A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Gartree in June 2012

Our Vision

‘To be a leading, independent investigatory body, a model to others, that makes a significant contribution to safer, fairer custody and offender supervision’

This is the report into the death of a man at HMP Gartree in June 2012. The man died of a heart attack. I offer my condolences to his family and friends.

The investigation was carried out by one of my investigators with the cooperation of Gartree prison. A clinical reviewer was appointed to review the man's clinical care.

The man did not present any symptoms consistent with heart disease. On the morning of the man's death at 5.35am, night staff heard noises from the man's cell and saw that he was unwell but did not go into his cell to assist him until 6.08am as they waited to get authority from the duty governor who was not at the prison. An ambulance was not requested until 6.10am. Despite efforts by staff and paramedics to revive the man once they had gone into the cell, he was pronounced dead at 7.00am. The clinical reviewer has outlined the chance of survival for patients experiencing a sudden onset cardiac arrest, and finds that this delay significantly affected the man's chances of successful resuscitation.

I am satisfied that the general level of medical care the man received at Gartree was appropriate and that his sudden heart attack could not have been predicted. However, the delay in entering the man's cell to provide emergency assistance was wholly unacceptable. This office has raised the issue of delayed entry into cells in two previous investigations of deaths at Gartree in the last two years. Recommendations made in those cases were accepted but this case appears to indicate that that there is still reluctance by prison staff to use their judgement and, subject to a personal risk assessment, to enter a cell in an emergency during the night state without the permission of a duty governor. The Governor of Gartree must now take effective steps to ensure that all staff fully understand their duty to act to help protect lives.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2012**

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SUMMARY

1. The man was sentenced to life imprisonment on 21 October 2005. He transferred to Gartree on 13 July 2006.

2. On entering custody, the man said he had lower back pain and shoulder pain, which were later exacerbated by an injury sustained in the gym. He had no other chronic medical conditions and there was no indication that the man was suffering from cardiac problems.

3. On the morning of the man's death, he was observed at 5.35am to be breathing unusually. Rather than following the night procedures and entering the cell, the operational support grade, an officer, and a nurse waited for the senior officer in charge of the prison during the night to telephone the duty governor at home for authority to enter the cell. This led to a delay of more than 30 minutes before prison healthcare staff entered the cell and tried to revive him. An ambulance was not called until that stage. Paramedics pronounced him dead at 7.00am.

4. The clinical reviewer makes a number of recommendations which are reflected in the investigation findings. He concludes that the overall medical care provided to the man at Gartree was good. However, the delay in entering his cell significantly reduced the man's chances of being successfully resuscitated.

5. We are concerned that, despite making recommendations about delays in entering a cell following two previous investigations, there remains a lack of awareness and reluctance to enter a cell in a medical emergency. Communication of an emergency needs to improve. There is also a need for a dedicated family liaison role whenever there is a death in custody to ensure families are informed quickly.

THE INVESTIGATION PROCESS

6. The investigator visited Gartree on 19 June. She met the prison's liaison officer for this investigation and who was also the first family liaison officer. The investigator was given copies of the man's records and visited his wing and his cell. Notices about the investigation were issued to staff and prisoners at Gartree asking anyone who had relevant information to contact the investigator. No one came forward.

7. Following the initial visit, the investigator wrote an urgent letter to the Governor, highlighting concerns that the protocol for entering a cell during the night had not been appropriately followed and had resulted in a delay in providing the man with immediate medical attention. The Governor responded to this letter on 27 June, advising that an internal investigation had been started.

8. A clinical reviewer was appointed to review the man's clinical care. He was provided with all relevant documentation. The investigator and an assistant ombudsman, returned to Gartree on 16 and 17 July. They interviewed eight members of staff and five prisoners. The clinical reviewer joined them for four staff interviews on 17 July. The clinical review was received on 20 August.

9. The investigator and the assistant Ombudsman met the Governor after the conclusion of their interviews to give preliminary feedback, which was confirmed in writing on 18 July. The investigator conducted a telephone interview with an officer on 15 August.

10. The investigator contacted East Midlands Ambulance Service who provided details of the contact they had with Gartree on the day the man died.

