

**Investigation into a death in custody of  
a man at HMP Bristol in June 2004**

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

**June 2005**

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This is the report of an investigation into the circumstances surrounding the death of a man at HMP Bristol in June 2004.

The investigation was conducted under the terms of the transitional arrangements agreed between my office and the Prison Service, which came into effect on 1 April 2004. The bulk of the investigative work has been conducted on my behalf by a Governor from the Prison Service, assisted by a member of staff from her own prison. An independent clinical review was conducted by Bristol North Primary Care Trust. I am grateful to all members of the team for their work.

I have structured this report so that the Prison Service investigator's work can be separately identified.

A member of staff from my office liaised with the Prison Service investigator during this investigation.

My officer spoke several times to the man's sister, who was his next-of-kin. I know my officer has offered his sympathy and condolences but I, too, would like to take this opportunity to add my sincere condolences to the man's sister and friends.

I should record here my thanks to the governing Governor at HMP Bristol and his staff for the help the investigators received during the investigation. All staff co-operated fully and readily with the inquiry.

**STEPHEN SHAW CBE  
PRISONS AND PROBATION OMBUDSMAN**

**JUNE 2005**

## **SUMMARY**

The man arrived at HMP Bristol on an afternoon in June 2004. He had been convicted that day on a count of theft, but was awaiting sentencing. The man named his sister as next-of-kin, although he told one of the prison chaplains that they had fallen out with one another and he did not have her telephone number. The man's mother had died some years previously at a time when the man was also a prisoner at Bristol. All in all, it seems that the man had few external support networks.

During his preliminary health screening, the man declared that he was a regular user of heroin and benzodiazepines, and an occasional user of methadone and cocaine/crack. He denied any thoughts of self-harm. The man was seen by a reception doctor that same afternoon, who recorded that the man's mood was stable and that he was not suicidal. Following standard practice in reception when dealing with self declared illicit drug users, the man was given once only prescriptions of dihydrocodeine and diazepam. He was also given a once only dose of zopiclone. A urine sample was taken for drug testing. The results of which would indicate whether the person required a detoxification programme.

The man was located in A-Wing, which specialised in inducting and detoxifying new prisoners. He was allocated to a single cell, the decision to allocate him to a single cell was primarily due to the lack of availability of double cells.

When tested the following morning, the man's urine sample was found to be clear. The man was not told of that result at the time. At 4pm that afternoon, Healthcare nurses began to issue medication to those prisoners with existing or new prescriptions. The man reached the treatment hatch and it was then that he was told that there was no prescription for him. The man argued with the Healthcare nurses, but they were adamant that they could not issue him with medication. Although the nurses assessed the man as angry, he was displaying no physical signs of drug withdrawal. The man then went to the landing office where he confronted a governor who, in turn, asked discipline staff to escort the man back to his cell.

The man was let out of his cell in order to collect his evening meal and at around 5.30pm was locked back in his cell. At around 7pm, the man was found to have hanged himself using a ligature that he had tied to a window latch. He left no suicide note.

This investigation has found that the level of care offered to the man, both as a newly arrived prisoner, and as a patient of Healthcare

services, was appropriate. The negative urine test result, combined with the fact that the man never developed symptoms suggesting him to be suffering from withdrawal, meant that the withholding of detoxification drugs was an appropriate and safe course of action. Despite this, the report makes recommendations for the development of good practice in relation, in particular, to drug testing processes, prescribing procedures and communication to prisoners in relation to prescribing decisions.

# **PRISON SERVICE INVESTIGATOR'S REPORT**

## **INVESTIGATION PROCESS**

As this investigation was undertaken within the period of transition between internal inquiries and those under the auspices of the Prison and Probation Ombudsman (PPO) the method of investigating reflects shared responsibility and inputs.

The PPO officer made the initial visit to the prison and established early contact with the man's next-of-kin, his sister. The PPO officer made the preliminary contact with the Governor at HMP Bristol and representatives of the Prison Officers Association, and also collected and scrutinised the written evidence and accounts by staff. I, as investigator, together with my assistant arrived the following week and carried out interviews over two days with all those staff on duty who had had dealings with the man.

