

Confidential A Review of 21 Unclassified Deaths in Custody

2013

A REVIEW OF UNCLASSIFIED DEATHS IN CUSTODY- 2010-12

1. Professor Eilish Gilvarry a Consultant in Addiction Psychiatry familiar with prison clinical practice was commissioned by Department of Health to undertake an independent analysis of 21 initially unclassified deaths in custody that occurred during 2010 to 2012. The aim of which was to identify whether the deaths were drug related, whether there was any commonality and the learning points that may need to be considered
2. A striking feature was the complexity of cases from a healthcare and security perspective. Also the presence of drug and often alcohol abuse and possible dependence, combined with additional physical and mental health issues; suspicion of and availability of illicit and/or diverted medication. These factors combined with the uniqueness of the prison environment such as volume of cases, available contact time, and accessibility of health records, observation facilities and knowledge of and exchange of relevant healthcare issues by both security and health care staff, added to management complexity.
3. The simultaneous use of multiple central nervous system (CNS) depressant drugs, such as antidepressants, anxiolytics, and analgesics was a common feature. Consequently, prescribing decisions, particularly related to these drugs, need to be cognisant of the links with substance abuse and potential additive effect on sedation with other drugs.
4. Prof. Gilvarry made a number of recommendations to improve the clinical management of those with alcohol and drug dependence, its complications and other co-morbidities. These include the need to improve initial health assessment for such co dependencies, drug testing prior to start treatment, the pharmacological regimes prescribed, subsequent clinical monitoring and review and specific overdose training and treatment
5. Further generic recommendations included the need to consider reviewing DH 2006 prison treatment guidelines, essential clinical competences for managing substance misusers, the clinical governance of treatment, the leadership role and other operational issues.
6. **DH has considered the report, its findings and recommendations.**
7. **DH accepts the clinical recommendations and will agree with relevant partners including NHS England, Drugs and Alcohol and Health and Justice Public Health England (PHE) how best to achieve them.**
8. **DH accepts the intention of the operational recommendations; further work with NOMS and NHS England will be essential to develop an implementation plan.**

Review of 21 deaths in custody

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1. *Summary and recommendations*

- 1.1 As a Consultant in Addiction Psychiatry and familiar with prison clinical practice, I was commissioned to undertake this specialist independent analysis of 21 deaths in custody that were initially unclassified.
- 1.2 The aim of the review was to ascertain whether the deaths were drug related, whether there was any commonality between them and the learning points that may need to be considered.
- 1.3 Its objectives were to:
 - Identify individual causes of death and whether there are factors common to a number of deaths, such as:
 - A diagnosis of opiate dependence in combination with benzodiazepine and/or alcohol dependence
 - Significant physical comorbidity, such as chronic liver disease, ischaemic heart disease, inter-current infections
 - Significant mental health comorbidity, such as a psychosis
 - Illicit drug taking
 - Any potential interaction between prescribed and/or illicit medication
 - Failures of clinical or operational practice
 - Identify any risk factors that would enable health care professionals to monitor the substance misuse management of such individuals more closely to minimise the risk of death.
 - Make recommendations for clinical or operational practice that could assist the prevention of such deaths in the future and that would have the confidence of professional peers, prison clinicians and operational staff.
 - If there is a common cause of death identified, make recommendations for policy development and implementation i.e. a group of experts to meet and advise on simultaneous detoxification in prison from heroin, alcohol and benzodiazepines.
 - Identify future methods of investigation that should be adopted at an early stage should any concerns arise in the future that a death or deaths of a person in prison is considered an untoward clinical event.

Methodology

1.4 In the preparation of this report (May to June 2013), I had sight of the following documents:

- List of deaths
- Prisons and Probations Ombudsman reports (PPO) on deaths
- Post mortem findings and toxicology reports
- Independent clinical review for each death
- NOMS review of unclassified deaths: M McFeely (2012)
- Discussions with Dr Mary Piper at PHE

1.5 A short Task and Finish clinical expert group has been undertaken in the preparation of this report with the aim of achieving consensus on the clinical assessment and management of substance misusers including the pharmacological recommendations arising from this review. The findings from this expert group have assisted my recommendations especially the changes and implementation required to improve the management of complex substance misusers in this unique clinical environment.

1.6

Main Findings

Investment over the last ten years both in community and in prisons has given more people access to long term, high quality treatment that has substantially improved health. The integrated drug treatment system (IDTS) aimed to increase the volume and quality of substance misuse treatment available to prisoners, with particular emphasis on:

- early custody;
- improving the integration between clinical and CARAT Services; and
- reinforcing continuity of care from the community into prison, between prisons, and on release into the community.

