

**Investigation into the circumstances  
Surrounding the death of a man at  
HMP North Sea Camp in October 2006**

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

**August 2008**

This is a report into the circumstances of the death of a man at HMP North Sea Camp in October 2006. The man was found in his room and was pronounced dead by paramedics, shortly after having been discovered. He was 39 years old.

The man's family is understandably devastated by the loss of this popular and well-loved man. I know that the investigation team have already expressed their condolences to the family, and I take this opportunity to add mine.

The investigation was carried out on my behalf by one of my colleagues. A clinical review of the man's healthcare at North Sea Camp was co-ordinated by Lincolnshire Primary Care Trust and undertaken by a medical practitioner. I am grateful for her comprehensive report.

I would like to thank the Governor of North Sea Camp and his staff for their co-operation and assistance with this investigation. Particular thanks go to the Duty Governor who has been most helpful throughout.

The man was a popular prisoner. Having served the majority of his sentence, he was looking forward to returning home, and his family welcomed this. Sadly, his addiction to heroin seems to have got the better of him. It appears that having not used heroin for a considerable time, he used it again the night before his death. I have commented before about drugs in prison, albeit in closed conditions. Substance misuse is a problem for all prisons and North Sea Camp is no exception. However, having reviewed the prison's drug policy, I do not feel that the man's death could have been foreseen.

I apologise for the delay in producing this report. Unfortunately, severe delays occurred in concluding the clinical review. I have commented further on this issue in the report.

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**Prisons and Probation Ombudsman**

**August 2008**

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## SUMMARY

The man had been sentenced to seven and a half years imprisonment in 2004, and was about half way through the time he was expecting to serve. He had spent time at Nottingham, Stocken and Wellingborough before progressing to HMP North Sea Camp, an open prison. This had been his only involvement with the criminal justice system, save 'a few close shaves on youthful drunken nights out'. Prior to his imprisonment, he had run his own business. His family described him as a good father and husband.

The man was described by staff and prisoners as a bright and engaging prisoner. He appears to have formed many close friendships with other prisoners. He was constantly 'telling stories and keeping others entertained'. Having undertaken courses in prison, particularly Estate Agent Management, he had intended to set up his own business on release. He had a complex medical history, having been diagnosed with high blood pressure, heart disease, asthma. He was also taking medication for depression.

The day before he died, the man had a town visit with his family which went well. They said he had been 'his usual self' and was quite cheerful when they dropped him off at the prison. He was later seen going into the room of a prisoner who was alleged to be using heroin.

Later that night the man was seen by other prisoners and staff and appeared unwell. The night officer spoke to him at midnight and also called the night orderly officer to speak to him. The man told them that he had taken too much of his prescribed medication and said he would lie down. The following morning, he was discovered in his room, unresponsive. The officer raised the alarm and staff came to assist him, but they were unsuccessful in their attempts to resuscitate him. He was pronounced dead by the paramedics.

The post-mortem showed evidence of hypertensive heart disease and acute pulmonary oedema. The cause of death was given as hypertensive heart disease and heroin intoxication. Whilst not directly related to the man's death, the clinical reviewer has identified three areas of learning to improve clinical practice. I urge the Prison Health Partnership to consider these and how best to implement them.

## **THE INVESTIGATION PROCESS**

The investigation was opened at HMP North Sea Camp on 11 October 2006, by one of my investigators. Notices were issued, informing staff and prisoners of the investigation and inviting anyone with information to come forward. The investigator subsequently visited the prison on 12 January 2007, to speak to staff and prisoners. She also toured the prison to familiarise herself with the environment and the wing on which the man had lived. All documents relating to the man were examined, including his medical record. The investigator also obtained details of the prison's drug policy and spoke at length to the Governor responsible for the implementation of the policy.

An independent clinical review of the man's health needs at North Sea Camp was carried out by the medical practitioner of Lincolnshire PCT.

The investigator and one of my family liaison officers met the man's family during the course of the investigation. The family raised issues for further investigation and clarification. They were concerned about the man's medical care, in particular his prescribed medications. They were surprised at the volume of medication the man had in his possession and were worried about the possibility of over or inappropriate prescribing of medication. They also wanted to know if he had told the prison staff he was feeling ill the night before he died and if any checks had been made to ensure he was alright. Although in the main they were happy with their treatment by the prison, they were upset to find the prison had sent its contribution to the man's funeral directly to the undertaker without letting them know they had done so. I hope this report goes some way to answering their questions.