The Governor was briefed on the emerging picture at the close of the second day. Further interviews were carried out by my assistant on a subsequent visit and, with the agreement of the PPO officer, further non-critical interviews were conducted by telephone.

Staff and prisoners were alerted to the investigation by published notice. Other than those identified for interview by the investigation team, one further prisoner took the opportunity to meet and offer information to us.

Initial interviews were taped, but a problem then developed with the tape recorder. By agreement between the investigators, a contemporaneous, detailed written record was made of each interview which has been endorsed by interviewees. It was felt that this would present a common sense and unthreatening approach and provide good quality accessible and comprehensive transcripts for the investigators to work from and interested parties to read.

It was explained to all interviewees that the objective of the investigation was to learn the circumstances of the man's death and to draw from these any lessons to help prevent a further similar occurrence. Interviews were conducted in this spirit. All interviewees were offered the opportunity to have a supporter or representative present; none took up this opportunity. The investigators were content that all interviewees were open and honest with them and that no information was wilfully withheld.

## **HMP BRISTOL**

HMP Bristol is a medium sized Victorian-built local prison, serving courts in the city of Bristol, Avon, North Somerset, South Gloucestershire and Wiltshire. The prison's reception handles on average thirty departures and new arrivals daily in addition to prisoners attending further court appearances and returning at the end of the day. Prisoners are brought into the establishment from court by the escort contractor, Reliance. At busy times of day, in the morning and evening, there are large numbers of prisoners waiting to be processed into or out of the prison.

As a local prison serving a major city with an acute drug problem, Bristol receives large numbers of men presently or previously addicted to 'class A' or controlled drugs. A major role for the establishment is therefore to detoxify new arrivals, both to wean off illegal drugs and to provide support and care to make this experience bearable. Specialist substance misuse nurses and a doctor are employed to ensure this is properly done. Part of their role is to distinguish between those with an acute need for substitute drugs or medication to help with withdrawal symptoms, and others who wish for, but do not actually need, such medication. There is a duty to prevent the creation of an internal market in prescription drugs between prisoners who are prescribed medication and others who will buy or bully this from them. For this reason the detoxification regime is highly regulated and dispensing is closely supervised.

The majority of newly-arrived prisoners will be accommodated for their first few weeks on A-wing, a traditional four-storey galleried wing holding up to 121 prisoners, the majority of whom will share a cell with one other man. A-wing specialises in inducting and detoxifying new prisoners; the average length of stay on this wing is 14 to 21 days, after which prisoners will move to one of the other wings, according to need.

The regime on A-wing commences with unlock at 7.45am when prisoners receive their prescribed medication. Much of the morning is taken up by work, education and exercise. A very brief session of work and education occurs in the early afternoon, and that is followed by a one-hour session when prisoners can associate with one another. From 4pm, prisoners receive their second, and final, doses of prescribed medication for the day. Prisoners also collect their evening meal and return to their cells. Cells are locked for the night by 5.30pm.

Where a prisoner declares on reception that he has a drug addiction, a urine sample will be taken for testing. Medication is prescribed on a once only basis to keep the prisoner comfortable overnight. Contact with the prisoners GP is not made on the first day, instead contact is attempted the second day. We were told that sometimes GP surgeries

respond quickly to being contacted, but this is not always the case. On the morning following arrival, the prisoner is examined by a doctor in the prison's detoxification clinic, and the urine sample is tested in the mandatory drug testing (MDT) unit. Based upon these findings, appropriate medication is prescribed. However, the prisoner is not told about the prescribing decision and no medication is issued in the detoxification clinic. Prisoners receive their medication at the time of treatment rounds in A-wing. The morning treatment round in A-wing takes place before the detoxification clinic is held, so prisoners prescribed medication will not receive their first dose of prescribed medication until 4pm at the earliest. One of the officers interviewed for this investigation described some prisoners in the afternoon treatment queue as 'desperate'.