11. The HM Coroner was informed of the investigation. The investigation report will be sent to the Coroner. A post-mortem report was received on 20 August and indicated that the man died of a heart attack.

12. One of this office's family liaison officers contacted a representative of the man's family on 12 July to ask if his family had any issues they would like the investigation to cover. However, this was a distant friend of the family who knew very little of the man, but provided contact details for the man's sister. The man's sister was contacted on 20 July and she did not raise any specific issues with the office's family liaison officer which she wished the investigation to take into account. The man's family received a copy of the draft version of the report as part of the consultation period. The man's family told my family liaison officer that they had found the report helpful and informative. They however remained unhappy with the amount of time taken before the man was

given any assistance and welcomed the recommendation made with this mind.

HMP GARTREE

13. HMP Gartree is near Market Harborough in Leicestershire and holds up to 677 life sentenced prisoners. Leicestershire County and Rutland Primary Care are responsible for delivering primary healthcare services in the prison and mental health services are delivered by Northamptonshire Healthcare NHS Foundation Trust.

HM Inspectorate of Prisons (HMIP)

14. The Inspectorate last carried out an announced inspection of Gartree in May 2010 and found the prison much improved from earlier inspections. The inspection occurred at a time when the inpatients unit had just closed and a new outpatient health care clinical centre had yet to open. Inspectors reported that health services were improving, with good support from a proactive PCT and the Governor. Health care was described as reasonable, with good GP provision.

Independent Monitoring Board (IMB)

15. In the annual report for 2010/11, the IMB described the pressures of delivering healthcare at Gartree under transitional arrangements. The IMB recognised the role of the Governor and his senior management team in bringing improvement to healthcare services over the previous year. Overall, the IMB were satisfied that the healthcare team ran a good service.

Previous deaths at Gartree

16. The man's death was one of three deaths from natural causes at Gartree in the past year. Concerns were raised in the investigations into two of these cases about procedures for entering a cell at night. Despite recommendations relating to this being accepted, and the night time policy being revised, prison staff were evidently still reluctant to go into the man's cell even when it was clearly a medical emergency. The previous concerns about delays in entering cells at night in an emergency are repeated in this investigation report.

KEY EVENTS

17. The man lived in London. He was sentenced to life imprisonment on 21 October 2005. He had been in prison before. He went first to Belmarsh prison and transferred to Gartree on 13 July 2006, where he spent the rest of his sentence.

18. On entering prison, the man said that he had a shoulder injury and occasionally had lower back pain. In May 2009, he aggravated his shoulder injury in the gym. He was referred to an orthopaedic consultant (a specialist in bones, joints and ligaments) for specialist assessment. He was advised, during a follow up appointment on 8 December, that he could need surgery on his shoulder as he had torn the muscles in the shoulder. The man was seen periodically over the next few months by the prison doctor for his shoulder pain.

19. In February 2011, the man was assaulted by another prisoner. He sustained a serious injury to his lower lip and was taken to accident and emergency at Leicester Royal Infirmary. He required reconstructive surgery and was referred to the mental health team for counselling following the assault.

20. While the man waited for information about his shoulder, he was regularly reviewed by the prison doctor and healthcare staff and his pain relief medication was altered to provide symptomatic relief. On 6 June 2011, against medical advice, he signed a disclaimer refusing treatment.

21. On 13 November 2011, the man told a mental health nurse, that he had become more anxious following the assault in February, had difficulty sleeping and found it hard to concentrate. He explained that he was still suffering pain and discomfort due to his shoulder injury. The mental health nurse referred the man to the prison doctor because of the ongoing pain in his shoulder and for a post-traumatic stress disorder (PTSD) assessment (PTSD is a severe anxiety disorder that can develop after exposure to any event that results in psychological trauma). The man also registered for the stop smoking clinic on 15 November, where he was prescribed nicotine patches.

22. Prison doctor A, assessed the man on 17 November. He explained that he had been experiencing low mood for two to three months. The doctor prescribed citalopram (an antidepressant medication) to be reviewed in three to four weeks.