There have been substantial improvements in treatment for prisoners on entry, while in custody and on discharge to community services with the roll out of IDTS to all prisons. Over 66,000 individuals per annum receive a clinical drug treatment programme in prison in addition to those who also receive treatment for alcohol withdrawal. The true significance of the size and demands of this workload in the prisons can be understood when viewed alongside the community programmes; the total number of people engaged with English community drug treatment programmes is about 180,000. Furthermore, there is no doubt that the IDTS programme has been

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beneficial to many prisoners and their families, with much reduction in suicide rates in prisons, better management of withdrawal symptoms from various drugs of dependence when admitted to prison, availability of psychological and medical services and much improved continuity of care from and to prisons. The concept of equivalence is important between community and prison treatments. Continuation of the IDTS programme is crucial to continue these greatly improved treatments, reduce suffering and prevent significant consequences e.g. suicides is crucial. The deaths reviewed in this report were small in number, when compared to the number of prisoners in drug treatment and in prison as a whole. Though tragic and with learning points, it is important to keep a perspective.

- 1.7 In this review of 21 cases, a striking issue among all of the deaths was the complexity of cases both from a healthcare and security perspective. The cases were characterised by the presence of drug and often alcohol abuse and possible dependence, combined with additional physical and mental health issues, suspicion of and availability of illicit and/or diverted medication. These factors combined with the uniqueness of the prison environment such as volume of cases and available contact time, accessibility of health records, observation facilities and knowledge of and exchange of relevant healthcare issues by both security and health care staff, add to management complexity. Treatment was initiated within the constraints of this physical environment, such as difficulties with frequent observation. More often the treatment delivered in prisons is far greater in volume and complexity than occurs regularly in community settings.
- 1.8 An issue common to almost all these deaths was the toxicological presence of prescribed methadone. However, often it was difficult to ascertain from toxicology reports whether levels were of a fatal level or related to tolerance. The results of methadone levels often showed the presence of methadone at a level within the quoted therapeutic range, which overlaps within the quoted toxic to lethal range. This is because the same blood level can cause a fatality in those who are opiate naïve, though is well tolerated in those with an opiate dependence. In a number of deaths that occurred early on in treatment, more often on the 3rd to 4th day of initiation of treatment, other prisoners or staff noted sedation and loud snoring prior to death (this may be related to toxic effects of the drugs and respiratory depression).
- 1.9 A further significant issue fitting with complexity of the management of these cases was the use of multiple central nervous system (CNS)

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depressant drugs: such as antidepressants, anxiolytics, and analgesics. Consequently, prescribing decisions, particularly related to these drugs, need to be cognisant of the links with substance abuse and potential additive effect on sedation with other drugs. Drugs such as mirtazapine are used primarily in the treatment of depression, though in prison it is used sometimes as a form of night sedation only and often requested by prisoners. Benzodiazepines possess sedative, hypnotic, anxiolytic, anticonvulsant, muscle relaxant and amnesic actions; their sedative effects in particular can increase the sedative effects of other CNS drugs. Similar drugs such as pregabalin and gabapentin, prescribed for neuropathic pain and for anxiety, may further potentiate sedative effects. Further, opiates or similar drugs such as Tramadol may be prescribed for pain relief, hence with concerns of possible abuse and diversion and additive effects. It is the context of multiple sedative drugs being used together that is of concern.

- 1.10 Six of these deaths were actually due to or compounded by physical disease, for example lobar pneumonia, and liver failure. These deaths illustrate the importance of detection, diagnosis and management of comorbid physical health difficulties, and its consideration when prescribing drugs. It further illustrates the importance of integrated care to prisoners, who perhaps are smokers, may have problems consequent from drug use and/or alcohol misuse such as hepatitis C, chronic liver disease and other physical health problems.
- 1.11 The deaths spanned a period of time from 2010 to 2012, and from a range of prisons. With this small number, there were difficulties drawing conclusions on issues such as age, gender, sentencing etc. Most were male, and though the age range was broad, more were younger. No commonality could be drawn from the geographical area of the prisons themselves. Some of the deaths occurred in the first few days, after reception to prison. A history of drug abuse and alcohol abuse was a common feature, with history of prior treatments for substance dependence in the community.
- 1.12 With each death there had been a thorough review of clinical issues, alongside the PPO. Recommendations were made on clinical issues, security etc. on each of these deaths. These have been incorporated into this report.
- 1.13 Other themes noted were:
 - At reception to prison, an assessment and then diagnosis was made of opiate, alcohol and/or benzodiazepine dependence

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with little clinical information available. This was often followed by simultaneous pharmacological treatment of this dual and/or triple dependence.