## **THE EVENTS LEADING UP TO THE MAN'S DEATH**

The man arrived at Bristol prison from Crown Court at 3.30pm on an afternoon in June 2004. Included in the documentation which accompanied the man was a Prison Escort Record (PER) form, which is a form used to pass on information about a prisoner when he is transferred from one agency to another. Box 4 of the form is entitled 'Risk Categories', and it contains a list of 21 possible risks, which are ticked if it is thought that they apply. The man's PER form had been ticked, by the police who took him from court to prison, to show that the risks in his case were: 'drugs/alcohol issues'; and 'suicide/self-harm' issues.

The First Reception Officer said at interview that he only had a vague recollection of seeing the man that day. The Second Reception Officer knew the man from his previous time at Bristol and they chatted briefly. The man was in good humour.

The man was then seen by a reception nurse who carried out a health screening interview. Information taken during that interview included that the man was registered with a GP and that he had been in a psychiatric hospital in 1987 because of a problem with drug addiction. The man declared himself to be a daily user of heroin and benzodiazepines, and an occasional user of methadone and cocaine/crack. The man also reported that he had harmed himself at the age of 20 by cutting his arm. It was possibly this incident that led to the police marking the PER form that the man was at risk of 'suicide/self-harm'. The nurse went on to ask the man whether he had any current thoughts of self-harm or suicide, and he answered that he had no such thoughts. The nurse then ticked a box on the health screening form that she had no concerns about the man's behaviour or mental state. After the nurse had completed her assessment, the man was then assessed by a reception doctor who noted that the man's mood was stable and that he was not suicidal.

Based on his statement of need, and to ease him through his first night, the man was written-up for once only prescriptions of dihydrocodeine (DF 118), diazepam and zopiclone. At the same time, he provided a urine sample for testing to confirm his declared drug use. The man was then located in a single cell on A-wing. The decision to allocate him to a single cell was solely due to cell availability.

The man had a routine pastoral visit from one of the prison chaplains at 10.30am the following morning and this lasted around 20 to 30 minutes. The man was still waiting to see the doctor at that time and he was feeling angry generally with the prison, believing he was being ignored. The man said that being back in Bristol brought back unhappy memories

for him as his mother had passed away the last time he had been in the prison. The man had no contacts outside of prison apart from his sister, but he had fallen out with her and did not have her telephone number. The Chaplain said that if he wanted to resume contact with his sister, he would have to write. At that, the man laughed and pointed to the plaster cast on his right arm. The Chaplain offered to write a letter at his dictation if he wished her to do so. The Chaplain said that the man's mood calmed as they spoke, she believed because he felt he was being listened to.

Later in the morning, the man was seen by a doctor in the substance misuse clinic. It was recorded that the man showed no physical signs of withdrawal and that the urine test result had been received as a negative. The man was consequently not prescribed either maintenance or detoxification drugs, although it would not seem that he was told of that decision at the time.

At midday, the man spoke to a number of the other prisoners when he went to collect his lunch. The man was reasonably content at that time and he asked one of the cleaners for a cigarette. The cleaner replied that he would give him a cigarette later on. Another prisoner told the investigation team that the man had been talking about medication all day and at one stage he said that if he did not get his medication he would be swinging by the end of the night. The prisoner did not report this comment to staff as he had heard that sort of comment from other prisoners in the past and it was not the sort of comment to take seriously.

Some time after 4pm, the man joined the line of prisoners queuing to collect medication. He reached the treatment hatch at 4.45pm and requested diazepam. The First Nurse told the man that there was no prescription of diazepam for him because his urine test had been negative. The man became angry, insisting that the doctor had prescribed diazepam that morning. The Second Nurse, who was standing by the treatment hatch, joined in the conversation to reiterate that as there was no prescription for the man, he could not be given medication. Neither the First Nurse nor the Second Nurse thought that the man was displaying any of the overt signs of drug withdrawal, such as sweating and shivering. Both of these witnesses described the man as angry because he was being denied medication, but not distressed because he was in need of it.