23. On 5 December 2011, the man was examined by a specialist registrar at Leicester Royal Infirmary, about his shoulder injury and was prescribed more pain relief. On 30 December, the man again attended Leicester Royal Infirmary, this time for a review of the reconstructive surgery on his lip. The injury had healed well, although he was still experiencing pain. An oral and maxillofacial surgeon (a specialist in treating injuries to the mouth and face) wrote to the prison advising that the man might

benefit from a low dose tricyclic antidepressant which is also effective as pain relief.

24. The last formal contact the man had with health services at the prison was on 17 May 2012, when prison Dr B reviewed the man's lip and further increased his pain relief medication.

Events on the day the man died

25. There is no evidence that the man had been unwell during the day on 15 June. Officers had no concerns and during interviews with his friends, they said he went to the gym, socialised and cooked with them as normal. During the evening, the man was in his single cell watching a European Championship football match on television. A number of his friends described how the man was excited when France scored a goal and heard him cheer.

26. The Officer Support Grade (OSG) who was on night duty and was responsible for the man's wing. The OSG said that he would have checked the man's cell at around 9.00pm on 15 June, although he had no specific recollection of doing so.

27. At approximately 5.35am, during his roll check (a physical counting of prisoners for security purposes), the OSG heard what he described as groaning noises. The OSG looked through the observation panel of the cell that the noises were coming from and saw the man lying on his bed. The OSG turned on the light from outside the cell, saw the man's stomach moving, his eyes open and shut, and noticed he was breathing rapidly. The man did not respond when the OSG called his name.

28. The OSG decided not to use his radio, as he did not want to disturb other prisoners on the wing. He went to the wing office and telephoned Officer A in the communications room (the communications room is the central point for radio contact and making requests) to request contact from the Night Orderly Officer (the NOO is responsible for the prison during the night period; radio call sign Oscar 1). Officer A radioed the NOO, Senior Officer (SO) A, who was conducting a check around the outside of the prison and unlocking the gates ready for the day shift. This was some distance from the man's wing so he asked Officer A to contact his assistant night orderly officer, the assistant night orderly officer who was closer.

29. The OSG returned to the man's cell and the assistant night orderly officer arrived at 5.40am. The officer did not open the cell and got no response from the man through the door, although he noticed the man's lower lip was moving, as though he was breathing. The assistant night orderly officer telephoned the communications room and asked for SO A and healthcare to attend. (He tried to use his radio but the battery had discharged.) He then returned to the man's cell. The assistant night orderly officer waited outside the cell until the nurse arrived on the wing.

He assisted her with the emergency response bag and went to the man's cell.

30. In her written statement, the nurse said that she received the call to attend the wing at 5.55am. No emergency code was used, but she took the emergency resuscitation bag (containing oxygen, defibrillation machine [a portable electronic device used to diagnose heart rhythms] and a blood pressure monitor), as she had been told that the man was having trouble breathing. The nurse went directly to the man's cell. She looked through the observation hatch and could see the man. She thought he was asleep, but could see no obvious signs of him breathing. There was no response from the man when the nurse banged on his door and she requested urgent entry to the cell. However, the assistant night orderly officer did not assess the situation as life-threatening and was waiting for SO A.

31. The assistant night orderly officer and the nurse went back towards the wing office to "speed things up with Oscar 1". SO A then arrived on the wing, and was met by the nurse as she was walking down the stairs to the staff office. SO A telephoned the duty governor, who was also the prison's liaison officer, at home for authority to unlock the cell. The duty governor said that he received the telephone call at 6.06am and the communications log record shows that staff went into the man's cell at 6.08am.

32. The nurse assessed the man. He was warm but had no pulse, his pupils were fixed and there was no sign he was breathing. The nurse began cardio pulmonary resuscitation (CPR – an emergency procedure to maintain blood circulation in someone not breathing). Officer B (who had previously worked as an officer in healthcare for 29 years) heard a radio message for assistance and went to the man's cell and assisted the nurse with resuscitation. A defibrillator machine was attached to the man, which indicated no shock was required, but to continue CPR. An emergency ambulance was requested by Officer A in the communications room at 6.10am.