- These diagnoses were made with little objective evidence of the physical signs and symptoms of dependence being documented other than self-report, a possible urine test result and some use of adjunctive clinical withdrawal scales.
- Continuation of prescriptions from community GP and/or community substance misuse services without clear justification or review of diagnoses and without knowledge of the adherence to these prescriptions regime especially for such drugs as gabapentin / analgesics / antidepressants.
- Simultaneous prescription of multiple different types of drugs with similar side effects i.e. sedation.
- Concern regarding the integration of assessment and treatment between prison primary care, IDTS and/or mental health services leading to the possible lack of oversight of prescribing of these multiple CNS drugs.
- The additional presence of complex mental health problems and/or additional presence of complex physical health problems.
- Significant suspicion of use of illicit drugs and/or diverted medication by individuals in addition to their prescribed medication.
- This knowledge or suspicion of use of illicit drug use was not always available to healthcare staff.
- Delays and/or inadequate information sharing of clinical information from police cells to reception healthcare staff.
- Delayed requests and confirmation from community services and GPs of prescriptions and other medical issues.
- The lack of adequate clinical observation at least twice daily in the early stages of treatment.
- Difficulties with clinical documentation by clinical staff.

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- Concern about the consistency and competence of workforce, especially locum and agency staff to manage these complex cases as well as their access to specialist support when required. This support is essential as treatment in a prison setting is often far more complex than community clinical settings. Clinicians are often confronted by greater severity of dependence and multiple comorbidities, in an environment where easy observation and regular assessments are difficult and with much less information available than in community settings.
- Death often early in time in custody or soon after starting a new treatment regime.
- Issues of recognition and awareness of the signs of overdose and its treatment.

1.14 **RECOMMENDATIONS:**

I make a number of recommendations in this report. These in my view would aim to improve the prison assessment and treatment of those with alcohol and drug dependence, its complications and other co-morbidities.

Some of these recommendations are specific to treatment and its management, other are more generic. From section 1.15 to 1-20. I make recommendations on assessment, drug testing, pharmacological treatments, monitoring and review, and specific overdose training.

I further then make more generic recommendations 1.21- 1.24: consider review the prison guidelines of 2006, competences, clinical governance and leadership and some operational issues.

Some of these recommendations are already in prison guidance and may require review of their implementation. With regard to clinical interventions, recent clinical guidance e.g. from NICE (2010-2012) did consider the clinical justice system in their recommendations. However, they did not specifically address the unique prison environment.

1.15 **Assessment**

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- It is important that comprehensive information from police cells health care and escort services, including treatment initiated in this setting accompanies the detained person to prison and is available to health care staff at reception.
- The assessment process should be clear and comprehensive, with clarity of the expectations at reception and review at a specified time. Assessment should include a history and assessment of dependence, other consequences of dependence and/or comorbid problems, such as liver or heart disease, observation of the signs of withdrawal for drugs or alcohol and other corroborative evidence available. If information such as GP records, police cells records were not available this should be documented. Each member of the health care team relies on each other to deliver continuity of care. To achieve this, it is important that the records are of an excellent quality and to take account of different shifts patterns and at times transient / locum staff.
- Safe clinical judgement and experience of substance dependence and its management in prison environments is crucial. Competence of clinical staff is important especially with greater complexity and often with little information to guide. To enhance assessment and case management supervision and on call support should be available 24 hours.

1.16 **Drug testing in assessment and management:**

- Prior to the initiation of opiate prescribing in prison, a urine test should be taken and interpreted at the least in collaboration with history and assessment; this is no different to the procedure in the community.
- A positive test result should be obtained prior to any prescribing which should be clearly documented with rationale for prescribing and its schedule noted.
- Steps should be taken to limit the opportunities for individuals to tamper with urine specimens.
- All health care staff should have training in interpretation of test results and their relevance to the initiation and continued use of medication. It should be clearly documented what actually has been tested in the sample.

1.17 **Pharmacological treatments:**

- For those being considered for detoxification, (the medical process to assist withdrawal from a drug or alcohol) or continuation of a community prescription (e.g. methadone), staff should give greater weight to objective signs of withdrawal rather than the individuals description of symptoms, particularly when tolerance to opiates has not been established and when there is not reliable documentation or evidence of use
- Pharmacological treatment for dependence on the first night must not be initiated using evidence simply and solely acquired from self-report.
- When initiating medication for detoxifications, the clinician should consider prescribing no more than 2 sedative drugs in the first few days.
- Those being prescribed drugs for detoxifications and continuation of community prescriptions should have the medication regime reviewed in 48 hours with a full review on Day 5.
- Consider stopping all other sedative drugs, e.g. mirtazapine etc., while undergoing detoxification. This can be reviewed later to assess if initiation is required.
- All doctors prescribing medication in prisons should consider the potential for abuse and diversion, patient safety and safety of other prisoners.