The argument between the man and the two Healthcare nurses continued for four or five minutes. A third nurse witnessed the argument and she too saw no signs that the man had symptoms of drug withdrawal. At interview, the Third Nurse acknowledged that there had been occasions when Healthcare staff had been surprised with urine test

results – specifically, when a negative result had been returned when staff had expected a positive result. The First Nurse gave the same evidence as the Third Nurse with regard to the possible reliability of urine test results. The First Nurse also said that she believed that there had been two other prisoners in the treatment queue on 23 June who had to be told that there was no prescription for them. The First and Third Nurses were both aware that an on-call doctor could be telephoned and asked to authorise a prescription for a prisoner who was showing symptoms of withdrawal, but for whom no prescription had previously been made. The Second Nurse, who had only worked at Bristol for a month, was unaware that this could be done.

Unsuccessful in obtaining medication, the man left the treatment queue and went to the adjacent wing office where he confronted a governor. The governor asked discipline staff to intervene and they escorted the man off the landing and locked him in his cell. Staff then arranged for the man to collect his evening meal on his own after the main body of prisoners had been served and had returned to their cells. This was done in order to avoid confrontation between the man and other prisoners. One of the officers present when the man was collecting his meal made an entry in the wing observation book at 5.10pm: '*[this prisoner] is in an aggressive mood [regarding] his treatments. Be aware of this when unlocking Thurs morning.*'

Just before 7pm the cleaners were let out of their cell to make telephone calls. The cleaner who had earlier promised the man a cigarette went to his cell and saw that the observation window was obscured by a newspaper. The cleaner looked through the small gap between the door and the door-jamb and was able to see that the man was not on his bed. The cleaner called to the man and also kicked the door to attract his attention. On gaining no answer, the cleaner called one of the officers.

The officer went to the man's cell and, on unlocking the door, found the man slumped against the back wall with a ligature around his neck. Help was summoned using a code blue alert – a code blue signifies a prisoner hanging or asphyxiated, a code red signifies a prisoner bleeding. The man was released from the ligature and placed on his bed. Staff could not detect a pulse so cardiopulmonary resuscitation (CPR) was attempted. Healthcare nurses were called to the scene and the ambulance service was summoned. Despite all efforts, the man could not be resuscitated. His food was untouched.

## **AFTER THE MAN'S DEATH**

On arrival at Bristol, the man had named his sister as next-of-kin. He had supplied her address, but not her telephone number. The prison's Deputy Governor, accompanied by one of the prison chaplains, visited the man's sister to break to her the sad news of her brother's death.

## **SUMMARY OF CLINICAL REVIEW**

In accordance with normal practice in investigating deaths in custody, an independent clinical review was carried out into the man's death by Bristol North Primary Care Trust.

In summary, the review concluded that:

- the reception screening was well managed and properly detailed, offering the view that the man was not suicidal and that his mood was stable.
- prescribing diazepam and dihydrocodine was appropriate for the first night. Thereafter, following a negative urine test, there was no reason to continue the medication, indeed this would have been inappropriate without other supporting evidence of withdrawal.
- the negative urine test suggests any prescribed medication or illicit drugs would have to have been taken a long time prior to admission to Bristol.
- the man's care was well managed in Bristol.

## **FINDINGS**

The man was probably not physically addicted to heroin at the time of his reception in Bristol prison. Clearly he was not displaying physical withdrawal signs during his two days in Bristol and he gave a urine sample that tested negative for controlled drugs.

Nevertheless, he was anxious to receive a detoxification prescription, perhaps as a means of smoothing out his period in custody, or for currency, or because he had a psychological dependence on controlled drugs and was undergoing a degree of anger and/or panic at his inability to gain medication.