## **HMP NORTH SEA CAMP**

HMP North Sea Camp is an adult male open prison for category D prisoners, located on the outskirts of Boston, Lincolnshire. The operational capacity is 306. There are four living units, two with multi-occupancy rooms and single rooms in the two resettlement units.

Since April 2005, healthcare at North Sea Camp has been commissioned by Lincolnshire Primary Care Trust. The healthcare unit at North Sea Camp is equipped to provide basic primary care only and there are no in-patient facilities. Healthcare facilities are available from 7.30am – 5.00pm Monday to Friday, and 8.00am – 11.00am at weekends. General practitioners from a local surgery provide clinics Monday to Friday.

The last full inspection by Her Majesty's Chief Inspector of Prisons (HMCIP) was in April 2004. The report found that healthcare services at that time were delivered in a poor environment, but the standard of service to prisoners was good, clinically competent and respectful. Since the Chief Inspector's report, there has been a change in healthcare management. A new healthcare unit has been built, improving both facilities and services.

North Sea Camp has had three other deaths from natural causes in the last two years. One happened after the man's death and is still under investigation. I have identified no pertinent issues with the other two.

## KEY FINDINGS

On 21 April 2004, the man was charged with possession of a class A drug with intent to supply and remanded to HMP Ranby. Shortly after, he moved to HMP Nottingham to await trial. In his pre sentence report, the man reported that he became involved in serious crime in order to fund his own addiction to heroin. He started using heroin in 2000, after someone recommended it to him as a way of relieving stress. He said that as his life became increasingly pressurised, he found it more difficult to cope and was diagnosed with anxiety. He quickly became addicted, with a daily consumption costing £100. He soon lost his business and home and acknowledged that he had put his family at risk.

The man went through the usual first night in custody procedures at Nottingham prison. He was inducted into the prison regime and reported no problems to staff. He was placed on E wing. This is a voluntary testing wing where all the residents commit to being drug free and make themselves available to be drug tested at any time.

His medical record shows that he had been diagnosed with hypertension at the age of 22, for which he had been prescribed medication. However, he said he had not taken it for a year. His blood pressure at the time was recorded as high. The man told healthcare staff that he had a five year history of drug use, mainly heroin. He explained that he had tried detoxification treatment in the past, but his attempts had been unsuccessful. He was prescribed bendrofluazide and quinapril for hypertension and arrangements were made for weekly blood pressure monitoring. Routine blood tests were also performed. The man was given guidance on the importance of taking his medication as prescribed. He was also advised on diet as he weighed over 20 stone.

A month later, a report from wing staff commented that he had settled onto the wing and got along well with both staff and prisoners. He was described as a good worker who carried out his duties to the best of his abilities. In spite of this, there was some suggestion that the man struggled to conform to prison life and he was subject to several disciplinary charges during this time.

The man's medical notes also show that despite medication, his blood pressure remained high. He was therefore referred to a Consultant Physician at the local hospital. This appointment was cancelled at the man's request. However, the Consultant subsequently wrote to the prison's medical officer. He confirmed that the combination of medication looked good and he made suggestions for treatment modification, if necessary.

In October 2004, the man complained of anxiety and feeling low. He was prescribed paroxetine, used for the treatment of depression, which is documented as improving his mood. He was sentenced to seven years and six months imprisonment on 15 December 2004. In March 2005, he again reported feeling low. At that time, he was assessed as having panic attacks, but was not clinically depressed. The management plan was to increase the dose of paroxetine, to be maintained for 6 months before consideration was given to reducing the dose.

The man transferred from Nottingham to HMP Stocken on 5 April 2005. He did not have a happy time there. His father had been diagnosed with cancer in May of that year, and died the following August. His father had been too frail to visit him during his illness and the man was unable to attend the funeral. He said his father's death had 'knocked him for six' and being unemployed at Stocken did not help, as he spent most of his time in his cell. He applied to move and on 12 September, transferred to Wellingborough. He had hoped to undertake the bathroom course, but by the time he got there it had finished. Fortunately, he was able to do a motorcycle course and completed the City & Guilds Certificate in Motorbike Maintenance. He also began studying in his cell for a certificate in Mortgage Advice and Practice. His wing history file reflects that he had settled down at Wellingborough.