1.18 **Monitoring / observation:**

- All those started on pharmacological treatments for substance dependence should have at least twice a day formal monitoring, and this will be recorded. This should occur regardless where the prisoner is placed.
- As much as possible, detoxifications should occur in stabilisation units.

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- These monitoring checks should be recorded and available to all healthcare staff.
- All individuals undergoing detoxification regimes should be checked every morning and not allowed to sleep in without being roused to check for over sedation.
- Staff should have training and review of competencies in utilising and interpreting scales used in screening, detoxification and stabilisation.
- When prescribing for depression and anxiety, in addition to clinical judgement the use of standardised assessment tools may be of value.

1.19 **Continued / regular review:**

- Consider a review of prescribing regime at 48 hours.
- There should be a full review at Day 5 for all pharmacological treatments.
- For those who continue on drug treatment and are receiving other drugs, such as for depression and for pain, there should be formal regular reviews throughout their stay of all medications with primary healthcare team and IDTS staff – this to review diagnoses, integrated care plan and supervision of medication.

1.20 **Overdose training:**

- Information about risk and overdose should be given to all prisoners, this to include advice on how to seek health support for fellow prisoners if considered sedated or any concern. There should be available information on risks from drug abuse in various locations throughout the prison.
- For those on medication and/or treatment for drug and alcohol use, information on risks of overdose and especially if using any illicit medication should be given at each and every opportunity.

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- All staff, health care and security staff should have overdose awareness training. This training could be delivered jointly to both health and operational staff and be part of mandatory training.
- All health care staff should be competent to assess intoxication, sedation and to manage possible overdose including use of naloxone and emergency procedures.
- There should be naloxone available with all staff, both security and healthcare staff, trained in its administration.
- This training for all in overdose awareness and management should be regularly available and audited.
- All who are on detoxification regimes should be checked every morning in their cells and not allowed to sleep in without formal check of sedation.

Guidelines

1.21 I recommend that a review of 'Clinical Management of Drug Dependence in the Adult Prison Setting' published by the Department of Health in 2006 and other related IDTS documents be undertaken. This is required, both to update the specific prison guidance in view of much production of guidance since 2006 and especially to review the management of detoxifications, especially that of dual dependence at reception and in the first few days in light of these deaths. The NICE guidelines and their evidence updates (2010-2012) do consider the criminal justice system; hence their clinical guidance is most relevant for the prison settings. However, it does not address the uniqueness of this prison setting and the delivery of interventions in this setting.

These guidelines could also consider:

- Standardised protocols for assessment of pharmacological treatments for dependence.
- Monitoring and review of pharmacological treatments for substance dependence
- The continued use of other antidepressant medication, hypnotics and especially pain management in those with drug problems and the consequences of stopping prescribed drugs on entry to prison.
- Initiation of CNS drugs such as antidepressants when initiating pharmacological drug treatment.

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- Monitoring and review
- General update of the prison guidance

1.22 Competences and training

- As much as possible there should be a commitment that all doctors should be trained to Royal College of General Practitioners Level 2 Training for GPs with a special interest in substance misuse. The deaths reviewed were those with complex needs requiring a high degree of expertise for treatment. There are further specialist training courses available such as alcohol management and working in secure environments. However, Level 2 is not in itself satisfactory for this level of complexity of morbidity and requires much clinical experience and supervision.
- As much as possible, consistency of health workforce is crucial when managing drug dependence and this level of complexity. The medical director should ensure core clinical competencies for locum staff, with clear supervision and support.
- There should be access to specialist addiction doctors, either GPs or addiction psychiatrists, as noted in Roles and Responsibilities (RCPsych and RCGP 2012), this especially for those with dual dependence and multiple complex needs. Access for support and supervision and advice should be available over 24 hours. Commissioners should ensure these competencies are available in this highly complex environment and ensure on call availability.
- Regular Continuing Professional Development (CPD), supervision and on-going training for doctors and health care workers is essential. Staff should have annual appraisals, with organised processes for CPD and revalidation.
- Clinical leads for IDTS in prisons should review the skills of the workforce and their training both in overdose and management of assessment and treatment. These are very complex cases to deal with and experience and training is essential. Medical leads should consider the competencies of the doctors, the training needs, the provision of formal supervision, the advice and support available at all times, both in prison and on call.

