PRISONS AND PROBATION
OMBUDSMAN
for England and Wales
Independent Investigations

Investigation into the circumstances surrounding the death of a man at HMP High Down in August 2011

Report by the Prisons and Probation Ombudsman for England and Wales

August 2012

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This is the report of the investigation into the death of a man at HMP High Down in August 2011. The man, who was 74 years old, was found unresponsive in his cell in the morning. A post mortem examination recorded his death as due to internal bleeding caused by a ruptured abdominal aortic aneurysm. I extend my condolences to the man's family and friends.

The investigation was conducted by one of my investigators. A clinical reviewer carried out a review of the clinical care the man received at High Down. Staff at High Down cooperated fully with the investigation. I apologise that the report has been delayed.

The man had never been in prison before he arrived at High Down on 20 December 2010, to await trial. Because of his age, and existing mental and physical health problems, he was admitted to the prison's healthcare inpatient unit. He spent all of his seven months in prison either on that unit, or the step down unit, which offers closer supervision and medical support than a normal prison wing.

On 4 January 2011, a prison doctor diagnosed that the man had an abdominal aortic aneurysm and he was immediately referred to the local hospital. Specialists there took over the care and treatment of the aneurysm. Before the aneurysm could be operated on, he developed a blockage in one of the vessels in his lung. He was prescribed medication to treat the blockage and it seems that repair of the aneurysm was put on hold in the meantime.

On a day in August 2011, the man was found guilty of attempted murder and sentenced to 12 years in prison. The following morning, he could not be roused, attempts to resuscitate him were unsuccessful and he appears to have died in his sleep.

The investigation identified some areas for improvement in healthcare record keeping, unlock arrangements and emergency response procedures. However, I am satisfied that staff at High Down treated the man with appropriate care and generally responded well to his physical and mental health conditions.

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 **August 2012**

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SUMMARY

1. The man was remanded into the custody of HMP High Down on 20 December 2010, charged with attempted murder. He was 74 years old and had never been in prison before. He had a history of depression and staff were concerned that he might try to harm himself and so he was placed on suicide and self harm monitoring procedures. He also had some health problems and so he was admitted to the prison inpatient unit.

2. On his first full day in the prison, the man was examined by a doctor who noted that he suffered with chronic obstructive pulmonary disease (COPD, a term for a range of conditions which affect the lungs). He was prescribed a number of medications. Following a mental health assessment, he was also prescribed antidepressant medication.

3. In late December, the man began to experience auditory and visual hallucinations (hearing and seeing things that are not there). He was referred to the prison psychiatrist for further assessment. He complained of feeling generally unwell and having a pain in his abdomen. On 4 January, he was examined by a doctor who diagnosed an abdominal aortic aneurysm. (An abdominal aortic aneurysm is the ballooning of one section of the major blood vessel taking blood to the pelvis, abdomen and legs. Larger aneurysms are prone to bursting, which causes a massive internal bleed. This is normally fatal.) The man was referred to the local hospital for tests. He spent three days in hospital before being discharged to the prison. Hospital specialists concluded that the aneurysm was not leaking and so he could attend outpatient clinics for treatment. He was readmitted to the prison inpatient unit.

4. Staff continued to have concerns about the man's mental health because he appeared to be experiencing paranoia. He was assessed and prescribed antipsychotic medication. His mental health was regularly monitored and the dose of medication was slowly increased until he became more settled. On 16 January, the suicide and self harm monitoring procedures were ended because he was not considered to pose a risk to himself. Towards the end of March, he was deemed fit to move from the inpatient unit to the step down unit (which houses prisoners who require support from officers and healthcare staff).

5. The man attended an outpatient appointment at the hospital on 1 April. The specialist found that the aneurysm was seven centimetres in diameter and needed to be treated. However, its position in his abdomen meant that surgery would be difficult. To further complicate matters, on 4 May, hospital staff discovered that he had a pulmonary embolism (a blockage in one of the vessels in the lung, which can be fatal if not treated). He was prescribed medication to thin his blood. It would seem that the specialists decided that the aneurysm could not be operated on until the embolism had been treated. He attended hospital appointments in June and July, but no information about what happened during the appointments was noted in his prison medical record.

6. On a day in August, the man was found guilty and sentenced to 12 years in prison. His cell was unlocked at about 8.00am the following morning. The member of staff who unlocked him thought that he was still asleep. A healthcare support worker came to his cell a little later and, when he could not rouse the man, raised the alarm. Healthcare staff responded quickly and,

despite believing that the man had died, attempted to resuscitate him. An ambulance was called, but the man could not be resuscitated.

