

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Paul Day, a prisoner at HMP Sudbury, on 23 March 2017

A report by the Prisons and Probation Ombudsman

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OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE



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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

Mr Paul Day died in hospital on 23 March 2017, from the toxic effects of taking a synthetic cannabinoid, while a prisoner at HMP Sudbury. He was 55 years old. I offer my condolences to Mr Day's family and friends.

Mr Day had very little contact with healthcare services at Sudbury but I am satisfied that he received a good standard of care, equivalent to that he could have expected to receive in the community. However, it is not acceptable that staff did not attempt to resuscitate Mr Day when they found him unconscious in the toilet on the wing and that they did not use a defibrillator. The Governor should address this.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman

October 2017

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Summary

Events

1. On 18 September 2015, Mr Paul Day was sentenced to four years and six months in prison for possession of controlled drugs with intent to supply. He was sent to HMP Norwich. On 4 October 2016, Mr Day was moved to HMP Sudbury.
2. On arrival at Sudbury, Mr Day told a nurse that he had a history of respiratory disease and had suffered from a dry cough for several months. The nurse referred him to the GP and a prison doctor saw him two weeks later. He told the doctor that his cough had resolved itself but that he wanted help to stop smoking. The doctor referred him to the smoking cessation clinic.
3. The doctor also noted that Mr Day had a heart pacemaker fitted and needed an annual check in February 2017. Mr Day began smoking cessation treatment and managed to stop. Otherwise he had very little contact with healthcare staff.
4. Mr Day had a history of substance misuse. He was appropriately referred to substance misuse services. On arrival at Sudbury, he told substance misuse staff that he did not take illegal substances and did not need a further referral. Mr Day did not give staff any cause to suspect that he might be taking illegal drugs.
5. On 22 March 2017, at approximately 11.00pm, a prisoner found Mr Day unconscious on the floor of the toilet in their residential block. Water from the broken toilet cistern was falling onto Mr Day and flooding the floor. The prisoner could not find a pulse or signs of breathing.
6. Prison staff were alerted and arrived within a few minutes. They could not rouse Mr Day or find a pulse. The officers radioed an emergency medical code and requested an ambulance. They turned off the water but did not move Mr Day out of the toilet or begin first aid.
7. The first medical responder arrived about 15 minutes later and immediately moved Mr Day out of the toilet and into a clear dry area. He remained unconscious, with no pulse or sign of breathing. The first responder, assisted by prison staff, began advanced life support treatment. They put a heart monitor onto Mr Day's chest and began cardiopulmonary resuscitation. The first responder gave him adrenaline.
8. An ambulance and a critical care team joined the first responder and managed to get Mr Day's heart re-started and to stabilise him. On 23 March at 00.08am, Mr Day left the prison in the ambulance and went to hospital. A prison officer went with him but did not apply restraints. Shortly after his hospital admission, Mr Day had two cardiac arrests and at 1.50am he died.
9. A post-mortem examination later confirmed that Mr Day died from the toxic effects of a synthetic cannabinoid.

Findings

10. A pathologist found that Mr Day had used a synthetic cannabinoid, a new psychoactive substance (NPS), before he died and that this was the likely cause of his death. Mr Day had worked with substance misuse service staff at his previous prison but when he moved to Sudbury he told staff there that he did not use illegal substances and declined a referral to their services.
11. After Mr Day's death, his cellmate said that he suspected Mr Day took 'Spice' or 'Mamba' (NPS) and another prisoner said that in recent weeks he had been acting differently. However, Mr Day's drug use appears to have been very surreptitious and we are satisfied that staff had no reason to suspect that he took illegal drugs.
12. Mr Day had very little contact with healthcare services, other than to assist him to stop smoking. He missed an annual appointment to check his pacemaker due to poor communication between prisons but, overall, the clinical reviewer was satisfied that his care was equivalent to that he could have expected to receive in the community. However, she noted that healthcare staff do not have ready access to information contained in substance misuse service records, which are held separately.
13. After a prisoner told staff that Mr Day was unconscious in one of the toilet cubicles on the wing, staff were not able to feel a pulse or detect signs of breathing but did not attempt resuscitation or deliver any first aid intervention. They were unaware of the local directions under which resuscitation must be attempted. They were also unaware of the circumstances in which a defibrillator can be used.
14. Although there was no delay in calling an ambulance on this occasion, we are concerned that this is not always the case and that often an ambulance is not called until healthcare staff or a supervising officer confirms the need for one.

