

**Investigation into the death of a man whilst in
the custody of HMP High Down in December 2009**

**Report by the Prisons and Probation Ombudsman
for England and Wales**

July 2010

This is the report of the investigation into the circumstances surrounding the death of a man who died at HMP High Down. He was a long time alcohol misuser and had been at High Down for less than 48 hours when he died in the inpatients' unit of the prison's healthcare centre. The post mortem revealed coronary heart disease to be the cause of his death. He was 46 years old when he died.

The investigation was conducted by one of my investigators. I would like to thank the Governor of High Down and his staff for their co-operation with the investigation. Particular thanks go to the prison investigation liaison officer.

I am grateful to Surrey Primary Care Trust (PCT) for commissioning the clinical reviewer, a substance misuse specialist based at HMP Dorchester, to conduct an independent review of the clinical care the man received while at High Down. Thanks are also due to the clinical reviewer for his review.

The man was released from prison on a life licence in 2008, the conditions of which stipulated that he address his alcohol use. When he failed to do so, his offender supervisor became concerned about his welfare and requested that he be recalled to prison. He was arrested by the police on 10 December 2009, arriving at High Down that evening.

On his arrival, the man was clearly suffering alcohol withdrawal symptoms and felt very unwell. His pulse and blood pressure were checked and found to be high, but he complained of no chest pains or shortness of breath. The man was admitted as an inpatient to the prison's healthcare centre so that staff could observe him more closely, and he started an alcohol withdrawal programme. During the night of 11 December, staff could not rouse the man. The paramedics were called and declared that he had died.

The clinical reviewer concludes that the man received a good standard of care and was treated with compassion during his brief time at High Down. I do not think the man's death could have been foreseen, nor therefore, prevented. I make one recommendation to the Head of Healthcare concerning checking patients' blood pressure and pulse, which was accepted at the draft report stage.

The man was the third prisoner to die of natural causes at High Down since 2004, when the Ombudsman became responsible for investigating all deaths in prisons. One more prisoner has died of natural causes since December 2009. I have found no similarities between the circumstances of the earlier deaths and that of the man.

The 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.

Jane Webb
Acting Prisons and Probation Ombudsman

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SUMMARY

In 1991, the man was convicted of the murder of his father, and sentenced to life imprisonment. He was released on life licence in 1997 and the conditions ordered that he address his alcohol misuse. His failure to do so led to his first recall to prison in 2004. He was released in 2008, again on the condition that he manage his alcohol use. In late 2009, the man's offender supervisor became concerned for his welfare because his alcohol use had increased. She began the process to have him recalled to prison for the second time.

On 10 December 2009, the man was arrested by the police. While in police custody, he began to show signs of alcohol withdrawal and was clearly unwell. The police took him to the local hospital, where he was given medication to ease the withdrawal symptoms.

At 6.53pm, the man arrived at HMP High Down. Prison reception staff realised that he was suffering alcohol withdrawal symptoms and alerted the nurse and doctor on duty in reception. They made a joint assessment of the man's condition, noting that he looked and felt very unwell. His pulse rate and blood pressure were checked and both were slightly high (frequent symptoms of alcohol withdrawal). The man himself complained of no chest pains or shortness of breath and said he had no concerns.

The man started an alcohol withdrawal programme straight away. He was taken to the inpatients' unit in the healthcare centre and placed in a gated cell, where staff could observe him more closely. The reception nurse asked that his blood pressure be checked again later (although this did not happen).

As the man continued the detoxification programme, his withdrawal symptoms lessened. Healthcare staff who had contact with him during the day of 11 December were not concerned about his health. However he was not examined by a doctor that day. Early in the evening, it appeared that his withdrawal symptoms had worsened and he was restless. The man was advised to drink plenty of water and try to stay in bed.

During the night, the nurse on duty in the inpatients' unit checked the man every half an hour. At 12.40pm, she became concerned when she noticed that he had not altered his position in bed for an hour. She failed to rouse him through the gated door, so called for help from the officer on duty. When the officer also failed to wake him, they called for the assist night orderly officer who unlocked the cell. The man did not have a pulse and was not breathing, so two nurses tried to resuscitate him. The paramedics arrived and, after carrying out a number of tests, pronounced that the man had died.

The clinical reviewer concludes that the man's health was appropriately assessed and he received a good standard of care at High Down. He finds that staff treated the man with compassion. I do not think that his death was preventable. He had abused alcohol for a long time in the community, which had a detrimental effect on his health, although his death was due to heart disease. I make one recommendation which would not have altered the outcome.