7. We conclude that, in general, the man received a good standard of healthcare while at High Down. However, there is insufficient information from the hospital about the plans to treat the aneurysm. High Down should have pursued the hospital for information about the vascular surgeon’s plans. We make four recommendations as a result of the investigation.

THE INVESTIGATION PROCESS

8. The Ombudsman’s office was notified of the man’s death on 4 August and the investigator visited High Down on 10 August when he met a number of prison staff including a residential governor, the lead for prison health and one of the prison’s family liaison officers. He also met a representative from the Prison Officers’ Association (POA) and a member of the local Independent Monitoring Board (IMB).

9. Notices were issued to staff and prisoners at High Down informing them of the investigation and inviting them to contact the investigator should they wish to talk to him about the investigation. No-one came forward in response to the notices.

10. A review of the clinical care the man received at High Down was undertaken on behalf of NHS Surrey by a clinical reviewer. The clinical reviewer was provided with a copy of the man’s medical record and other relevant documentation.

11. The investigator and the clinical reviewer carried out interviews with staff in November 2011. The governor was provided with verbal and written feedback following the interviews.

12. HM Coroner for Surrey was informed of the investigation and provided the investigator with a copy of the post mortem report. A copy of this report will be sent to the Coroner to assist his enquiries.

13. One of the Ombudsman’s family liaison officers contacted the man’s sister shortly after his death. She explained the investigation process and gave her the opportunity to raise any concerns or questions she wished to be addressed as part the investigation.

14. As part of the consultation period the man’s sister and brother received a copy of the draft report. Although they had no specific concerns about the care provided by High Down, they felt, however, that the stress of the months he spent in prison and the fact that he received a lengthy prison sentence the day before he died contributed to his death. The man’s sister provided further comments in response to our draft report. She wished to comment about her brother’s conviction. She said that her brother was not an aggressive person and had “not been in his right mind” at the time of his offence. Character witnesses would have been able to attest to this at court. The man’s sister was generally appreciative of the health care delivered by the staff at High Down, but she thought her brother should have received closer attention on the morning of his death and attempts made to wake him: especially as he had had a difficult time in court the day before. The man’s sister and brother were angered at a comment made by a member of the High Down staff who said that the death of a person of this man’s age (74) is not as traumatic as the death of a younger person. The man’s sister also expressed her concern at the failure by the outside hospital to operate on her brother’s aneurysm.

15. The man’s sister did, however, wish to thank the Governor of High Down and especially the Family Liaison Team for their kindness and understanding following her brother’s death.

HMP HIGH DOWN

16. HMP High Down is a category B local prison in Surrey. The prison holds around 1,000 adult male prisoners either on remand or convicted by courts in the catchment area. It was last inspected by HM Chief Inspector of Prisons (HMCIP) in July 2011. The Inspectorate noted that the prison did a good job keeping most of its needy and challenging population safe. As the man spent all of his time at High Down either as an inpatient or on the step down unit (explained below) this section will focus on the provision of healthcare at the prison. The information included is drawn from the HMCIP inspection report, the Independent Monitoring Board's most recent annual report and staff interviews conducted as part of the investigation.

17. At the time the man was a prisoner at High Down healthcare services were provided or commissioned by NHS Surrey. (Since the beginning of 2012, a private company, Assura, has held the contract.) General practice (GP) services were provided by the Cheam Family Practice. The doctors provided morning and afternoon sessions between Monday and Friday. An out of hours service was provided by a private company, Harmony. Mental healthcare was provided by Surrey and Borders Partnership NHS Foundation Trust.

18. High Down provides 24 hour nursing cover to prisoners. There is a 23 bed inpatient unit and a 12 bed step down unit. The step down unit is used to house those prisoners who need a little more staff and nursing input than they would get on a normal prison wing, but do not need the intensive level of care offered on the inpatient unit.

19. HMCIP reported that mental and physical healthcare provision at High Down was very good and supported by an impressive level and quality of staff. Access to nurses and doctors was fast, with very short waiting lists. The Inspectorate was positive about the inpatient unit, finding it clean and well resourced, and offering a range of activities to patients. According to the inspection report, cancellation of hospital appointments was rare. The healthcare centre was found to have good links with the local hospital. Emergency resuscitation equipment was widely available across the prison and was checked daily.

20. High Down is also monitored by an Independent Monitoring Board (IMB) consisting of unpaid members of the local community. The IMB produces an annual report, with the latest available for High Down covering the period October 2010 to November 2011. The IMB reported that High Down was a well run prison, treating prisoners humanely and fairly. The Board praised the standard of healthcare provision at High Down, however, it noted a significant difficulty accessing outside hospital appointments. The IMB explained that the difficulties were the result of tight staffing, meaning that freeing officers to undertake escort duties was sometimes a problem.