Recommendations

- The Governor should commission a disciplinary investigation into the actions of the staff involved in the initial response after they discovered Mr Day unresponsive in the toilet area.
- The Governor and Head of Healthcare should review the provision of first aid training, the deployment of first aid trained officers and, in particular, ensure staff know how and when to deliver cardiopulmonary resuscitation and are confident in using a defibrillator.
- The Governor should ensure that, in line with National Instructions, an ambulance is called immediately in an emergency medical situation and that ambulances have speedy access to prisoners in all parts of the prison.

The Investigation Process

15. The investigator issued notices to staff and prisoners at HMP Sudbury informing them of the investigation and asking anyone with relevant information to contact him. No one responded.
16. The investigator visited Sudbury on 29 March. He obtained copies of relevant extracts from Mr Day's prison and medical records and took statements from three prisoners.
17. The investigator interviewed four members of staff when he returned to Sudbury on 24 and 25 April.
18. NHS England commissioned an independent clinical reviewer to review Mr Day's clinical care at the prison. She conducted joint interviews with the investigator and they spoke to healthcare staff.
19. We informed HM Coroner for Milton Keynes of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
20. The investigator wrote to Mr Day's friend, his nominated next of kin, to explain the investigation and to ask if she had any matters she wanted the investigation to consider. Mr Day's friend did not respond to our letter.
21. We shared the initial report with the Prison Service. They pointed out some factual inaccuracies. This report has been amended accordingly.

Background Information

HMP Sudbury

22. HMP Sudbury is an open prison that houses over 580 adult men. In April 2016, Care UK won the contract for the provision of primary and mental health services. Inclusion, South Staffordshire and Shropshire Healthcare NHS Foundation Trust provide drug and substance misuse services.
23. Sudbury caters for prisoners in the latter stages of their sentence and specialises in rehabilitation and resettlement in preparation for release into the community. A number of prisoners are released each day on licence to help with their resettlement. Prisoners at Sudbury are required to sign up to a compact based drug testing regime.

HM Inspectorate of Prisons

24. The most recent inspection of HMP Sudbury was in November 2013. Inspectors reported that very low staffing levels created feelings of insecurity for the prisoners and the relationship between staff and prisoners was poor. Prisoners were unhappy about healthcare provision, which inspectors considered was partly due to more restrictive prescribing practices. Overall, inspectors considered that health services had improved but staffing shortages had had an adverse impact on service delivery.

Independent Monitoring Board

25. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to May 2016, the IMB reported that Sudbury was a well run prison providing a positive environment for most prisoners even though it was an old building with a limited budget and low staff numbers. Healthcare was described as patchy with some long waiting lists and the use of agency staff compromising provision.

Previous deaths at HMP Sudbury

26. Mr Day's death was the second at Sudbury since November 2013 to involve new psychoactive substances. We made recommendations about the emergency response in the previous report.

New Psychoactive Substances (NPS)

27. New psychoactive substances, previously known as 'legal highs' are an increasing problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate, raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of NPS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of

such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

28. In July 2015, we published a Learning Lessons Bulletin about the use of NPS and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of NPS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.
29. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements. Testing has begun, and HMPPS continue to analyse data about drug use in prison to ensure new versions of NPS are included in the testing process.