Further changes were made to his medication during this time and his blood pressure measurements improved temporarily. His Atenolol, a betablocker used to reduce hypertension, was stopped because the prison medical officer was concerned that the dosage of 100mg daily was only licensed for the treatment of angina. There were no adverse effects reported in response to this. The man later developed a swollen ankle for which he attended the local hospital Accident & Emergency Department. This was felt to be an adverse effect of nifedipine, a channel blocker used in heart conditions, and symptoms stopped after the medication was withdrawn.

The man also complained of progressive hearing loss in both ears. He was therefore referred to the Ear, Nose and Throat (ENT) department at the Royal Infirmary. There was some delay in attending for his audiology appointment because of his move from Stocken to Wellingborough. His ENT referral was therefore transferred to the local hospital. The man expressed his frustration about the delay in a letter to healthcare. He was eventually seen on 25 April, when the audiogram showed low frequency hearing loss. It was felt that a hearing aid would not be helpful at this stage and arrangements were made for review after 12 months.

Over the next 3 months, several entries in his medical record showed that he repeatedly failed to attend to collect his medication. On two occasions his medication was not available.

The man also complained of worsening anxiety symptoms and the prescription for paroxetine was changed to citaloprim, a different antidepressant. He was also prescribed diazepam, to take when he felt it necessary to assist with his symptoms and propranolol (80mg slow release, twice daily). He told healthcare staff that his anxiety was due to the death of his father and the impending palliative care of his mother, who had been diagnosed with breast cancer. He was also worried about his wife.

The man's medical notes show that on 6 March 2006, he tripped and injured his back and left knee. There was no evidence of significant injury and the pain was managed with painkillers. He was again advised to lose weight to assist recovery.

In July 2006, he transferred to HMP North Sea Camp as a category D prisoner. A review in early August notes that his blood pressure was 'satisfactory'. Other risk factors were checked including family history, blood glucose and cholesterol. He

was given advice and information on weight reduction, low fat diets, anxiety management and advised to start attending the gym. He was re-referred for a hearing assessment at the local hospital in July, because of continued complaints of deafness. He received an appointment for 21 September, but there is no record of him attending.

The man attended the asthma clinic at the prison on 7 August. He said he had no symptoms of asthma and his inhaler technique was assessed as good. He was encouraged to use his inhalers regularly and again advised to start an exercise regime to improve his cardiovascular function.

On 18 September, his blood pressure was recorded as 150/98. His dose of Adalat, an anti angina agent, was increased to 90mg daily. At this time, he was also taking bendrofluazide (a treatment for hypertension) 2.5mg daily; diazepam 10mg three times daily; omeprazole (an anti-ulcer medication) 20mg daily; propranolol LA 80mg twice daily (for hypertension) and perindopril (used in patients with hyper tension) 4mg daily. He was the subject of two voluntary drug tests between April and August 2006, which were both negative.

The head of healthcare at North Sea Camp said he had known him very well. He said the man had a long history of heart disease and hypertension and there was a continuous review of his medication and blood pressure. On 8 August, he had attended the asthma clinic and he saw the GP on 22 September. The head of healthcare said that the man had a good working relationship with the healthcare department. He generally saw the doctor when he should and was reviewed regularly.

### **The days leading up to the man's death**

On the night of 26 and 27 September, the night duty officer made an entry in the wing log book that the man had been up all night writing. He commented that he did not know if this had been a regular occurrence or a one off.

An officer support grade (OSG) was on night duty on 27 and 28 September. He noted in the wing log book that the man was still awake at 2.00am and echoed the comments of the night duty officer from the previous night shift. At 4.30am, the OSG noted that the man was still awake with his TV on. At 5.30, it is recorded that the man was up and about, doing his laundry and mopping out his room. When the OSG asked why he had been up all night, the man told him he had been "listening to a CD designed to reduce blood pressure and once he had learnt it by heart it would help!"