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- All clinical record keeping should be made in keeping with Good Medical Practice (GMC 2013) and Good Practice in Prescribing and Managing Medicines and Devices (GMC 2013). As outlined in GMC guidance and all other guidelines, all prescribing during a consultation and the outcomes of these consultations should be recorded. It is also important that the rationale for decisions (either to prescribe or not to prescribe) is also recorded, and the information that led to these decisions.
- For all practitioners there should be robust and comprehensive training in the use of the clinical system at induction and further on-going training.
- PHE should consider commissioning the RCGP to develop a training module for prison clinicians to take account of the findings of this review. The training should then be delivered to all prison clinical staff providing substance misuse services.

1.23 **Clinical governance and clinical leadership:**

- Excellence in clinical leadership within a robust integrated governance framework is crucial to ensure learning. This leadership to ensure enhanced patient safety is noted in reviews; for example the Francis and Berwick reports, (2013). This clinical leadership alongside Governors and commissioners should ensure this robust governance, with learning from all PPO reports and their recommendations alongside further internal audit reviews.
- A culture of audit and review is essential. While deaths in the prison system are already thoroughly reviewed, it is essential that all aspects of care are reviewed regularly with a clinical governance committee, this incorporating security staff. An audit programme could regularly review the action points from any untoward event, documentation in records etc. This continued clinical leadership is essential to develop a culture of learning and review with enhanced patient safety.
- There should be regular audit of clinical records, including prescribing, to ensure detailed record keeping of all contacts and observations.

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- The Accountable Officer for Controlled Drugs should regularly update medicines management system on recording and handling of controlled drugs.

1.24 **Operational issues:**

- Consider how healthcare staff and security can share issues such as suspicion and/or use of illicit drugs for the benefit of the prisoner and other prisoners. Knowledge/suspicion of illicit use is important to consider with any prescribing decisions. This sharing of security intelligence should be documented in clinical health care records especially for vulnerable prisoners on multiple prescribed medication and those on detoxification /stabilisation regimes.
- As much information as possible should be sought at earliest time, both from internal prison records past or current and from external agencies, e.g. GPs and community drug services. Guidance is given in PSO 3050 and IDTS.
- It is important that all prison health care services are integrated - mental health, IDTS and physical health so that all care is effectively coordinated.

1.25 **SUMMARY**

NICE guidance, UK clinical guidance and prison guidance on drug treatment as well as GMC and professional standards are clearly relevant to these cases. The key issues were of risk assessment of those with multiple vulnerabilities (including physical and mental health disorders) and issues related to multiple pharmacology for a variety of health problems, veracity of self-report without sufficient corroborative information, management of self-reported dual dependence with unclear tolerance, need for earlier reviews especially for those on multiple pharmacological regimes, the practical difficulties of the prison environment and monitoring, the possible availability of illicit and diverted drugs, the consistency and competence of health care staff, the need for integration of primary care / mental health and IDTS, and the importance of records and excellence in decision making.

1.26 **THE WAY FORWARD – NEXT STEPS**

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There is no doubt that the IDTS programme has been beneficial to many prisoners and their families, with much reduction in suicides, better management of withdrawal symptoms from alcohol and drugs in prison, availability of psychological therapies, better continuity of care and discussion with external provider agencies. IDTS has been successful and much of the guidance is most relevant alongside others such as GMC, NICE and local protocols.

However, while these deaths are small in number they are nonetheless tragic, for the prisoner, their families and the prison. In this review many of these cases were complex, with significant comorbidity. Further, the recommendations from the clinical reports and PPO reviews of these deaths noted many similar issues and made many similar recommendations such as the over reliance on self-report, the multiple CNS drugs and the need for overdose training. Some of the recommendations are not necessarily related to new guidance, they simply recommended that guidance already in existence is implemented, such as appropriate monitoring and excellent clinical documentation.

The themes noted in this review highlighted learning points, such as observation, documentation, sharing of information and regular medication reviews. In particular, this report noted some specific clinical points: a need for a review of pharmacological treatments in 48 hours, full review at Day 5, observations twice daily and no more than 2 sedative drugs at start of treatment. However, clinical judgment with availability of expertise at all times is required. Implementation of existing and new guidance on interventions and changes in ways of working is challenging and takes continued effort. It requires synergy between leadership, supervision, governance and training. I would recommend careful consideration of these clinical and generic recommendations.