Previous deaths at High Down

21. The man was the sixth prisoner to die from natural causes at High Down since the Ombudsman began investigating all deaths in prisons in 2004. We have found no similarities between the circumstances of the previous deaths or recommendations made as a result of the investigation.

Assessment, Care in Custody and Teamwork (ACCT)

22. ACCT, the Prison Service process for supporting and monitoring those prisoners thought to be at risk of harming themselves, was introduced in 2007. An ACCT plan can be opened by anyone working in the prison if they have any concerns that a prisoner might try to harm himself. The purpose of ACCT is to try to determine the level of risk posed, the steps that might be taken to reduce this and the extent to which staff need to monitor and supervise the prisoner. Levels of observations (where staff must check the prisoner) and interactions (where staff must have a conversation with the prisoner) are flexible and should be set according to the perceived risk of harm.

23. Part of the ACCT process involves drawing up a Caremap. A good Caremap will identify the prisoner's most urgent and pressing issues, set achievable goals to help resolve the issues and identify who is responsible for resolving each goal. The ACCT plan should not be closed until all of the actions on the Caremap have been completed.

KEY EVENTS

24. The man was remanded into prison on 20 December 2010, charged with attempted murder. Following his court appearance, escort staff responsible for his care at court and transporting him to the prison opened a Suicide/Self Harm Warning Form. Staff opening the form wrote that the man did not currently feel suicidal, but they were not sure how he would feel when he arrived at HMP High Down because it would be his first time in prison. Staff noted that he suffered with depression. While in the care of the escort company, he was monitored at all times in case he tried to harm himself. The Suicide/Self Harm Warning Form was passed to reception staff at High Down at 6.35pm.

25. At 7.10pm, reception staff opened an ACCT plan for the man. They noted that he was 73 years old, had never been in prison before, was charged with attempted murder and had a history of depression. It was decided that he should be checked three times during the day and hourly overnight until he had an ACCT assessment interview and staff had a better idea of the risk he posed to himself.

26. Later that evening, the man's immediate mental and physical health needs were assessed by a nurse. The nurse recorded that the man suffered "breathing problems" and was prescribed an inhaler often used to treat asthma. However, the man was not sure if he was asthmatic. He also told the nurse that he was prescribed sleeping tablets, but was not sure of the name of the medication. The nurse recorded that he was "shaky" and had some thoughts of self harm. She noted that he was already on an ACCT plan. As a result of the man's health, he was admitted to the prison's inpatient unit.

27. The following day, a doctor examined the man. The doctor recorded that he had suffered a stroke in 2008 and had chronic obstructive pulmonary disease (COPD). The doctor prescribed:

    - seretide and salbutamol inhalers (to help the man breathe more easily)
    - lisinopril (to treat high blood pressure and heart failure)
    - tiotropium (for COPD)
    - simvastatin (to lower cholesterol)
    - bendroflumethiazide (for high blood pressure)
    - dipyridamole (to prevent blood clots)
    - carbocisteine (to help clear sputum)
    - varenicline (which is prescribed to people who want to give up smoking cigarettes)
    - aspirin (which can help to prevent heart attacks and strokes).

    The medications were not given to the man to keep but administered by a nurse as required.

28. A senior officer (SO) carried out the ACCT assessment interview at 4.15pm on 21 December. The man admitted to feeling very low but said he had never tried to harm himself in the past, or had any thoughts of harming himself while in prison. He told the senior officer that he had already made use of the Listener service and had found it very helpful. (Listeners are prisoners trained and supported by the Samaritans to provide confidential support to other prisoners.) The senior officer concluded that the man needed to be assessed

by the prison mental health team and possibly to be prescribed antidepressant medication. Shortly after the interview, the senior officer, the man and a mental health nurse met for the first ACCT case review. The group agreed that the man currently posed a low risk to himself. Two issues were identified on the ACCT Caremap (which identifies the prisoner's particular problems and suggests how the problem can be resolved). He was encouraged to engage with staff and use the Listeners or the Samaritans telephone whenever he felt low. (Most prisons are equipped with cordless telephones which prisoners can use in their cell to call the Samaritans.) Staff also noted that he needed to see a doctor to discuss being prescribed antidepressant medication.

29. On 22 December, the man underwent a mental health assessment with a doctor. The man said that he suffered with depression but had not been prescribed any medication to treat this for at least a year. The doctor assessed him as being "very low" in mood and prescribed citalopram (an antidepressant).

