Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Ming Jiang, a prisoner at HMP Swaleside, on 21 July 2024

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

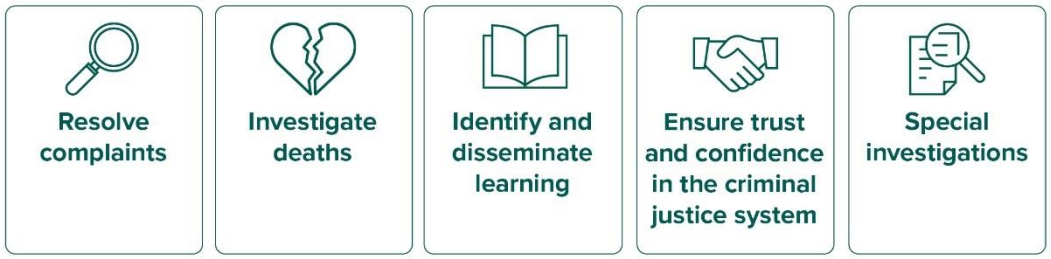
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T l 020 7633 4100

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

Summary

1. 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.

2. If my office is to best assist His Majesty's Prison and Probation Service (HMPPS) in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

3. Mr Ming Jiang died in hospital of leukaemia on 21 July 2024, while a prisoner at HMP Swaleside. He was 50 years old. We offer our condolences to his family and friends.

4. The clinical reviewer concluded that the clinical care Mr Jiang received at Swaleside was equivalent to that which he could have expected to receive in the community. However, there were clearly tensions between prison and healthcare staff on 20 July, the day Mr Jiang was sent to hospital. When prison staff became concerned that Mr Jiang's condition was deteriorating, they struggled to get a nurse to review him as nurses were busy with other duties. Prison staff called a medical emergency code to summon the emergency response nurse. However, she left to deal with another emergency and no one from healthcare stayed with Mr Jiang while staff waited for an ambulance to arrive.

5. The medical assessment of the escort risk assessment was left blank. A prison manager authorised the use of double cuffs on Mr Jiang when he left the prison. When Mr Jiang was taken to intensive care, a prison manager authorised the use of an escort chain, which was removed on the evening of 20 July.

6. Mr Jiang died in the early hours of 21 July, after his ventilator was switched off. A hospital doctor gave his cause of death as acute promyelocytic leukaemia (a type of blood cancer). He had not previously been diagnosed with this condition.

Recommendations

- The Governor and Head of Healthcare should review the systems and processes for prison staff to request a healthcare review of a prisoner with deteriorating health including how to apply the policy for calling emergency codes.

- The Head of Healthcare should review the role of Hotel 1 to ensure that all healthcare staff that hold the Hotel 1 radio are aware of their role and responsibilities including how to manage situations when multiple codes are being called in the prison.

- The Head of Healthcare should review the systems and processes for training and supporting staff to complete escort risk assessments for patients requiring emergency hospital admission.

- The Governor should review whether the quality assurance process for escort risk assessments is sufficiently robust and consider introducing SLT review of a random sample to identify any ongoing issues.

The Investigation Process

7. HMPPS notified us of Mr Jiang's death on 21 July 2024.

8. NHS England commissioned an independent clinical reviewer to review Mr Jiang's clinical care at Swaleside.

9. The PPO investigator investigated the non-clinical issues relating to Mr Jiang's care.

10. The investigator interviewed four members of staff at Swaleside on 4 September and one member of staff by video call on 29 August. The clinical reviewer accompanied the investigator for all interviews. The investigator and clinical reviewer also spoke with one prisoner on 4 September who raised concerns about the quality of care Mr Jiang received from healthcare staff when he became unwell. These issues have been addressed in this report and in the clinical review.

11. The Ombudsman's office contacted Mr Jiang's brother in China to explain the investigation and to ask if he had any matters he wanted us to consider. He did not respond.

12. We shared our initial report with HMPPS and the prison's healthcare provider, Oxleas NHS Foundation Trust. They found no factual inaccuracies. They provided an action plan which is annexed to this report.

Previous deaths at HMP Swaleside

13. Mr Jiang was the 24th prisoner to die at Swaleside since July 2021. Of the previous deaths, ten were from natural causes, ten were self-inflicted, two were drug related and in one, the cause of death was unascertained.