Key Events

30. On 18 September 2015, Mr Paul Day was sentenced to four years and six months in prison for possession of controlled drugs with intent to supply. He was sent to HMP Norwich but was transferred to HMP Wayland just over two weeks later. On 4 October 2016, Mr Day was moved to HMP Sudbury.
31. On arrival at Sudbury, a nurse completed Mr Day's initial health assessment. He told her that he had a history of respiratory disease and had suffered from a dry cough for several months. Mr Day was an ex-cigarette smoker. She referred him to the prison GP.
32. A prison GP saw Mr Day on 20 October. His cough had resolved itself but he told the doctor that he had started smoking again. The GP referred him to the smoking cessation clinic. He also noted that Mr Day had a heart pacemaker which was last checked in February 2016. He recorded that the pacemaker needed to be reviewed every 12 months.
33. The local hospital had arranged his next review for 20 February 2017 and notified HMP Wayland. By then Mr Day had transferred to Sudbury, and Wayland cancelled the appointment. Although the hospital letter was later scanned by staff at Wayland onto Mr Day's medical records, it was not brought to the attention of healthcare staff at Sudbury, so went unnoticed.
34. A locum GP saw Mr Day on 9 November. Mr Day said he had started smoking again and wanted to stop. He told the doctor that he had successfully taken Champix (medication used to treat nicotine addiction) in the past. The GP prescribed Mr Day Champix and arranged to review him in two weeks' time.
35. The healthcare support worker responsible for smoking cessation reviewed Mr Day weekly and a GP saw him monthly, for medication monitoring and to prescribe Champix. Each GP checked for side effects, specifically depression and noted that Mr Day did not report any. Mr Day successfully completed the 12-week programme on 9 February 2017 and was awarded his 'quit' certificate.
36. Otherwise Mr Day had very little contact with healthcare services at Sudbury, other than to access dental and podiatry services.

Substance Misuse Services

37. Mr Day had a history of substance misuse. He was appropriately referred to substance misuse service (SMS). On 30 October 2015, Mr Day told SMS staff at Wayland that he had previously taken ecstasy, cannabis and more recently amphetamines, but was not dependent on any of these drugs. He told them he had suffered previous bouts of depression.
38. On 10 October 2016, after his transfer to Sudbury, Mr Day had an induction talk from the SMS. He said that he had previously worked with the SMS at Wayland and did not need a referral to the service at Sudbury. As part of the process a peer mentor also discussed engagement with the SMS.

39. Due to his previous history, Mr Day's offender supervisor suggested he undertake some drug relapse prevention work. On 7 December, Mr Day met a substance misuse worker. Mr Day told her that he did not have issues with drug misuse but was happy to complete any work she required him to do.
40. The substance misuse worker saw Mr Day again on 29 December. Mr Day said that he still did not consider that he needed SMS support. She repeated the substance misuse information first given during Mr Day's induction. This included information about new psychoactive substances. Mr Day signed a SMS 'Harm Reduction Information' form to indicate that this been explained to him and to confirm that he did not use any substances.
41. Sudbury has a random and frequent drug testing programme. The prison could not confirm if Mr Day had been tested, only that he had never given a positive result.

Events of 22-23 March 2017

42. Mr Day lived on residential block 'West 7', in room 15, a double room that he shared with another prisoner. On 22 March at 8.30pm, Mr Day was in his room for the evening roll check. After the roll check prisoners can leave their rooms but must remain within their residential block. Mr Day's cellmate confirmed that Mr Day left their room sometime between 9.15pm - 9.30pm and did not return.
43. At approximately 10.00pm, a prisoner on West 7 went to use the toilet, located towards the centre of the residential block. He was aware of someone in one of the cubicles. The cubicle door was shut but he could hear movement. There was no conversation. He did not notice anything unusual or the smell of smoking and there was no water on the toilet floor. He returned to his room and went to bed.
44. Shortly before 11.00pm, the block cleaner on West 7 and occupant of room 4, was disturbed by another prisoner who knocked on his door and told him that the toilet block was flooded. He made his way to the toilet area where another prisoner said that he could hear water running from behind the toilet cubicle door. He could see water on the floor which appeared to be coming from inside the cubicle.
45. The block cleaner knocked on the cubicle door, but no one answered. The door was locked. He could hear the toilet cistern constantly re filling. He forced the toilet door open and saw Mr Day inside. He was fully clothed, lying on the floor to the side of the toilet in a pool of water.
46. Mr Day's head was underneath the cistern, the water pipe between the cistern and the toilet pan had come off and water was flowing straight onto Mr Day's head. The block cleaner told one of the other prisoners to go and get an officer and a prisoner made his way to the centre office.
47. The block cleaner put his hand on Day's shoulder, shook him and called out his name but he did not respond. He moved Mr Day's head from under the cistern to prevent any more water falling on to it. He then took hold of his wrist and felt for a pulse but could not feel one.
48. When the prisoner got to the centre office he told a Senior Officer (SO) that someone on West 7 was locked behind the toilet door. The SO immediately made

his way to West 7 together with an officer and two Operational Support Grades (OSGs).