30. In late December, the man began to experience auditory and visual hallucinations (seeing and hearing things that are not real) and paranoia. He was examined again by the same doctor on 29 December who referred him to a psychiatrist. On 31 December, a doctor examined him because staff on the inpatient unit were concerned about him. The doctor recorded that the man was confused and feeling depressed and exhausted. The man said that he was not eating well and had diarrhoea. He denied any pain when passing urine or blood in his urine. His pulse rate was normal, but the right side of his abdomen was slightly tender. The doctor concluded that he was depressed and might have early memory loss. He also wrote that the man might have problems with his kidneys. The doctor ordered further investigations to rule out a urinary tract infection or prostate problems. The man provided a urine sample for examination.

31. A second ACCT case review was held on 2 January 2011, chaired by an officer and attended by the man, an officer and a nurse. The man denied any thoughts of self harm and seemed more concerned that other people were "out to get him". The officer chairing the ACCT case review recorded that mental health staff were working with the man to address his paranoid thoughts. A third goal was added to the Caremap which directed staff to continue to support him when he experienced mental health problems.

32. On 4 January, the man complained of feeling unwell, with stomach pain and shaky legs. His blood pressure, temperature and pulse rate were measured and found to be within normal ranges. A doctor examined him that morning, recording that blood and urine tests showed some problems with the man's kidneys. The doctor also examined his abdomen and felt an abnormality that he suspected was an abdominal aortic aneurysm. He referred the man to the local hospital for urgent treatment. He was transferred to outside hospital that day.

33. The man returned to High Down on 7 January, having been diagnosed with an abdominal aortic aneurysm. Tests carried out at the hospital showed that the aneurysm was not leaking and there was no particular reason why he was experiencing pain. Because the aneurysm was not leaking, the vascular consultant (who specialises in problems concerning the veins and arteries)

was happy for him to be discharged and attend his clinic as an outpatient. He was prescribed omeprazole to treat his abdominal pain.

34. On his return to High Down, the man was re-admitted to the inpatient unit. The hospital provided a discharge summary and directed that he return for an outpatient follow up appointment in three to four weeks. Healthcare staff recorded that he needed to be checked every 15 minutes and that he would be examined by a doctor the following day. After a peaceful night, with no further health problems, staff decided to reduce the level of observations.

35. On 8 January, the man complained of a severe headache. His pulse, blood pressure, temperature and blood oxygen levels were measured and found to be within satisfactory ranges. He also seemed to be suffering another episode of paranoia. He was given paracetamol to treat the headache and nurses checked him every two hours throughout the night.

36. Another ACCT case review was held on 9 January. The two members of staff present and the man agreed that he had made good improvements in dealing with his mental health issues. As a result of the review, the staff decided that he need only be checked five times during the night, rather than every hour.

37. A doctor examined the man on 10 January. The doctor noted that the man complained of discomfort and problems when passing urine. The doctor diagnosed the man with an enlarged prostate gland and prescribed dutasteride and tamsulosin (in combination, these medicines relax the muscles in the prostate gland and shrink the gland). The doctor also noted that the man had been experiencing headaches since he had been discharged from hospital. The doctor suggested that this might be a side effect of omeprazole and so he stopped the prescription.

38. Later that day, the inpatient ward manager noted in the man's medical record that hospital staff had suggested that he undergo a psychiatric assessment. Apparently, he had been paranoid and experienced hallucinations which the hospital doctors advised was not related to his physical health. The inpatient ward manager noted that the prison psychiatrist agreed that the man should be assessed.

39. On 11 January, a nurse carried out a mental health assessment. She recorded further information about the man's episodes of paranoia and hallucinations. She described him as low in mood, emotional and tearful. However, he denied any thoughts of self harm. The following day, he was assessed by a psychiatric trainee. The trainee wrote that the man was prescribed a number of different medications and that staff needed to check whether any of them could be causing the paranoia and hallucinations. The doctor concluded that the man might be suffering with late onset psychosis and, if that was the case, would need to be prescribed antipsychotic medication. The following day, the psychiatric trainee discussed the man at the Mental Health In reach Team (MHIRT) meeting. Having ruled out any link between the man's mental health and his physical health problems and medications, the trainee prescribed a low dose of the antipsychotic medication quetiapine.

40. The man began complaining of feeling dizzy on 14 January and checks indicated that his blood pressure was low. He was examined by a doctor who amended his medication for a few days and directed that nursing staff monitor

him for any signs that his abdominal aortic aneurysm was causing the problems. Although his blood pressure remained low over the following days, the man said that he had no abdominal pain. His condition was also monitored by the prison doctors who made adjustments to his medication and ordered blood and urine tests.