33. Prison staff administered CPR until the arrival of the ambulance at 6.35am, an hour after the man had first been found unresponsive. Paramedics continued emergency treatment, but the man was pronounced dead at 7.00am.

Support for prisoners

34. The man had been at Gartree many years and was a well-liked member of the wing. Those who lived on the same landing as the man were aware that he was being treated by healthcare and overheard the response efforts, so they knew he had died. They were unlocked and moved to a different area of the wing. A notice to prisoners was issued by the Governor the same day which announced the man's death and expressed condolences. This notice reminded them of the available

support, from wing staff, the prison chaplaincy and Listeners (prisoners trained by the Samaritans to provide confidential support other prisoners).

35. The man was a Sikh and his death coincided with a Sikh memorial festival (the martyrdom anniversary of Guru Arjan). The festival was celebrated in the prison chapel and was open for all those who wished to attend and pay their respects to the man. His friends told the investigator that the memorial was a celebration of his life and was well attended by Sikh and non-Sikh prisoners.

Liaison with the man's family

36. In May 2011, the man told the prison that his cousin in Shropshire was his next of kin. The man's cousin was not informed of his death until 12.00 noon, as the nominated prison FLO, was also the duty governor that day and also had other tasks to complete in relation to the man's death. After discussion with the duty governor, the prison's visiting Sikh minister telephoned the man's cousin to break the news. His cousin explained that he was not a close relative, and had been nominated as the man's family lived abroad, but that he would contact his brother in France. The man's brother telephoned the duty governor later that day and a friend of the man interpreted. A letter of condolence was sent to the man's brother and funeral expenses were offered. Another member of staff took over responsibility for family liaison from the duty governor when she returned from annual leave the following week.

37. Over the next few weeks, there was some difficulty in establishing a single point of contact to act as next of kin and to agree the funeral arrangements the man's family requested that his body be repatriated to India for burial. Despite problems obtaining permission from the High Commission of India, in London, the man's body was repatriated on 2 August. The man's friends at Gartree had collected over £400, which was given to his family. Gartree paid the full cost of repatriation.

Support for staff

38. The duty governor held a hot debrief with staff who were directly involved with the incident (a hot debrief is a meeting immediately after an incident, designed to reassure staff, and provide them with support), which was also attended by a member of the post-incident care team. During interview, officers said that they were aware of the care team and that, if they chose to, they could contact them at any point for ongoing support.

Post-mortem report

39. A post-mortem examination was undertaken on the day the man died. The doctor who did the post-mortem concluded the man died of ischaemic heart disease (reduced blood supply to the heart) and coronary artery atheroma (a heart attack).

ISSUES

Clinical care

40. The clinical reviewer's clinical review concludes that the medical care and treatment the man received at Gartree was appropriate and equivalent to care in the community.

41. When the man entered Gartree he underwent an initial health screen and subsequent assessment by a prison doctor. There were no significant or ongoing medical issues. The man had aggravated a shoulder injury and had been referred to an orthopaedic surgeon. He was assaulted in February 2011, when his lip was bitten off by another prisoner. The man underwent reconstructive surgery and received the appropriate follow-up care and pain relief medication.

42. The clinical reviewer concluded that the man had no symptoms consistent with coronary artery atheroma and his death was not predictable. In respect to the level of clinical care provided to him while at Gartree the clinical reviewer says:

> "I believe the overall standard of clinical care provided to the man in HMP Gartree was good. He underwent a Well Man check; he was referred to and followed up in the Stop Smoking Clinic in 2006 and 2011; he was appropriately referred to a physiotherapist, to a dentist and to an orthopaedic surgeon; the attempt to resuscitate him was performed correctly, following a delay in access to his cell."

Emergency response

Communication

43. The clinical reviewer concludes that the delay in making the decision to enter the cell could have been critical to the eventual outcome for the man. Few resuscitation attempts are successful if they are started 10 minutes after a sudden cardiac arrest.

