invited to the second review, but was not. There was also no record of him seeing a member of the chaplaincy, despite his request on 29 May. The caremap which is used to record actions to help a prisoner only had one action: to give him telephone access to his solicitor, rather than other actions to help reduce his risk.
97. Prison Service Instruction (PSI) 64/20011 notes a number of triggers that might indicate a prisoner is likely to harm himself. These include further charges, court appearances and a family or relationship breakdown. On two occasions staff could have considered raising an ACCT for the man, but did not. In July, the doctor recorded that he had suicidal ideation, but did not consider him at risk of self-harm and prescribed him nortrpyline for pain. On the second occasion, his personal officer spoke to him because she had been told he said he was going to kill himself during a telephone call, but he raised no concerns. An ACCT should at least been considered on both of these occasions, and the reason for not opening it should have been recorded.

The Governor should ensure that all staff consider when to open an ACCT, are competent in completing ACCT documentation, and in the taking the actions required.

Informing the next of kin

98. PSI 64/2011 says that prisons should break the news of a prisoner's death to their next of kin face to face as soon as possible. It is unfortunate that, despite the protocol in place between the police and the prison, police decided to break the news of the man's death to his family. However, had the prison visited the family more quickly, this situation would not have arisen. He was pronounced dead by the paramedics at 1.40am. The chaplain was telephoned at home at 4.00am and arrived at the prison at 7.00am. He waited for death to be confirmed by a doctor at 9.30am (as an on-call doctor was unavailable to visit the prison), before leaving for the family's home. This was unnecessary. He had been pronounced dead by paramedics nearly eight hours earlier and there was no reason to wait for the doctor to certify death.
99. The prison's delay in notifying the man's family was regrettable. There is no reason why they could not have visited the family once the chaplain had their contact details, but instead they did not arrive at the family home until 11.10am. By this time the police had visited the family, although they provided very limited information about the circumstances of his death, which they found distressing.

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

RECOMMENDATIONS

1. The Governor should ensure that staff respond to emergency calls without delay.
2. The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately when a prisoner appears seriously ill.
3. The Governor should ensure that face masks for administering rescue breaths are easily accessible for use in an emergency.
4. The Governor and Head of Healthcare should ensure that staff have clear guidance that in an emergency incident, unless there are clear signs of death, resuscitation attempts should continue until paramedics arrive.
5. The Head of Healthcare should ensure that doctors and nurses safely prescribe, record and dispense medication, and that there are clear procedures to assess the risk of a prisoner holding medication in possession.
6. The Governor and Head of Healthcare should ensure there is an effective drug strategy to help reduce trading of prescribed medication.
7. The Governor should ensure that all staff consider when to open an ACCT, are competent in completing ACCT documentation, and in the taking the actions required.
8. The Governor should ensure that in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.

No	Recommendation	Accepted/Not accepted	Response	Target date for completion	Progress (to be updated after 6 months)
1	The Governor should ensure that staff respond to emergency calls without delay.	Accepted	A Notice to Staff will be published and the Heads of Residence will raise this issue at the Residential Managers meeting for further line briefings.	Complete	
2	The Governor should ensure that all members of staff understand that they should call an emergency ambulance immediately when a prisoner appears seriously ill.	Accepted	Notices to Staff 17/2013 & 30/2013 will be re-issued. The Heads of Residence and Head of Operations will formally raise this matter with their staff on line briefings and monitor compliance.	Complete	
3	The Governor should ensure that face masks for administering rescue breaths are easily accessible for use in an emergency.	Accepted	Face masks are available in all Self-Harm Emergency Response Kits.	Complete	
4	The Governor and Head of Healthcare	Accepted	The De-Fib Policy has been reviewed, updated and re-published to reflect the recommendation.	Complete	

	should ensure that staff have clear guidance that in an emergency incident, unless there are clear signs of death, resuscitation attempts should continue until paramedics arrive.				
5	The Head of Healthcare should ensure that doctors and nurses safely prescribe, record and dispense medication, and that there are clear procedures to assess the risk of a prisoner holding medication in possession.	Accepted	An In-Possession Risk Assessment is now conducted for each prisoner.	Complete	
6	The Governor and Head of Healthcare should ensure there is an effective drug strategy to help reduce trading of prescribed	Accepted	The Clinical Governance Meeting is fully multi-disciplinary including representatives of the 4 providers. Whilst there is no Policy in place this group will review the strategy to address this recommendation.	For discussion 27/06/13	

	medication.				
7	The Governor should ensure that all staff consider when to open an ACCT, are competent in completing ACCT documentation, and in the taking the actions required.	Accepted	Introduction to ACCT, Case Manager & Assessor training will continue to be delivered as resources permit. A NTS will be generated to inform all staff of the flow of actions necessary.	Complete.	
8	The Governor should ensure that in line with PSI 64/2011, the next of kin are informed as soon possible after a prisoner's death.	Accepted	The Governor is committed to continue to ensure this takes place.	Complete.	