14. We have made recommendations to Swaleside in two previous cases about ensuring there is medical input into the escort risk assessment and authorising managers demonstrating that they have taken this information into account when authorising the use of restraints. The prison told us in September 2023, that staff and managers had been briefed on expectations and that a member of the Senior Leadership Team checked all escort risk assessments to ensure that they had the necessary input and authorisation.

Key Events

15. In May 2017, Mr Ming Jiang was given a life sentence for murder. On 4 October 2023, he was moved to HMP Swaleside.

16. Mr Jiang had no significant health concerns when he arrived at Swaleside. From November 2023 to February 2024, he complained of neck and back pain. He was prescribed pain relief and seen by the physiotherapist and pain clinic. He disengaged when healthcare staff refused to prescribe stronger medication and he was discharged from the pain clinic in February 2024.

17. On 15 July, a nurse assessed Mr Jiang as he said he had flu-like symptoms. The nurse advised him to drink fluids, rest and take paracetamol.

18. On 17 July, a nurse went to check on Mr Jiang but he was asleep. The nurse advised prison staff to contact healthcare staff if there were any concerns and said that a nurse would review him again the next day.

19. On 18 July, a nurse recorded that she reviewed Mr Jiang but no other information is recorded.

20. On 19 July, a GP saw Mr Jiang who said he had had a cough for three weeks, was hot and feverish, and had itchy rashes on his chest and lower limbs. The GP prescribed antibiotics.

Events of 20-21 July

21. On the morning of 20 July, staff asked Nurse A, who was working in the wing's medication hatch, to check on Mr Jiang as he was unwell in his cell. Mr Jiang was coughing up phlegm, was cold and clammy, and his left arm was numb.

22. At approximately 10.00 am, Nurse A went to Mr Jiang's cell. She thought Mr Jiang looked very unwell. He was pale in colour and appeared to be in a lot of discomfort. She took his clinical observations and calculated a NEWS2 score of 3. (The National Early Warning Score (NEWS2) is a tool used to assess clinical deterioration. A score is calculated from the clinical observations taken and the higher the score, the higher the risk. A score of 3 is low risk.)

23. Nurse A called Nurse B (Hotel 1 – the emergency response nurse) for a second opinion. Nurse B arrived approximately five minutes later to review Mr Jiang. Nurse A and Nurse B were in Mr Jiang's cell for 28 minutes undertaking an assessment. This is evidenced by the CCTV.

24. Nurse B took a full clinical assessment of Mr Jiang, and her assessment was that Mr Jiang had a NEWS2 score of 2. She told Nurse A to check on Mr Jiang after lunch.

25. CCTV footage shows that Mr Jiang came out of his cell after the nurses had left and sat on the sofa on the wing.

26. At approximately 10.45am, Officer A was told by another officer that Mr Jiang was becoming more unwell. Another prisoner was caring for Mr Jiang and CCTV shows him getting Mr Jiang tissues and a bin.

27. Officer A went to the medication hatch and asked Nurse A to see Mr Jiang. Officer A told the investigator that Nurse A said that she had already seen Mr Jiang earlier that morning and to contact Hotel 1. Officer A told the investigator that he knew Hotel 1 would tell him to speak to the nurse on the wing unless it was an emergency so he radioed a Code Blue (a medical emergency code used when a prisoner is unconscious or having breathing difficulties that alerts healthcare staff and tells the control room to call an ambulance immediately) to ensure that Hotel 1 attended. Nurse A told the investigator and clinical reviewer that she told Officer A that she was dispensing medications and did not have capacity to assess Mr Jiang again. She said she told Officer A to call a Code Blue to ensure that Hotel 1 attended. Officer A called the Code Blue at 11.27am.

28. Officer A was not wearing a Body Worn Video Camera (BWVC) so there is no BWVC footage of the incident. There was CCTV footage but no audio of the events that followed.

29. In interview, Officer A said that after he called the Code Blue, Nurse A left the medication hatch to see Mr Jiang. She took some clinical observations.

30. Nurse B said that she heard the Code Blue for Mr Jiang while dealing with a Code Red (a medical emergency involving severe blood loss or burns) in a different part of the prison. Nurse B assessed the Code Red incident as not life threatening and left to attend the Code Blue.