44. The man was observed by the OSG to be struggling for breath at about 5.35am and unable to respond but no one went into the cell until 6.08am, 33 minutes later. An ambulance was not requested until 6.10am. The night time protocols outline that any member of staff can enter a cell if a situation is assessed as life threatening without the duty governor's approval. Night staff carry a sealed cell key for this purpose. Officer A in the communications room said he was not told it was an emergency. SO A said that a request to contact a wing during the night was not unusual and did not require an emergency response, therefore he asked assistant night orderly officer to attend as he was closer.

45. The OSG told the investigators that he had asked for urgent assistance and that the telephone call was the equivalent to a code blue (an

emergency response to someone with breathing difficulties). The OSG did not use his radio to make this request as he did not want to disturb the other prisoners. The local instruction for Nights A-D Patrols [OSG wing patrol] states: *If urgent assistance is required the patrol will use the radio to raise the alarm*.

The Governor should ensure that all staff use their radio and the code system in the event of a medical emergency.

Entering a cell

46. Both the OSG and the assistant night orderly officer told the investigator that, although they did not obtain a response from the man when they called his name, they believed that they could see movement, indicating that he was breathing. In interview, the assistant night orderly officer said when he was unable to get a response from the man "that's when the concern came, that's why I went for the radio".

47. The assistant night orderly officer did not think that he had the authority to enter a cell without three officers being present and permission from a governor. He explained he did not consider it a life threatening situation and he was aware of the potential risk to staff of opening a cell without sufficient support and authority.

48. The assistant night orderly officer requested the attendance of the NOO and spoke to the nurse explaining that the man was not breathing normally. The nurse interpreted this as a 'code blue' situation, although no emergency code was used. Despite the nurse explicitly requesting urgent entry to the cell, the assistant night orderly officer still thought he needed authority from the NOO.

49. The local instruction for unlocking a prisoner during the night states:

> "*where there is, or appears to be, immediate danger to life, cells maybe unlocked without the authority of the NOO and an individual member of staff may enter the cell on their own*."

Separate instructions for unlocking a prisoner at immediate threat of life state that authority to unlock a cell must be given by the duty governor in communication with the NOO. The instruction goes on to outline that:

> "*preservation of life must take precedence over security concerns but night staff should not take action that they feel would put themselves or others in unnecessary danger"*.

In the instructions for patrol staff (OSG grades normally undertake this role during the night) at point 8 states:

> "*The decision to unlock a prisoner will only be taken by the NOO*" and point 13 "*In the event of an emergency night staff will contact the NOO in the first instance*".

50. A number of staff involved in this incident either did not know they had the authority, or did not feel confident to make the decision to enter the cell at an earlier stage. It is a concern that the prison staff involved did not appear to regard an unresponsive prisoner who was apparently not breathing as a potentially life threatening situation. Despite assurances from the Governor and Head of Operations and Security that the circumstances when staff have authority to enter a cell has been clarified and reinforced, it is evident that there is still some uncertainty and possibly an embedded cultural reluctance to do so. Even when the nurse indicated that she needed to attend to the man urgently, his door was not unlocked. SO A, who was in charge of the prison that night, said at interview:

> "It is pretty much drummed into us that we shouldn't just enter a cell willy nilly. We should gain governor's authority."

51. Some of the instructions to staff we have examined are unclear. All of those covering unlocking a cell at night start off with the default position that authority must first be obtained from the duty governor in communication with the night orderly officer, and that no cell will be opened unless a minimum of two/three staff are present. This is even the case with the instruction headed 'Nights Unlocking a Prisoner At Immediate Threat Of Life'. The purpose of the instruction is described as: 'To make staff aware of the correct procedures to follow when opening cells at night' rather than to make staff aware of what to do in an emergency. The general instruction for unlocking a prisoner at night starts by saying: 'If a cell must be unlocked, at least the Night Orderly Officer and the Assist must be present, except in an obvious emergency, such as fire'. While the instructions also say that an individual member of staff may enter the cell on their own where 'there is or appears to be, immediate danger to life' we do not think that this is given sufficient prominence. The instruction for night staff deployment and duties says that the decision to unlock a prisoner 'will only be taken by the NOO' and at least the NOO and ANOO and another person must be present. It requires the NOO to be contacted in an emergency and refers to the 'Nights Incident Immediate Response' instruction which does not cover entering a cell in an emergency.