Prisoner A said he had arrived at North Sea Camp a week after the man and they were soon paired up to share a room. He described him as a humorous, gregarious character who told great stories and kept everyone entertained. However, prisoner A said he felt that underneath it all, the man had struggled with depression. He said there was another side to him and he believed his sentence was taking its toll on him. He was often with the man when he took his medication, in particular diazepam. He said the man would often take more than he should, for example, he would take three tablets instead of one. On many occasions the excessive

medication would make him drowsy and at times he would spend most of the day sleeping because of this. Prisoner A said that as a result of this, he had got in the habit of checking the man at roll call times, ensuring he was awake and able to answer the roll call.

On 30 September, prisoner A and the man both had a town visit. The man and his family gave prisoner A a lift to Grantham station and back to the prison in the evening. Prisoner A said during the journey back everything appeared fine. He said the man was in the back of car with his wife, laughing and talking. Two hours later at 8.00pm, prisoner A went to see the man to check he was awake to respond to the roll call. He said the man seemed very dopey and he realised that he must have taken some of his medication, 'probably more than he should have'.

Prisoner B said he saw the man after he got back from his visit on that Saturday afternoon and he seemed to be his normal self. He saw him again that evening at the 9.30pm roll check. He noticed the man was in the room of another prisoner. Prisoner B explained to my investigator that it was not unusual for a prisoner to visit another prisoner's room, but he had taken particular notice that evening as the inmate the man was visiting was known to use heroin and also the door to the room was closed. He further explained that prisoners go in and out of each other's rooms all the time, but it would be unusual for the door to be closed.

The OSG was doing his usual midnight checks on 1 October 2006, when he met the man, in the corridor outside the bathroom area. As the man seemed unwell, he asked him if he was alright and checked that he felt well enough to return to his room by himself. The man replied that he was okay to return alone, although he was feeling "a bit sick and dizzy". The OSG had intended to finish his rounds and then return to see the man in his room.

At the same time, prisoner C emerged from the bathroom area. He told my investigator that he was in the shower area that night at about midnight. When he came out he saw the man at the top of the stairwell holding onto a door frame and rubbing his head against it. He said he vaguely knew the man from around the prison, but did not know him well. He knew he was a bit of a character who often did odd things and thought perhaps he was just play acting. He said he then saw the OSG speak to the man and after a brief conversation, the man returned to his room. Prisoner C then told the OSG that the man appeared unsteady on his feet, holding on to the door post for support, and had stains down the front of his shirt, 'like he had been throwing up'.

The OSG said he finished his roll check, which took about five minutes, and then returned to the man's room. The man said he was alright, but still had the symptoms of nausea. He went on to explain to the OSG that he was taking medication for hay fever and high blood pressure, as well as another medication prescribed by healthcare after the recent death of his father. The OSG asked if he was perhaps feeling unwell as a result of taking the medications together. The man explained he had often taken them together. He mentioned that healthcare had recently increased his dose, although he did not say which medication he was referring to. The OSG suggested he lie down and get some rest. The man agreed to this and asked if he could keep his door open for fresh air.

The OSG returned to his office at around 12.15am, and radioed the night orderly officer to ask him to attend the unit. The OSG said the man then appeared in the recess area and made himself a cup of tea. On the way back to his room, still unsteady on his feet, he spilt some of his tea. The OSG told the man not to worry about the spillage, but the man insisted on mopping it up before he returned to his room. The orderly officer then arrived at the unit and he and the OSG went to see the man in his room. He again explained that his prescribed medication was making him feel slightly nauseous, but assured them that he would be fine after a lie down.

The second OSG and the assistant orderly officer were patrolling the prison when they received a call from the OSG on Llewellyn unit. They both went to the unit and saw the OSG and the orderly officer talking to the man in his room. The assistant orderly officer waited in the unit office while the OSG joined the others in the man's cell. It was agreed that the man should be allowed to keep his door open to get some fresh air in. He insisted that he was 'alright' and just needed to rest. The orderly officer told the man that staff on the unit would check him later in the night and he should alert staff if he felt any worse. An entry in the wing log by the OSG at 12.45am, notes that the man appeared to be asleep. The OSG told my investigator that having checked him on three further occasions during the night, he appeared asleep.