41. On 16 January, a mental health nurse attended the man's ACCT review chaired by a senior officer. During the review, the man said that he could not remember ever having expressed any thoughts of suicide when he arrived in prison. The review group agreed that there were no signs that he was thinking of harming himself and so the ACCT plan was closed.

42. The psychiatric trainee reviewed the man's mental health on 2 February. He noted that the man continued to experience paranoid thoughts and hallucinations, so he increased the dose of quetiapine. The dose was increased again on 9 and 15 February because the man was still having paranoid and delusional thoughts and said that he was feeling low in mood. By 22 February, healthcare staff noted that the man's mental state seemed improved. However, the psychiatric trainee assessed him again the following day and decided that the quetiapine dose needed to be raised again because he was still feeling low.

43. The prison health lead was interviewed as part of the investigation. She explained that decisions about when to discharge someone from inpatients and move them to the step down unit are made following regular reviews of the prisoner's care. In this man's case, a note was made in his medical record on 28 March that he would be moved to the step down unit that week. The prison health lead said that care plans are devised for all inpatients and that staff allocated to work with the prisoner monitor progress against the care plan. A support worker with the mental health team was also interviewed during the investigation. He knew the man fairly well because of the amount of time he had spent on the inpatient unit. The support worker explained that staff thought the man was ready to move to the step down unit when he began coming out of his cell more and interacting with staff and other prisoners. He also said that a number of patients on the unit have mental illnesses and can be noisy and disruptive. For that reason, prisoners often prefer to be on the step down unit because it is quieter and calmer. There is no entry in the man's medical record to explain how the decision to discharge him from the inpatient unit to the step down unit was made, or who took the decision.

44. The man told healthcare staff that he felt more settled on the step down unit. Over the following weeks, his mental and physical health was monitored and staff noted that he seemed to be doing well.

45. The man had a hospital outpatient appointment with the vascular surgeon on 1 April. The vascular surgeon wrote a summary of the appointment for the prison doctors in which he noted that the man's aneurysm measured seven centimetres in diameter. He explained that repairing the aneurysm would not be straightforward because of its location. However, he wrote that "at this size we should be considering getting on and fixing it". He asked the prison for an update on the man's mental status so that any relevant issues could be borne in mind when he returned to the hospital for further treatment.

46. On 6 April, the man complained of pain in his left groin and lower back, which was worse when he walked. A doctor examined him and found no evidence that the pain was linked to his abdominal aortic aneurysm. The doctor prescribed an anti-inflammatory pain relief medication, naproxen.

47. The man had an appointment with the vascular surgery team at outside hospital on 19 April. There is nothing in the man's medical record to indicate that the prison sought or received any information about what took place during the appointment.

48. On 26 April, the man told the nurse in charge of the step down unit that he had a hospital appointment that afternoon. She explained to the investigator that checks established that an appointment had been made, but the prison was unaware of it and was unable to make the escort arrangements to allow the man to attend. The vascular nurse at the outside hospital emphasised that the man's condition was serious, which is why the doctor had arranged to see him again so quickly. The appointment was rescheduled for 3 May.

49. On 4 May, healthcare staff recorded details of the previous day's appointment. (There is no written feedback from the hospital in the man's file although it is possible that prison healthcare staff sought further information by telephone.) They wrote that tests carried out in hospital had revealed that he had a large pulmonary embolism in his right lung. (A pulmonary embolism is a blockage in one of the blood vessels in the lung, normally caused by a blood clot which may have travelled from another part of the body. It is a potentially life threatening condition.) He was immediately prescribed heparin and warfarin (which prevent blood clots from forming by thinning the blood). The vascular surgeon also confirmed that his aneurysm was now very large. Although surgery was the best option to treat the aneurysm, this could not take place until the embolism had been successfully treated. The man was due to attend a further hospital appointment on 17 June.

50. On 25 May, a doctor stopped the man's prescription for naproxen because he was also prescribed warfarin. He was told that he could ask for paracetamol if he experienced any further pain.

51. The man's mental health was monitored every two weeks and he was referred to the specialist older adults mental health service in his local area for assessment. His other existing physical health problems were also treated. He continued to be prescribed medication to help him stop smoking and his COPD was appropriately monitored.

52. On 24 June, the man was taken to hospital for a positive emission tomography (PET) scan, which produces a three dimensional picture of the body. He had another hospital appointment on 22 July. There is no information about what happened at either appointment recorded in the man's medical record. The nurse in charge of the step down unit contacted the hospital consultant for an update on the man's condition and treatment on 25, 26 and 28 July but was unable to speak to anyone.