In a previous period in custody at Bristol, the man had suffered bereavement on the death of his mother. It would seem that he felt he had no one he could rely on or talk to. He had fallen out with his sister, his only remaining family member and having his arm in a plaster cast might have been an added frustration.

The man had been identified as having self-harm potential by the police who ticked the appropriate box on the PER form. No further information was provided about the perceived risk.

The man was seen in reception by a nurse and, separately, by a doctor. The man was noted to be generally in good health. He had had previous regular medical services provided by his GP. The man had had one self-harm incident of cutting his arm. This had occurred many years earlier. He had had one admission into a mental health in-patient facility, also in the long distant past. He was on life-long antibiotic medication following the removal of his spleen. The man's reception health screening did not identify any current self-harm risk.

Staff were not aware that the man had said to another prisoner that he would be 'hanging by morning' if he did not receive medication.

In the case of patients for whom no prescription has been written, it is potentially highly beneficial that where they appear seriously distressed by withdrawal symptoms, nurse-led prescribing occurs. In such a case, the nurse would form an assessment and make recommendations to a doctor. However, in the man's case, the Second Nurse, a new staff member, did not know of the process. Notwithstanding this, the Second Nurse, did not see signs of withdrawal or distress in the man.

There are questions about the reliability of the urine test used at Bristol. Nurses described sometimes suspecting a wrong outcome from this test. The MDT equipment used at Bristol is presumably calibrated to avoid marginal positives and it may be that in some cases prisoners are given

a clear test when they should show positive. It is crucial therefore that clinical judgements are also based on personal observation of the patient and his symptoms, which was the case with the man who died.

Use of the MDT equipment builds an unhelpful element of delay in substance misuse decisions.

Intervals between treatment rounds are rather long for those in withdrawal. Doctors in the detoxification clinic do not see substance misuse patients in time for the morning treatment round and there is no lunchtime treatment dispensing for A-wing. It is our view that for prisoners who may be withdrawing from drugs there is a rather long wait between their reception health check with medication offered to help them through their first night, and their second opportunity to receive prescribed medication, after 4pm on their second day. Many find it hard to wait so long, and were described to us as 'desperate' in the treatment queue.

It would seem that prisoners who have not got a prescription from the doctor do not know this until they arrive for their medication at tea-time on their second day. This leaves them potentially angry and upset at a time of day when there is very little support they can access. Prisoners in this situation would benefit from being told when seen by the doctor in the morning, whether or not they are to be prescribed medication. Prisoners would also benefit from additional advice, whether written and/or verbal advice, that they remain under review and the doctor's decision may be reversed if withdrawal symptoms develop.

The information flows between the prison and patients' GPs is unwieldy and often makes it difficult for prison doctors to make fully informed decisions within reasonable time-scales.

The regime for new prisoners in A-wing is very limited and does not provide opportunities for assessing and supporting new arrivals. This can be exacerbated if new arrivals are placed in single cell accommodation.

## **CONCLUSIONS**

A well developed detoxification strategy operates at Bristol and the needs of addicted and detoxing patients are taken seriously. It is important to note that nurses' observations and opinions can trigger an 'override' in the system so that there is no absolute reliance on urine test results.

Whilst this human element in the clinical decision making process is to be applauded, it does not appear to be as thoroughly understood by those involved as it needs to be. In particular, the Second Nurse was not aware that he could trigger the override through nurse led prescribing, and patients are perhaps not aware of this either. When an addicted prisoner is told that he will not receive any medication for detoxification, he is unlikely to be in a positive or constructive frame of mind, and some greater effort to help them understand the decision is not necessarily final, could be helpful. In the case of a dispute, it might be appropriate for the prisoner to be offered the chance of a second urine test.

In this man's case, there is little reason to believe that a different prescribing outcome would have been reached had nurse-led prescribing been universally understood. Although declaring himself to be in need and clearly expecting to receive detoxification medication, he was not displaying the physical signs of distress that might cast doubt on the negative urine test result.