The wing officer took over from the OSG on Llewellyn unit at 7.15 on 1 October. The OSG told him that the man had been sick and dizzy and had been seen by the orderly officer the night before. He also mentioned that the man had not had any sleep for two nights and was now 'sparked out'. The wing officer said he collected a cup of coffee and returned to the unit. He relayed the information he had received from the OSG, spoke to the second wing officer, who had also just started work on the unit. He and the second wing officer then went to check on the man as soon as other prisoners were up and moving about the unit. The OSG said he quickly realised that something was wrong as he could not see the man breathing. He touched his arm, which was 'freezing cold' and he could not feel a pulse. He called for the orderly officer to attend and requested an ambulance.

The second wing officer gave a similar account. He arrived at the prison at about 7.05am and was in the reception area for about 30 minutes before receiving a handover from the first wing officer. At 7.45am, he went with the first wing officer to check on the man as it had been mentioned that he was poorly. The second wing officer could not see the man breathing and remarked that he seemed a funny colour. He said the first wing officer then touched the man's arm which was cold and checked for a pulse, but could not find one. The first wing officer then used his radio to call for the orderly officer and request an ambulance. The principal officer (PO) and the senior officer (SO) arrived at the unit office and asked if there was a first aider on duty. The second wing officer made some enquires and found out that a prison officer, a trained first aider, was on duty.

The prison officer said he was asked to attend Llewellyn Unit. He went into room 5 and saw the man on his bed, lying on his back. He noticed there appeared to be staining to the front of his t-shirt. He spoke to the man and pinched his earlobe, but there was no response. He said the man did not appear to be breathing so he

removed the pillow from under his head, checked his mouth for obstructions and started resuscitation. He noted that the man was pale and cold to the touch.

The first wing officer started an incident log, logging all movements in and out of Llewellyn Unit and particularly the man's room. At 7.53 am, the prison officer and the duty governor went to the man's room and the ambulance crew arrived shortly afterwards at 8.05am. The duty governor explained to my investigator that he came on duty at 6.45am that morning. He had been in his office about an hour when he heard the first wing officer request the SO attendance over the radio. Shortly afterwards he heard a request for an ambulance. At 7.49am he received a call asking him to attend the unit and arrived at 7.53. He confirmed the prison officer had tried to find a pulse and get a response from the man. At this point, the duty governor noticed that the man's lips were blue. The second wing officer then passed a first aid kit into the room and the prison officer used the face mask in the kit, in an attempt to resuscitate the man. The ambulance crew arrived at 8.05am and confirmed the man was dead at 8.06am.

### **Events after the man had died**

The duty governor left the unit to activate the contingency plans and inform all the relevant agencies and authorities. He was then told by the Principal Officer that the man's family were at the gate. They had arrived to pick him up for a further community visit as previously arranged. The duty governor instructed his staff to escort the family to the Governor's office. He met them there and broke the news of the man's death, explaining all that happened. After speaking to them, he offered refreshments and left them to contact other family members.

In the meantime, the police had arrived and the duty governor went to meet them. The family asked to see prisoner A and he spoke with them for some time. They then asked to see the man's room and to have his property returned to them. The duty governor explained that they could only release the room when the police had finished their investigations, but assured them he would do so as soon as he possibly could. He also explained the process that would take place, including this investigation. I am pleased to be able to report that the family have expressed their appreciation of the care and sensitivity shown to them when the news of the man's death was broken to them. The man's daughters have said they were made to feel very welcome when they visited and were touched that a memorial service for the man had taken place.

As part of the Death in Custody Contingency Plan, all staff involved were seen and offered the support of the prison's care team. They also attended a hot debrief where issues were raised, such as emergency phone numbers that had been missing from the contingency plan folders and no incident log sheets. I understand the contingency plans have since been amended to include these important numbers and a folder with incident log sheets have been provided on each unit. I commend this prompt action to an identified learning opportunity.

## ISSUES

### Medical Care

The clinical review was undertaken by a medical practitioner on behalf of Lincolnshire Primary Care Trust (PCT). I summarise her findings below.

The man was at risk of developing an acute cardiac condition as a result of long term, poorly controlled hypertension, clinical obesity and a history of opiate abuse. His risk factors appear to have been managed, both within the prison medical service and by referral to secondary care. The clinical reviewer does suggest the poor control of the man's hypertension might have been partly due to the severity of his condition, but also points out there is repeated documented evidence of non compliance with treatment. The clinical reviewer states, "All contacts with healthcare were recorded and there was repeated reference to his hypertension and asthma during individual consultations." It is pleasing to note that the records were well kept and that healthcare staff have a good awareness of the professional responsibilities with regard to records and record keeping.