53. The man's criminal trial began on 1 August. He attended court on 1, 2 and 3 August. While at court, his medication was dispensed by escort staff as prescribed. During his three days at court, no concerns were raised about his health. On 3 August, he was found guilty and sentenced to 12 years in prison. He arrived back at High Down at 6.20pm that evening. There are no

entries in the man's medical record to indicate whether any members of healthcare staff saw him that evening.

54. An officer who was working on the step down unit on the day of the man's death explained that a roll check had been carried out at about 5.45am by night staff. During the roll check, staff count the number of prisoners on each wing. The purpose of the roll check is to establish that the right number of prisoners are in the prison. Staff carrying out the roll check do not have to get a response from prisoners as they count them. The officer arrived on the step down unit at about 7.20am. He attended the morning briefing, where incidents that took place overnight or the previous day were discussed. He said that there were no issues concerning the man.

55. At 7.55am, staff moved onto the wing landings, ready to unlock prisoners. The officer who unlocked the cells on the step down unit explained that, when unlocking prisoners, he looks through the observation flap in the cell door first, then unlocks the door. He said that he normally looks quickly into the cell once he has opened the door, as he is responsible for checking that the prisoner is in his cell and apparently well.

56. The officer unlocked the man's cell and, on checking, thought that he was still asleep. He described the man as curled up in a sleeping position with the blankets over him. The officer explained that, as the man did not go to work or education in the prison, he often slept for longer in the mornings and was not woken at unlock time. He explained that prisoners on main wings are woken up at unlock because they need to be ready for morning activities. The routine on the step down unit is different and nursing staff visit the prisoners to dispense their medication. Having unlocked the man's cell, the officer moved on.

57. A support worker with the mental health team explained that healthcare staff cover both the inpatient unit and the step down unit. At the beginning of each shift, the nurse in charge decides which unit they will cover. The support worker said that he knew him quite well because the man had either been on the inpatient unit or the step down unit since he arrived at the prison.

58. The support worker said that he began his shift at 7.15am. After the healthcare morning briefing the nurse in charge asked him to work on the step down unit. He arrived on the unit at about 8.05am. First, he checked the medical equipment on the unit and then began to check the patients. The man was the first prisoner he checked that morning.

59. The support worker explained that, normally, the man was already up watching television and drinking a cup of tea by the time healthcare staff checked him. He saw that the man was still in bed and so he spoke to him to try to wake him. When he got no response, the support worker went further into the cell and quickly realised that there was a problem. He described the man as looking very pale, with his hand in a strange position. He tried rousing the man by speaking to him, and when this did not work, touched him. He said that the man felt very cold. He explained that he was not carrying a radio but he realised that he needed help from other staff. He went to the wing office and telephoned the nurse in charge, who said he would come straight away. The support worker did not know who was acting as the emergency response nurse (responsible for attending all medical emergencies in the prison during that shift), however he called the healthcare unit and told the

nurse who answered about the emergency. She said that someone would come straight to the step down unit.

60. The officer who had unlocked the man's cell door earlier was on landing two helping another prisoner when he saw the support worker with the mental health team looking very surprised. He asked the support worker what was wrong, but got no response. The nurse in charge was following the support worker and, at this point, the officer said that he began to suspect that there was a problem. He went with the two healthcare staff to the man's cell and they moved the blanket. The man still appeared to be asleep. The nurse checked for a pulse or signs of life, but found none so asked the officer to collect the emergency medical equipment from the wing office on the landing above, and the support worker to collect the blood pressure monitor. The nurse in charge said that he radioed to alert the prison to a code red emergency. (The use of a code system is common in prisons in England and Wales. It helps to establish the nature of the emergency and means that officers and nurses responding to the emergency call have an idea of the situation they will be facing. It also helps healthcare staff to bring the right medical equipment to the scene. At High Down, a code red emergency indicates that someone is experiencing chest pain or breathing difficulty.)

61. The officer returned to the man's cell with the emergency equipment. The nurse in charge said that he turned the man onto his back and began to deliver cardiopulmonary resuscitation (CPR, the delivery of rescue breaths and chest compressions to try to restart the patient's heart). In interview, the nurse said that he believed the man had died but did not think that nurses were authorised to pronounce death and so thought he was obliged to attempt to resuscitate him. As other members of staff arrived in the cell, they helped the nurse to move the man onto the cell floor and assisted with the resuscitation attempts. (CPR is best attempted on a hard, flat surface.)

62. A further officer reached the cell at about 8.20am and the nurse in charge asked her to call for an emergency ambulance. Several additional members of nursing staff arrived at the cell, including a nurse practitioner. The nurse practitioner explained that he carried out a number of checks on the man and found him pale, clammy and with signs of rigor mortis. (Rigor mortis is the stiffening of the limbs that occurs naturally after death.) However, he thought that the man's torso felt warm and so directed that CPR should continue.