49. The officers were at West 7 within a couple of minutes and one OSG immediately went into the toilet. The block cleaner said to the officers, "Gov, I think he's gone. I can't feel a pulse".
50. The OSG attempted to rouse Mr Day. He felt for a pulse in his wrist and neck and for signs of breathing. Mr Day remained unresponsive and he described him as cold to touch. He called a Code Blue (which signifies a medical emergency such as someone being unconscious or having difficulties breathing). The SO relayed the Code Blue emergency over the radio and instructed the officer in the Gate Room to call an ambulance. Sudbury does not have healthcare staff on duty at night.
51. The OSG turned the water off and the SO checked Mr Day for signs of life. He could not detect a pulse or signs of breathing. He described Mr Day as very cold, yellowish in colour and stiff to touch. He believed that Mr Day was dead and did not give first aid.
52. The officers only knew the identity of Mr Day from other prisoners. The SO returned to the centre office to get a defibrillator but on the way he went into Mr Day's room to get his ID card to confirm who he was. The OSG stayed with Mr Day and continued to check for a pulse and signs of breathing. He did not give first aid but, during interview, he told the investigator that he made sure that Mr Day's airway was open. While at the centre office the SO told another officer to get information that the paramedics would need about Mr Day from the prison computer records.
53. At 11.20pm, the SO returned to West 7 with the defibrillator. The officer at the gate told him that the first medical responder had arrived and he sent an officer to escort them to the scene. Due to the amount of water on the floor in the toilet area he decided not to use the defibrillator. A prisoner who knew Mr Day told him that Mr Day had a pacemaker fitted. He took photographs of the scene.
54. The first medical responder arrived at West 7 a few minutes later and immediately moved Mr Day out of the toilet and into a clear dry area. Mr Day remained unconscious, with no pulse or sign of breathing. A heart monitor was applied and some electrical activity was detected in his heart. The first responder, assisted by prison staff began advanced life support treatment. The first responder put a tube into Mr Day's airway and the officers started cardiopulmonary resuscitation (CPR). The first responder gave him adrenaline.
55. An ambulance crew got to the prison at 11.30pm and a critical care team vehicle about ten minutes later. They joined the first responder and managed to get Mr Day's heart re-started and to stabilise him, though he remained unconscious.
56. On 23 March at 00.08am, Mr Day left the prison in the ambulance and went to hospital. A prison officer went with him but did not apply restraints. Shortly after his hospital admission, Mr Day had two cardiac arrests and at 1.50am he died.

Contact with Mr Day's family

57. On 22 March at about 11.50pm, a senior prison manager telephoned Mr Day's next of kin, a friend, and left a voicemail message telling her that Mr Day had been taken to hospital and asking her to contact the prison.
58. The next morning, at about 5.00am, the prison appointed a prison officer as the family liaison officer. She arrived at the prison shortly after 6.00am. At 7.15am, she and a prison driver left the prison to tell Mr Day's next of kin that he had died. Mr Day's next of kin lived some distance from the prison, a journey by car of approximately four hours.
59. However, at about 8.50am, Mr Day's friend telephoned the prison. A senior prison manager called her back approximately 20 minutes later having first established that the prison officer was still some considerable distance away. During the course of the telephone conversation Mr Day's friend specifically asked her if he had died, and she told her that he had. She offered her condolences.
60. The prison officer met Mr Day's friend at her home at about 1.35pm. They discussed the circumstances of Mr Day's death and the officer offered her condolences. Mr Day's friend said that she was surprised that Mr Day named her as his next of kin as, although they spoke regularly, he had family, including a number of children. Mr Day's friend said that she would inform his family of his death.
61. The prison officer remained in contact with Mr Day's friend and also with members of his family. She arranged for them to visit the prison and to collect his property, however when this was not possible, she delivered Mr Day's belongings in person. She also helped with the funeral arrangements.
62. Mr Day's funeral was held on 24 April, and the prison contributed towards the cost in line with Prison Service Instructions.

Support for prisoners and staff

63. After Mr Day's death, a senior prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.
64. The prison posted notices informing other prisoners of Mr Day's death, and offering support.

Post-mortem report

65. A post-mortem examination recorded that Mr Day died at hospital on 23 March 2017, at 1.50am, from the toxic effects of a synthetic cannabinoid.