The clinical reviewer goes on to note that, in spite of the above, there should be much clearer identification of adverse reactions to drugs in the medical record. In this case, previous adverse reactions were recorded in the hand written notes, but this information could only be gathered by reading all of his records. It is unlikely that this would be done routinely.

The man was treated with nifedipine, a calcium channel blocker. Despite documented evidence that this drug caused him to experience 'peripheral oedema', the collection of large amounts of fluid around his lower legs and ankle, this was increased to a maximum dose of 90mg daily in the two weeks before his death. This would account for the bilateral pitting oedema affecting the lower legs and feet found at post mortem examination. Overdose of calcium channel blockers is implicated in the development of pulseless electrical activity associated with cardiac arrest. Lack of calcium reduces the contractility of the heart and in the presence of severe hypoxia (as in the case of acute pulmonary oedema) would further restrict cardiac output and contribute to a state of cardiac arrest. 90mg of nifedipine a day is the maximum licensed dose for hypertension. That said, the increase to maximum levels of hypertensive agents is not recommended, particularly in the presence of adverse effects at a lower dose.

The pathologists conducting the biochemical analysis expressed concern that propranolol was present in a patient known to have asthma. Propranolol is a non-cardioselective betablocker, licensed for use in anxiety, hypertension and angina. In this case, it had been prescribed for anxiety, but would have also had a lowering effect on his blood pressure. He had been taking propranolol for over 4 months prior to his death with no adverse effect. He had also been prescribed propranolol in the past with no documented reports of adverse effects. Propranolol can cause acute asthma in susceptible patients, which may be fatal. Similarly, it can be taken by patients with asthma without any adverse effect. It is impossible to predict susceptibility to the broncho-constrictive effect of propranolol and therefore, the recommendation is that propranolol should not be used in asthmatic patients.

Medical Practitioners who prescribe any drugs that are contra-indicated or relatively contra-indicated must give full consideration to the clinical reason behind the decision to use that drug and the warnings that must be given prior to use. Ideally, drugs should not be prescribed in these circumstances, but if they are, there should be clear documentation of the decision process and management plan

Cardio-selective betablockers, such as atenolol, are the drug of choice if it is clinically necessary to use a betablocker in a patient with asthma. Cumulative evidence shows that cardioselective betablockers are safe in patients with asthma and may actually benefit patients by enhancing their sensitivity to inhaled asthma medication.

Non cardio-selective betablockers should not be prescribed for patients with asthma or any other obstructive lung disease. If there is a clinical need for the prescription of betablockers in a patient with asthma, a cardio selective type should be used with close monitoring for any adverse effects

The man was prescribed atenolol for hypertension and also, although not at the same time, propranolol for anxiety. Medical evidence suggests that propranolol should be avoided in asthmatic patients and atenolol used with caution and only if absolutely necessary. The man took both of these drugs for prolonged periods with no reported adverse effects. It is therefore, the opinion of the clinical reviewer, unlikely that the prescription of propranolol would have contributed to the man's death.

### **Actions on finding the man**

The first OSG said he came across the man in the corridor near the bathroom area and thought that he did not look well. When he talked to him, he was adamant that he was not ill and did not need any assistance. Nevertheless, the OSG went to see the man once he had returned to his room. He spoke to the man at length and he reiterated that he was not unwell, but that perhaps his prescribed medications were causing him to feel a bit out of the ordinary. Despite the man's resistance, the OSG decided it was best to contact the night orderly officer and ask him to see the man. The night orderly officer attended and checked with the man, who again insisted that he would be fine after a rest. He was told to let staff know if he felt any worse during the night and the man agreed to do this. The OSG said he checked the man a few times during the night. The final entry in the wing log shows that he checked him at 12.45am, when he appeared asleep. However, the OSG assured my investigator that he checked the man several times during the night as he carried out his routine checks. He said the man appeared asleep on each occasion. He was not surprised by this as he was aware the man had not slept properly on the two previous nights.

When staff discovered the man in his room on the morning of 1 October, they acted quickly and appropriately in calling an ambulance. They began cardio pulmonary resuscitation (CPR) until the paramedics arrived and took over the man's treatment, but were unable to save his life.