63. The nurse in charge said that they attached the automated external defibrillator (AED) to the man's chest. (The AED is a portable machine which can deliver electric shocks to a patient whose heart is not beating correctly. In some circumstances, using the AED can help to re-establish a normal heart rhythm. The AED gives audible instructions to those attempting CPR, which alter depending on whether the machine can detect a heart beat.) The nurse in charge said that the AED instructed that no shock be given to the man. After attempting CPR for some time, the nurse practitioner found no signs of life and, at 8.28am, directed that attempts to resuscitate the man should stop. The paramedics arrived at the man's cell about five minutes later.

Contact with the man's family

64. Two members of staff were appointed to act as family liaison officers. The man's sister was listed as his principal contact and she was informed in person of her brother's death. Prison staff later spoke to and visited the

man’s wife and returned her husband’s possessions to her. In line with national guidance, the prison offered to contribute towards the cost of the man’s funeral.

Support for staff and prisoners

65. A hot debrief was held by the deputy governor later that day and both officer and healthcare staff attended. (The purpose of the hot debrief is to offer support and reassurance to staff involved in the incident.) The nurse practitioner said that he also held a brief meeting with the nurses involved that day. Some of the nurses interviewed told the investigator that they also went to a more formal meeting arranged for healthcare staff. The prison health lead confirmed that the healthcare department holds a separate debrief when resuscitation has been attempted. The purpose of this debrief is to give staff an opportunity to talk about the incident from a clinical perspective and to learn any lessons arising from the emergency.

66. The staff care and welfare team offered support to all staff who had been involved in the incident. Staff informed other prisoners of the man’s death and Listeners came to the unit to provide additional support. A memorial service for the man was held at the prison.

ISSUES

Clinical care

67. A clinical reviewer reviewed the clinical care the man received at High Down. He found that much of the medical and nursing care provided to the man was of a more than satisfactory standard. He writes that the man's needs were assessed and mostly acted on.

68. On 4 January, one of High Down's doctors identified that the man might have an abdominal aortic aneurysm and referred him to a vascular surgeon. At hospital, the diagnosis was confirmed and the aneurysm was estimated to be 6.2 centimetres in diameter. The plan was for him to be reviewed at the surgeon's outpatient clinic.

69. The man attended the surgeon's clinic on 1 April when the aneurysm was found to have increased in size to 7 centimetres. The surgeon noted that repair of the aneurysm would not be straightforward but, given its size, a repair would need to be made. (The clinical reviewer explains that it is usual practice that an aneurysm greater than 5.5 centimetres, or that is growing rapidly, is operated on.) The man returned to hospital on 3 May. His prison health records contain no correspondence about this appointment, though the clinical reviewer presumes it was probably for pre-surgical planning. At this appointment, he was also diagnosed with a pulmonary embolism and he was started on warfarin (to thin the blood and break-up the embolism).

70. The man's prison health records contain limited information about his hospital appointments. It is not clear whether the prison did not receive written follow up following every appointment, or whether the information was simply not recorded by the prison. In addition, he missed a hospital appointment on 26 April because the prison was apparently unaware of the appointment. Given the seriousness of the man's condition, this is of concern. The clinical reviewer concludes that staff at High Down should have pursued the hospital for information and correspondence about the vascular surgeon's action plan. We make the following recommendation:

    The Head of Healthcare should liaise with staff at the local hospitals to ensure that timely correspondence is received when a prisoner has attended an appointment, and is promptly scanned onto the prisoner's medical record.

The emergency response

71. An officer explained that he unlocked the man's cell at about 8.00am but did not attempt to wake the man, as he assumed he was still sleeping. The officer explained that, if a prisoner on the step down unit is on an ACCT plan, staff unlocking the cell must get a response from the prisoner, but otherwise this was not required.

72. The step down unit consists of 12 beds and houses prisoners who, for a variety of reasons, are considered to need more support from discipline and healthcare staff. Some prisoners on the unit will have specific health needs, as this man did. Some are on an alcohol or drug detoxification programme. As prisoners on the step down unit have been identified as requiring a higher level of monitoring and support, we think that staff unlocking cells have an

especially important role in ensuring their well being. In any event, all prison staff should check the safety of prisoners when they unlock cells. We make the following recommendation:

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

73. The support worker explained that healthcare support workers are not issued with radios so when he found the man he had to telephone the nurse in charge to raise the alarm. In this man's case, the delay is unlikely to have had an impact because the evidence suggests that he had probably been dead for some time. However, in another situation, even a short delay in alerting healthcare staff to a medical emergency might have significant consequences. The prison health lead said that she had already raised the issue with the Governor and requested more radios for healthcare staff.