31. Officer A told the investigator that staff saw Nurse B at the end of the wing, waiting at the gate and she refused to enter the wing until she was escorted by an officer. Nurse B said in interview that she was scared to walk onto the wing unescorted as prisoners were out of their cells and she had started to feel unwell. Officer A said when Nurse B did arrive on the wing, she seemed annoyed and asked him why he had called a Code Blue. He said that Mr Jiang was having chest pains and coughing up blood. Officer A told the investigator that Nurse B asked if an ambulance was on its way and when he confirmed it was, Nurse B left the wing. He recorded that Nurse B said she had already seen Mr Jiang and “can’t be bothered”.

32. In her interview, Nurse B denied saying this. She recorded that she assessed Mr Jiang and noted that he was alert, pale and clammy, and not in pain. She noted that he was “spitting old brown colour bloods”. She made the decision to return to the Code Red incident and told prison staff to tell her when the ambulance arrived.

33. Officer A told the investigator that when the ambulance paramedics arrived at the prison, healthcare staff did not return to the wing. Nurse B told us that prison staff did not notify Hotel 1 when the ambulance arrived. (Nurse B had handed over Hotel 1 duties to another senior nurse due to feeling unwell.)

34. Mr Jiang was taken to hospital at approximately 12.30pm. He was accompanied by two officers and was double cuffed. (Double cuffing is when the prisoner’s hands are handcuffed in front of them and one wrist is attached to a prison officer by an

additional set of handcuffs. Mr Jiang was a Category B prisoner and this is the standard cuffing arrangement for Category B prisoners.)

35. Mr Jiang was admitted to hospital and later transferred to the Intensive Care Unit, where he was put on a ventilator (indicating respiratory failure). Hospital doctors diagnosed a severe bleed on the brain. At around 7.30pm, a prison manager authorised the use of an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner's wrist and the other to an officer's wrist) in place of the double cuffs.

36. At around 8.45pm, a prison manager visited the hospital and authorised the escort chain to be removed due to Mr Jiang's condition.

37. At 1.07am on 21 July, Mr Jiang was taken off the ventilator. He died at 1.25am.

Contact with Mr Jiang's family

38. On 21 July, the prison appointed a family liaison officer (FLO). Mr Jiang's brother, who lives in China, was listed as his next of kin. The FLO telephoned Mr Jiang's brother on 21 July, but was unable to break the news as Mr Jiang's brother did not speak any English. The FLO contacted the Chinese Embassy to see if they could assist but they said it was outside their remit.

39. The FLO log shows that the FLO and chaplaincy staff contacted Mr Jiang's brother on 23 July, using a telephone interpretation service and broke the news of his death with the help of a Mandarin interpreter.

40. The prison contributed to the costs of Mr Jiang's funeral, which was held in the UK, in line with national policy.

Support for prisoners and staff

41. After Mr Jiang's death, a custodial manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support.

42. The prison posted notices informing other prisoners of Mr Jiang's death and offering support.

Cause of death

43. No post-mortem report was completed as the Coroner accepted the cause of death provided by a hospital doctor. The doctor gave the cause of death as acute intracerebral haemorrhage (bleed on the brain), caused by COVID pneumonitis, sepsis and thrombocytopenia (fewer platelets in the blood), which had been caused by acute promyelocytic leukaemia (a type of blood cancer).

Findings

Response to Mr Jiang's deterioration on 20 July

44. While recollections of the events of 20 July differ between wing officers and nurses, it is apparent that relations between prison staff and healthcare staff were strained that day. Officers considered that Mr Jiang was deteriorating and needed to be seen urgently by healthcare staff, while the nurses concerned were dealing with medication duties and a medical emergency so were unwilling to attend to Mr Jiang.

45. This resulted in officers calling a Code Blue in order to elicit a healthcare response. While this ended up being the appropriate action for Mr Jiang as paramedics assessed he needed to go to hospital, medical emergency codes should be reserved for emergency situations and not to summon a healthcare review. Work needs to be done at the prison to improve understanding of the roles of prison and healthcare staff when prisoners become unwell, including how prison staff should summon assistance and how healthcare staff should respond.

46. We recommend:

The Governor and Head of Healthcare should review the systems and processes for prison staff to request a healthcare review of a prisoner with deteriorating health including how to apply the policy for calling emergency codes.