### **Drug use**

The man's heroin addiction impacted greatly on his family's material and emotional well-being. The man was remorseful and frank about the impact his addiction had on his family and about the harm drugs do in society. He said that he felt it had a huge grip on him and thought he would never be able to stop using drugs. He told his pre sentence report writer "I never thought I would be strong enough to get off it, but I feel like I've got my mind back now".

According to prisoner A, the man never took drugs when sharing with him. He said that the man had never mentioned drugs, indeed he did not know that the man had been a drug user. However, prisoner A said that in the days after the man's death there were rumours going around the prison about the inmate whose room the man visited the night he died and alleged drug use.

Prisoner B, another prisoner who had been friendly with the man, had been upset to hear of his death in the night. He said later that morning he saw the other prisoner, who the man had visited. This prisoner had been very ill, vomiting and according to prisoner B, was ill most of the following day. Prisoner B also commented that it had become common knowledge, amongst prisoners, that it was not unusual for prisoners to visit that particular prisoner on the evening of their return from town visits and the door would always be closed.

Prisoner B was frank when he told my investigator that having been a drug user in the past, it was 'not hard to put two and two together and come up with four'. He said he believed that the man and this prisoner had taken heroin on the evening of 30 September. He said he did not know where the heroin came from, but speculated that the man might have got some while on his visit.

There is evidence from other prisoners, albeit unsubstantiated, that prisoners on town visits might be bringing drugs back into the prison. If the man did obtain the drugs while on his town visit, the source cannot be readily identified.

North Sea Camp's duty of care includes, as far as possible, providing an environment free from drugs, where prisoners can live should they wish to, free from the constant temptation of drugs. This is very difficult to sustain. The threat from drugs within prisons is constant and forever changing.

The manager responsible for the implementation of the prison's drug policy, said the policy had been reviewed four times since 2004, the last occasion being in December 2006. Essentially the policy has objectives to help prisoners resist using drugs, overcome their addictions and stifle the availability of drugs in the prison. In terms of the support available to someone who may be tempted to use drugs, North Sea Camp provides four drug support workers and a peer support group, facilitated through the Integrated Drug Treatment Strategy (IDTS) programme. Following a recommendation from the Chief Inspector of Prisons, the prison now also employs a full time dog handler, with both a passive and an active drug dog.

All prisoners returning from work or town visits are subject to random searching, unless intelligence suggests something that will result in a targeted search. As the manager rightly points out, an open prison is an extension of the community and the

drug problems which we see in our communities are reflected in the prison. He also explained that prisoners do not necessarily have to bring drugs into the prison themselves. It is easy to have them thrown over the boundary and collected at night. However, he confirmed that, as per its policy, North Sea Camp pursues a zero tolerance to class A drugs and any prisoners found with such, or related paraphernalia, are returned to closed conditions. Equally, those with positive MDT results for class A drugs are similarly returned. In the manager's opinion, this is one of the reasons that there is little class A drug use in the prison. Of the 140 prisoners returned to closed conditions in the previous year, about two thirds of these were for reasons related to drugs.

The policy strikes a good balance between supporting prisoners who ask for help with their drug issues and the punishment of a return to closed conditions, should they continue to fail to prove themselves in open prison conditions. That said, each prisoner in an open prison is aware that they have been given an opportunity to take more responsibility for their lives in preparation for their return to the community. This includes abiding by the rules relating to drug use, as well as dealing with the temptations that a more open regime offers.

The Chemical Pathologist concluded that the man had used heroin prior to his death. The concentration of free morphine was just below the lethal range, but this range overlaps with the therapeutic range, particularly in patients who have not developed tolerance to opiates by regular use. In view of his imprisonment, it is likely that he had been abstinent for some time. Death from opiate toxicity is much more common in this situation. The man had also taken diazepam which would enhance the depressive effect on the central nervous and respiratory systems.

Overdose of heroin can cause acute pulmonary oedema, the onset of which may be delayed for up to 24 hours after administration. The post mortem examination confirmed the presence of severe pulmonary oedema with fluid in the lungs, airways and mouth. In addition to pulmonary oedema, heroin overdose can also cause profound cardiovascular collapse and arrhythmia.