During the argument at the treatment hatch, staff described the man as angry rather than desperate. He was already suffering negative associations as a result of returning to the prison where he had been held at the time of his mother's death. His anger could very probably have been an aroused and agitated response as a psychologically dependent, rather than as an addicted, person perhaps anticipating an easier experience in custody if in receipt of medication. This could explain his response to the disappointment of the refusal of medication, against his expectations, while coupled with the absence of proof of recent drug use, or of symptoms of detoxification.

We are unable to account for why this man killed himself as he left no evidence by way of a suicide letter. He had had an episode of self-harm many years before and it was possibly that incident that led the police to note his PER form that there was a possible risk of suicide/self-harm. However, the man was seen in reception by both a nurse and, in a separate consultation, by a doctor. Both of these clinicians explored with the man whether he had any thoughts of self-harm or suicide and both concluded that there was no such risk. The evidence of one of the prisoners interviewed suggests that the man may have been working

himself up through the day, and this is supported by the Chaplain's description of him as angry and his later behaviour at the treatment hatch and toward a Governor.

The man received appropriate care from the substance misuse and health care team. There were no decisions in his care that appear flawed. However, we have concluded that the regime on A-wing, given its role as a Detoxification Centre, was not very patient-friendly. While this may have had no impact in the man's case, there may be other scenarios where harm could be averted by tailoring the day's routine better to match the needs of the population. In particular, addicted prisoners have an extremely long wait on the day after reception, because the substance misuse clinic takes place after the morning treatment round and there are no lunchtime treatments. Having been medicated on reception, patients may not learn that they will receive nothing further until the following tea-time. Patients who are prescribed detoxification medication become increasingly anxious and unwell the longer they have to wait for this to be given, and this is very obvious when observing the treatment queue.

## **RECOMMENDATIONS**

### **Local**

- ◆ We recommend that the urine testing, drug prescribing and detoxification regime for newly arrived prisoners be reviewed. Whilst not wishing to be prescriptive, we suggest this review could consider:
  - Testing urine through the use of MDT equipment be supplemented or replaced by testing through the use of a dip strip test. The result of this could be shown to the prisoner and acted on by the prison almost immediately. In the case of a major dispute, a second urine test could be offered for verification.
  - Holding the detoxification clinic before the morning treatment round for A-wing to enable a quicker response in prescribing decisions.
  - Introducing a system to allow medication to be issued when a prescribing decision has been made after a treatment round has ended.
  - Re-introducing the lunchtime treatment round for A-wing to allow Healthcare and wing staff to support patients disappointed or unhappy with their prescription through the afternoon, rather than giving bad news just before the final lock-up of the evening. This would also serve to shorten the hours between medication doses for all prisoners.
- ◆ The regime of A-wing is more suited to the ease of processing and locating new arrivals than to offering a supportive and encouraging experience. A richer more prisoner-centred regime should be introduced for A-wing, ensuring prisoners spend more time unlocked and occupied. The regime pertaining in June 2004 was very thin and offered almost no distraction to prisoners who may be feeling very unhappy or distressed at being in custody.
- ◆ All staff should be reminded that when a PER form contains an entry indicating that a prisoner might be at risk, the reason and background behind that entry being made should be explored fully by reception staff and by the reception nurse and doctor.
- ◆ Cell sharing risk assessment should start with the assumption that first night prisoners should share cells unless contra-indicated.

- ◆ Steps should be taken to increase nursing and other staff awareness of the provision at Bristol for nurse-led prescribing where symptoms of addiction and withdrawal become apparent after a patient has been seen by the doctor.
- ◆ A written guide should be issued to prisoners on being told they will not be receiving medication. This would make clear that an initial refusal to prescribe need not be a once-for-all decision, but could be changed should the need to do so become established.

### **National**

- ◆ We commend the emergency assistance calls 'code blue' for hanging or asphyxiating patients and 'code red' for those who are bleeding. This enables a swift and appropriate response from health workers, wing staff and managers, who are prepared for what they will find before arriving on the scene of an emergency. We recommend this procedure be adopted more widely by prison establishments.