52. This is the third death in custody since October 2010 at Gartree when there has been a delay entering a cell. We understand that the actions of the staff involved on the day of the man's death are subject to a Prison Service investigation to see whether disciplinary action is required, which otherwise we would have recommended. However, managers need to take responsibility for ensuring that all staff fully understand their responsibilities to place the preservation of life above

security concerns where this would not put themselves or others in unnecessary danger.

The Governor must ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that all local policies and instructions reflect this prominently.

Notifying the man's family

53. After the man's death, the Head of Residence and Services who was duty governor that day, acted as the prison's family liaison officer (FLO), as well as coordinating the death in custody contingency plans at Gartree. His duty manager responsibilities diverted him from his family liaison duties, so the man's nominated next of kin was not informed of his death for five hours. As duty governor, he had to coordinate the prison's emergency contingency procedures and did not have the chance to seek the assistance of the Sikh minister until later in the day. He continued as the prison FLO until his colleague, the only other trained FLO, returned from annual leave the following week. He was also the liaison officer for this investigation.

54. Prison Service Instruction (PSI) 64/2011 Safer Custody was implemented on 1 April 2012. Chapter 13 states that:

> "In order to maintain role clarity and professional boundaries, it is advisable that the Suicide Prevention/Safer Custody Co-ordinator or the Investigations/Inquest Liaison Officer do not undertake the FLO role. The role of the FLO is to be a named point of contact for the family. Their role will start from the point that the news of the death is broken to the family. They will then maintain contact with the family, and provide information and practical support where appropriate."

55. Following a death in custody, each role should be allocated to individual members of staff to ensure the tasks of a FLO are undertaken more expediently and individual members of staff do not become overburdened. The investigator was advised by Gartree that there has now been an additional member of staff trained as a FLO, and that there has been another training place secured, which should ensure that this situation does not arise again. In the man's case this led to a delay in informing his next of kin.

The Governor should ensure that following a death in custody the news is broken to a prisoner's family as soon as possible.

56. The news of the man's death was broken to his nominated next of kin over the telephone. PSI 64/2011 further states in Chapter 13:

> *"Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of*

the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.

Where the prisoner had been located a long distance from their next of kin, consideration must be given to requesting the assistance of a FLO from the nearest prison.

If a face-to-face prison notification is not possible or where another prison's FLO or the police have visited the family, then a follow up visit by the prison must be arranged as soon as practicable."

57. The decision was made to break the news over the telephone, in consultation with the Sikh minister; a translator may have been helpful. The prison took reasonable steps to take into account the man's family's religion that day, which we consider was appropriate in the circumstances.

CONCLUSION

58. We agree with the clinical reviewer that the man was treated appropriately during his time at Gartree. However, there was an unacceptable delay entering his cell because of poor communication and perceived lack of authority. The local policy regarding authority to enter a cell during the night state should be clearer, and prison staff should be aware that, subject to personal risk assessment, they should enter a cell in an emergency. There was too much of a delay in informing his next of kin of his death because the family liaison officer had other responsibilities.

RECOMMENDATIONS

1. The Governor should ensure that all staff use their radio and the code system in the event of a medical emergency.

   Accepted - *All Senior officers will be spoken to face to face by the Head of Security and asked to confirm their understanding of the use of the radio in emergencies and the code system in the event of a medical emergency and sign to say that they understand this and then they will brief their staff. Target date for completion: 30th December 2012*

2. The Governor must ensure that all staff understand that, subject to a personal risk assessment, they should enter a cell at night when there is potentially a risk to life and that all local policies and instructions reflect this prominently.

   Accepted - *All Night Managers will be spoken to face to face by the Head of Security and asked to confirm their understanding of the night protocol and sign to say that they understand this and then they will brief their staff. Every member of staff undertaking nights will sign the nights protocol at the onset of their first night to say that they understand their responsibilities in an emergency situation and how this should be communicated. Target date for completion: 30th December 2012*

3. The Governor should ensure that following a death in custody the news is broken to a prisoner's family as soon as possible.

   Accepted - *Duty Governors have all been informed. Target: completed. Additional staff will be trained. Target: April 2012*