### **Funeral payment to the undertaker**

The man's family were upset to learn that the prison had sent a minimal contribution to the funeral expenses directly to the funeral director, without informing them. The man's wife and her children had wanted to ensure some dignity for the man and did not want people to know he had died in prison. However, the actions of the prison removed this as a possibility for them. When my investigator raised this with the Governor, he confirmed that he did so as the undertaker had contacted him directly. He had assumed the undertaker was acting on the man's wife's behalf. The Governor apologised that his actions had caused upset to the man's family. When he increased the prison's contribution to the funeral, he wrote personally to the man's wife, to let her know. That said, the contribution from the prison was significantly

less than the recommended amount identified in the Prison Service Order. Prison Service Order states at paragraph 4.29:

‘Offer to pay reasonable funeral expenses or, if the family want particularly expensive arrangements, offer a contribution. £3,000 is the sort of figure considered reasonable in 2005-6 but do not quibble over small sums. This offer should be made irrespective of whether the family is entitled to claim a grant from the Social Fund.

### **The delay in the production of the Clinical Review**

The clinical review was commissioned by my investigator on 23 October 2006. Lincolnshire Primary Care Trust selected a medical practitioner to carry out the review. The clinical reviewer sent her completed report to my investigator in mid-January 2007. Shortly after, the Head of Integrated Governance and Risk at Lincolnshire PCT, explained the report could not yet be used as it was a draft. She said that staff at North Sea Camp had not been interviewed as part of the clinical review and the information gained from them would need to be included in the report. The investigator agreed not to use the report and wait for further work to be completed. Despite several telephone calls and messages by my investigator, the report was not sent until there was another death at North Sea Camp.

An investigator working for my office spoke to the healthcare manager. He mentioned that he had a copy of the clinical review for this case on his desk and had been given the opportunity to comment on it. On learning of this, the investigator contacted the Head of Integrated Governance at the PCT, who explained that because staff had not been interviewed face to face, as planned, it was felt it was only fair to let them see the report and allow them to comment on it. The investigator explained the need for independence in such reviews. While it would be right to include staff interviews during the review, it was not appropriate to give them the opportunity to add to the report. The Head of Integrated Governance agreed and explained that this case had been different from all others conducted by them. They usually used another doctor who routinely interviewed staff as part of his review. She also agreed that showing the report to the medical staff involved at this early stage was not good practice and would not happen again. However she stressed that the report had not changed as a result of the disclosure. The investigator agreed she would look at the final report, but would not necessarily use the extra information which had been added after the disclosure.

The final report was received by my office on 6 June 2007. It shows that the clinical reviewer completed her work on the report in April 2007. The delay in receiving the final version of the report was caused, in the main, by the Trust’s desire to include staff in its review. As I have commented above, this would have been acceptable had it been done in the proper way. The need to maintain the independence of these reviews is paramount. However, despite these procedural/process issues, I consider this review has appropriately considered the man’s medical care.

## RECOMMENDATIONS

I make three recommendations. The Prison Service response to each is indicated in italics.

**The Prison Health Partnership should introduce a system for easy identification of significant medical conditions and previous adverse drug reactions in the medical record, to allow easy identification of these events at every patient contact.**

*Accepted. As part of the reception screening process, nursing staff will identify people with allergies, drug reactions and significant medical conditions and record this on the front of the medical record in addition to referral to the appropriate nurse lead clinic.*

**Non cardio-selective betablockers should not be prescribed for patients with asthma or any other obstructive lung disease. If there is a clinical need for the prescription of betablockers in a patient with asthma, a cardio selective type should be used with close monitoring for any adverse effects.**

*Partially accepted. In this instance the man had been prescribed propranolol prior to his period of custody at HMP North Sea Camp. This was long standing and his condition severe. He was, in addition, seen regularly by nursing staff to monitor his heart conditions and asthma. However, the introduction of a clinical IT system would reduce and highlight contra-indications regarding clinical prescribing.*

**Medical Practitioners who decide to prescribe any drugs that are contra-indicated or relatively contra-indicated must give full consideration to the clinical reason behind the decision to use that drug and the warnings that must be given prior to use. Ideally, drugs should not be prescribed in these circumstances, but if they are, there should be clear documentation of the decision process and management plan.**

*Accepted. Meeting with GPs responsible for the provision of primary care prescribing to ensure contra-indications are discussed with patients and the level of documentation is to the required level laid down by the GMC.*