Information received after Mr Day's death

66. Despite the fact that Mr Day told substance misuse service staff that he did not use any illegal substances, information from other prisoners suggested otherwise. Mr Day's cellmate said he suspected he took 'Spice' or 'Mamba' (new psychoactive

substances, previously known as legal highs) though when they spoke Mr Day always denied this.

67. Mr Day's cellmate said that he had never witnessed Mr Day take anything but from the condition he was sometimes in (eyes red, barely able to walk or stand) it was clear that he had.
68. Mr Day's cellmate went on to explain that he would often go off to the toilet late at night and come back "in a real state". He said that on one occasion when he came back into the room he had to hold on to a cupboard for about 15 minutes just to keep himself upright and could not make it onto his bed. He said this happened maybe once a week, usually on a Wednesday after Mr Day had collected his canteen. He suggested that Mr Day would trade items from his canteen for drugs.
69. The cellmate told the investigator that Mr Day had been acting differently in the previous few weeks and that he had noticed a definite change. He said that he didn't know that Mr Day took drugs which he said came as a complete surprise to him.
70. Mr Day's next of kin told the family liaison officer that he had a history of drug misuse. She said he sounded fine when they last spoke on the evening before his death but on a previous call the week before he sounded "weird" and she felt he may have been smoking Spice.
71. Unfortunately none of this information was brought to the attention of prison staff before Mr Day died.

Findings

Substance Misuse

72. Mr Day had a history of substance misuse but had shown no evidence of this since his last admission to prison. There were no concerns expressed by staff about ongoing use of illegal substances. Mr Day worked with substance misuse services at HMP Wayland and was offered similar support when he transferred to Sudbury.
73. Mr Day told substance misuse staff at Sudbury that he did not use illegal substances and did not need a referral to their service. When his offender supervisor suggested he undertake some drug relapse prevention work, Mr Day agreed but because there was the possibility of him moving prisons this work had not begun before he died.
74. The substance misuse service at Sudbury keeps separate care records which are not transferred onto SystemOne, the main healthcare record. As a consequence, healthcare staff are unaware of any substance misuse intervention. The clinical reviewer makes a recommendation that substance misuse records be integrated into SystemOne. As this was not material to Mr Day's death we do not repeat the recommendation but the Head of Healthcare and Governor will need to address it.
75. We are satisfied that staff had no reason to suspect that Mr Day was taking illegal substances.

Emergency response

76. On 25 October 2016, Sudbury issued Staff Information Notice (SIN) 179/2015 which gives guidance about when to perform CPR in prisons. The notice directs that resuscitation **MUST** be started on all people who are found not breathing and/or pulseless unless there is evidence of lividity (internal pooling of blood), rigor mortis, decapitation, massive cranial and cerebral destruction (such as catastrophic head injury), incineration, traumatic hemicorporectomy (where the body is completely cut below the shoulders and above the hips through all major organs and vessels) and decomposition/putrefaction.
77. The SIN also directs that if resuscitation is not carried out a full explanation of the circumstances and reasons for not attempting resuscitation must be given and documented.
78. When staff arrived at the toilet on West 7 on 22 March, Mr Day was unconscious and could not be roused. A prisoner and prison staff felt for a pulse and looked for signs of breathing but found neither. The officers who touched Mr Day described him as cold and stiff to touch and his complexion as pale or yellowish.
79. The OSG called a Code Blue and the SO directed the officer in the Gate Lodge to call an ambulance. The OSG stayed with Mr Day but there was no attempt to move him out of the toilet area or to begin first aid. The officers gave several explanations for leaving Mr Day where he was; these included not wishing to cause him further injury by moving him, preserving a possible crime scene and believing him to be dead. They had no knowledge of SIN 179/2015 and did not consider CPR.