Clinical care

47. The clinical reviewer concluded that the clinical care Mr Jiang received at Swaleside was reasonable and was equivalent to that which he could have expected to receive in the community.

48. However, the clinical reviewer found that when Nurse B (Hotel 1) left Mr Jiang to return to the Code Red incident, she should have handed over to other senior healthcare staff to stay with Mr Jiang while he waited for the ambulance to arrive. This would have ensured:

- Mr Jiang had continuing healthcare monitoring and assessment.
- A comprehensive handover to ambulance staff.
- Completion of the medical section of the escort risk assessment.

49. We recommend:

The Head of Healthcare should review the role of Hotel 1 to ensure that all healthcare staff that hold the Hotel 1 radio are aware of their role and responsibilities including how to manage situations when multiple codes are being called in the prison.

Use of restraints

50. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a serious medical condition. It said that medical opinion about the prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

51. Staff used the standard cuffing arrangement for Category B prisoners, double cuffs, when Mr Jiang left the prison. The medical section of the escort risk assessment was left blank. This should have been completed so that the authorising manager could take account of Mr Jiang's health and mobility when authorising the level of restraint to be used.

52. The investigator spoke to the manager who authorised restraints. He said that Mr Jiang was walking and talking normally when he left the prison and that in his view, the standard cuffing arrangement was appropriate. He also said that healthcare staff were suspicious of Mr Jiang and thought he might not be as unwell as he was making out, but he could not name the staff who thought this.

53. We disagree with the decision to double cuff Mr Jiang. He was clearly unwell when he was taken to hospital. While we accept that he was not an elderly man and was mobile, we do not accept that his risk of escape was as high as it would have been had he been physically fit and well. The use of double cuffs was disproportionate. We also consider that the use of an escort chain on Mr Jiang when he was in intensive care on a ventilator was also disproportionate.

54. In previous investigations at Swaleside, we found that medical information had not been added to the escort risk assessment and that authorising managers had not taken the prisoner's health into account when deciding on the level of restraints to be used. We identified repeat issues in this investigation. We were told in September 2023 that all relevant staff and managers had been briefed on the expectations of the Graham judgment and that an extra assurance level had been added into the process whereby a member of the Senior Leadership Team (SLT) checked all escort risk assessments to ensure they had the correct input and authorisation.

55. The manager who authorised restraints told us that escort risk assessments were supposed to be signed off by two SLT members but when Mr Jiang was sent to hospital, a second SLT member was not available. He said that to avoid any delay, he asked a custodial manager to act as the second signatory. They both signed the escort risk assessment despite there being no medical input. The manager said that healthcare staff raised no issues with the paperwork and it was important that Mr Jiang was sent to hospital without delay. We recommend:

The Head of Healthcare should review the systems and processes for training and supporting staff to complete escort risk assessments for patients requiring emergency hospital admission.

The Governor should review whether the quality assurance process for escort risk assessments is sufficiently robust and consider introducing SLT review of a random sample to identify any ongoing issues.

Liaison with Mr Jiang's family

56. Although the prison FLO telephoned Mr Jiang's brother in China promptly after his death, he could not break the news due to the language barrier. It was another two days before the FLO called again and used a telephone interpreter to break the news. We accept that it is unusual for a prison FLO to be faced with this situation, but we consider it took too long for the prison to use a telephone interpreter. We bring this to the Governor's attention.

Body Worn Video Cameras

57. Officers should switch on their Body Worn Video Camera (BWVC) when they call or respond to a Code Blue incident. Officer A told the investigator that he did not have a BWVC. He said that as he was not PAVA trained (PAVA spray is an incapacitant spray like pepper spray), he was not required to draw a BWVC due to the lack of BWVC available at the prison. He said he was unaware that the BWVC should be activated when there is a Code Blue. His understanding was that BWVC should only be activated to record violent incidents.

58. BWVCs capture audio as well as images, unlike CCTV which captures images only. Due to the lack of BWVC footage, we were unable to hear the interactions between prison and healthcare staff after the Code Blue was called for Mr Jiang on 20 July. All wing officers should be drawing BWVCs and activating them in response to Code Blue incidents. We bring this issue to the Governor's attention.

Adrian Usher
Prisons and Probation Ombudsman **February 2025**

Inquest

The inquest, held on 18 March 2025, concluded that Mr Jiang died from natural causes.

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