74. When the support worker first raised the alarm, he did not use a code system. Therefore the nurse did not bring the required equipment to the cell when they responded and had to send someone to collect it. The absence of a code also meant a delay in phoning for an ambulance. Neither would have affected the outcome for the man. However, it is important that staff are aware of the correct procedures and confident in their use in future emergencies.

The Governor should ensure that staff working with prisoners understand how to raise an alarm in an emergency and that key staff are appropriately equipped with radios to enable prompt action

75. The nurse in charge was the first member of healthcare staff to arrive after the support worker raised the alarm. In interview, the nurse in charge said that, on checking the man, he was quite sure that he was already dead. However, he did not think that nurses could pronounce that a prisoner had died and so he began CPR. The nurse practitioner arrived soon after. He told the investigator that he thought there were signs that rigor mortis had set in. However, because parts of the man's body still felt warm, he decided that CPR should continue. Carrying out CPR when rigor mortis is present can be very distressing for staff and undignified for the patient. The clinical reviewer comments on this in his clinical review. He commends High Down for developing a "Guidance for Resuscitation" policy. However, he believes that the document could helpfully include guidance on what to do if rigor mortis is present. (Such guidance had previously been included in a now cancelled Prison Service Order.)

The Head of Healthcare should amend the Guidance for Resuscitation to include what to do if rigor mortis is present.

CONCLUSION

76. The man arrived at High Down in December 2010. Because of his age, concerns about his mental health and some known physical health problems, he was first held in the prison's inpatient unit and then the step down unit. In January 2011, he was diagnosed with an abdominal aortic aneurysm. He was referred to the local hospital which took over the care of this condition. Although the aneurysm was large, it was not leaking and its position in his body meant that surgery was difficult. To further complicate matters, he developed a pulmonary embolism in May and surgery could not take place until this had been resolved. He was still undergoing treatment for the embolism when he died. The post mortem confirmed that his death was the result of the aneurysm bursting.

77. This investigation found that the man received a good standard of healthcare at High Down. We make four recommendations but do not think that his death could reasonably have been prevented by Highdown.

RECOMMENDATIONS

The following recommendations were made in the draft report. The Service responses are included in italics following each recommendation:

1. The Head of Healthcare should liaise with staff at the local hospitals to ensure that timely correspondence is received when a prisoner has attended an appointment, and is promptly scanned onto the prisoner's medical record.

   Recommendation accepted
   Currently the hospitals send a letter with the escort if immediate action is required but if not it can sometimes take a while to receive feedback. The Head of Healthcare will take ownership and liaise with the local hospitals again but cannot guarantee a positive outcome as there are so many departments all working to different timescales on discharge summaries. We tend to chase individual cases as the need arises. Discharge summaries are scanned into System 1 at the earliest opportunity. The Head of Healthcare will ensure completion in September 2012.

2. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   Recommendation accepted
   This was raised and discussed at the Safer Custody meeting in August 2011 (Minutes are distributed to all residential managers), which resulted in the decision that we would "greet" everyone in the morning and try and get a response. It was, however, understood that not all prisoners would be too "happy" to be woken by an officer every morning. In spite of this it was agreed that all prisoners on ACCTs would continue to be spoken to until a response was obtained in the evening, at the beginning of night shift, at the early morning roll check and morning unlock for activities. It was emphasised that any prisoner in HCC or in SRU, particularly on an ACCT, must respond before moving on to the next cell.

   A global email was sent out to all staff advising that they need to get a response from all prisoners at the above times.

3. The Governor should ensure that staff working with prisoners understand how to raise an alarm in an emergency and that key staff are appropriately equipped with radios to enable prompt action

   Recommendation accepted
   All staff get radio training as part of their induction key talk, via a powerpoint presentation and verbal communication. Staff using radios are monitored via the control room operator who will refer to their manager if someone's radio procedure needs improvement. Appropriate numbers of staff (nursing and disciplinary) are equipped with radios but we do not have enough radios in operation to be able to give one to every person. Implementation completed but ongoing for any immediate training needs.

4. The Head of Healthcare should amend the Guidance for Resuscitation to include what to do if rigor mortis is present.

   Recommendation partially accepted
   The Guidance for Resuscitation does say not to do CPR when signs of death are evident, including rigor mortis. However, the Head of Healthcare has made it more explicit by adding a definition for rigor mortis to the guidance to assist practitioners with their decision making. Staff are being trained in this and it is an ongoing development need which is being addressed. Completion date is 31 August 2012.