80. The SO and OSG and at least one other officer who attended the scene were first aid trained, although only the SO was trained to use a defibrillator. He returned to the centre office to collect the defibrillator, but with no urgency, and on the way he went into Mr Day's room to get his ID card to confirm his identify. When he returned with the defibrillator several minutes later he decided not to use it due to the amount of water on the floor and on Mr Day's clothes and because a prisoner told him that that Mr Day had a heart pacemaker fitted.
81. When the first responder arrived Mr Day was immediately moved out of the toilet to a dry area, a heart monitor was applied to his chest and staff began CPR. Though he remained unconscious they successfully restarted his heart and stabilised his condition.
82. We do not know exactly how long Mr Day had been unconscious in the toilet area but it is clear that staff should have started CPR immediately. Though they described Mr Day as stiff, there was no evidence of rigor mortis or of any of the other symptoms that would exclude starting CPR. We can not say if the outcome for Mr Day would have been different had staff begun CPR sooner or deployed the defibrillator, but self evidently there is a better chance of survival if first aid is started immediately. The delay was unacceptable.
83. Defibrillation is safe to apply to people with pacemakers; the guidance given is to avoid placing the defibrillator pads directly over the pacemaker device if at all possible. The SO was right to recognise that a defibrillator should not be used when the surrounding area is wet but should have known that it was safe to use otherwise. We make the following recommendations:
- The Governor should commission a disciplinary investigation into the action of the staff involved in the initial response after they discovered Mr Day unresponsive in the toilet area.**
- The Governor and Head of Healthcare should review the provision of first aid training, the deployment of first aid trained officers and, in particular, ensure staff know how and when to deliver cardio pulmonary resuscitation and are confident in using a defibrillator.**
84. Prison Service Instruction (PSI) 03/2013 directs that Governors/Directors of all prisons must ensure that a Medical Emergency Response Code protocol exists that enables staff discovering a prisoner in need of urgent medical attention to clearly and concisely convey the nature of the medical emergency simultaneously to all interested parties and contact the communication or control room.
85. Local procedures must ensure that staff understand they should not delay summoning emergency assistance. For example, it must not be a requirement for a member of the prison healthcare team or a Duty Manager to attend the scene before emergency services are called.
86. It is essential that an ambulance is called in all cases where there are serious concerns about the health of a prisoner and that access to both the prison and the individual prisoner is not delayed.
87. In July 2016, Sudbury issued Staff Information Notice 109/2016 about the use of emergency code procedures when a prisoner needs immediate medical assistance.

The notice directs that, in response to an emergency medical code an ambulance will be called automatically.

88. When the OSG discovered Mr Day unconscious in the toilet he immediately identified the situation as a Code Blue. The SO relayed the Code Blue over the radio and told the officer in the Gate Lodge to immediately call an ambulance and there was no delay.
89. However, during interview, when asked why it had been necessary after the Code Blue call to also call an ambulance, it became clear that ordinarily an ambulance would not be called automatically until either someone from healthcare or the senior officer on duty confirmed that one was needed.
90. It is also of concern that the SO waited for the ambulance to arrive at the prison gate before sending an officer to escort it to the scene causing an unnecessary, though not excessive delay. We make the following recommendation:

The Governor should ensure that, in line with National Instructions, an ambulance is called immediately in an emergency medical situation and that ambulances have speedy access to prisoners in all parts of the prison.

Clinical care

91. On arrival at Sudbury Mr Day presented as a well man. He very had little intervention from the healthcare team other than for smoking cessation which he successfully completed. He had a long term cardiac condition which was well controlled by a pacemaker and there were no signs or symptoms of him suffering from heart problems.
92. However, his 12-month pacemaker check was overdue by a month and had not been arranged due to the poor handover of information from his previous prison and the lack of local referral by the GP. The clinical reviewer recommends that healthcare staff at HMP Wayland should not scan appointments or clinical letters into SystmOne, after a prisoner has been transferred, without highlighting the fact that they have done so to the receiving prison. We do not repeat the recommendation in this report however the Head of Healthcare at Wayland will need to address this.
93. The clinical reviewer notes however that Mr Day was not experiencing problems with his pacemaker and did not consider this to be linked to his death. Overall, the clinical reviewer was satisfied that the care Mr Day received at Sudbury was equivalent to that he could have expected to get in the community.

Inquest

94. The inquest, held from 7 to 9 May 2024, concluded that Mr Day's death was drug related. The jury found that prison staff should have performed CPR on Mr Day though they did not find on the evidence that this omission contributed to his death.
95. Following the inquest, the Coroner issued a Prevention of Future Deaths Report to Sudbury. The Coroner expressed concern that the current guidance issued to prisons about when not to perform CPR (which says that CPR should not be performed when there are physical signs that the person is already dead, such as

rigor mortis), was not appropriate for prisons without 24-hour healthcare as prison staff were not trained in recognising signs of death.

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