THE INVESTIGATION PROCESS

1. The Ombudsman was notified of the man's death. The investigation was allocated to one of my investigators.
2. My investigator issued notices inviting staff and prisoners to contact her with any information they thought might be relevant to the investigation. There was no response to these notices. My investigator was provided with copies of the prison records relating to the man's short time at High Down, including his medical record.
3. Surrey PCT commissioned the clinical reviewer, a specialist in substance misuse at HMP Dorchester, to conduct an independent review of the clinical care the man received at High Down. The Quality and Clinical Governance Manager at Surrey PCT, and my investigator conducted joint interviews with healthcare staff at High Down. In compiling his review, the clinical reviewer had access to the transcripts of those interviews, the results of the post mortem and the man's medical record. The clinical review is attached as annex 1.
4. HM Coroner for Surrey was notified of the investigation and provided the results of the post mortem. The Coroner will receive a copy of the report to assist his enquiries.
5. The Ombudsman's family liaison officer invited the man's friend, his nominated next of kin, to be involved in the investigation. She provided some information about the man's life, but chose not to be involved any further in the investigation.

HMP HIGH DOWN

6. HMP High Down is a local category B prison for adult and young adult men on the outskirts of London, serving courts in the surrounding areas. As of July 2009, the prison can hold up to 1,103 prisoners.
7. Healthcare services at the prison are commissioned by Surrey NHS and provided by Surrey Community Health. There is a 23 bed inpatient unit, plus a 12 bed “step down” unit (for prisoners requiring a less intensive level of care) which is located on one of the house blocks. The prison also offers an integrated substance misuse service and employs a doctor who specialises in substance misuse treatment.
8. The National Offender Management Service (NOMS) publishes quarterly performance ratings for all prisons in England and Wales. The ratings are based on a set framework and prisons can be rated from one to four (with four indicating ‘exceptional’ performance). High Down has achieved a rating of three (‘good’ performance) for the last two published quarters.

HM Chief Inspector of Prisons (HMCIP)

9. The prison was last inspected by HMCIP in an unannounced inspection in May 2009. The inspection report noted that the prison’s size had increased by 50 per cent since the last inspection in 2006. The most recent inspection found that the prison had taken forward previous recommendations and progress had been made in improving the safety of prisoners there.
10. HMCIP found the healthcare centre to be “large, clean and well-maintained”. Prisoners had good access to primary care and access to doctors was “satisfactory”.

Independent Monitoring Board (IMB)

11. Each prison in England and Wales is also monitored by an IMB, consisting of volunteers from the local community. Members of the IMB have access to every part of the prison and each prisoner held there. Boards produce annual reports for the Secretary of State, with the latest available for High Down covering the period November 2008 to December 2009.
12. The Board noted the damaging impact of budget cuts on provision for prisoners and staff morale. However, the IMB otherwise judged the prison to be “well run”, with staff committed to providing a “secure and fair” environment for prisoners. The Board also recognised the work that had gone into maintaining and improving the healthcare service.

KEY FINDINGS

13. In August 2008, the man was released from HMP Stanford Hill on life licence. As part of the conditions of his licence, he was required to address his problematic alcohol use and engage with his offender supervisor. In December 2009, his offender supervisor began proceedings to get the man recalled to prison for breaching those conditions. As a result, Margate Police arrested him on 10 December.
14. At 6.50am that day, police officers in the custody suite noted that the man was shaking uncontrollably, due to alcohol withdrawal. Seven minutes later, he was given medication in his cell as he was shaking too much to leave it. Officers decided that the man should be constantly observed because he was unwell. They wrote in the custody log that the man had been sick.
15. The man was given food and a drink at about 8.00am and told officers he was feeling better. However, half an hour later he was sick again and said he felt "quite unwell". At 8.57am, police staff decided that he should be taken to Queen Elizabeth the Queen Mother Hospital (QEQM) for treatment. At 11.45am, hospital staff gave him anti-sickness medication and ten milligrams (mg) of diazepam (a drug with sedative properties) to combat his alcohol withdrawal symptoms. The doctor at QEQM advised that he could be prescribed up to 30 mg of diazepam per day. While in hospital his blood was tested and the results showed his liver was not working properly.
16. Following his hospital treatment, he returned to Margate Police Station at midday, still being constantly watched by police officers. At 3.20pm, the police doctor assessed him in his cell and concluded that he was showing no clinical signs of alcohol withdrawal and was fit to be detained. Just over an hour later, he left the police station for HMP High Down.
17. The man arrived at High Down at 6.53pm. A reception officer took him through the induction paperwork (which provides a brief overview of the important aspects of prison life). The officer recorded that the man was given a smokers' pack. She noted that he had been in prison before but, as he had not been at High Down within the last six months, he needed a full induction. The man said he had no immediate worries. The officer completed the first section of the Cell Sharing Risk Assessment (CSRA). (This assesses the risk the prisoner poses to other prisoners and whether they are suitable to share a cell.) She recorded that the man was dependent on alcohol but had no concerns about sharing a cell. The officer assessed the man as being a low risk to other prisoners.
18. While in reception, the man was sick. Reception staff told the nurse and the first prison doctor on duty that he was unable to control his bowels and was clearly unwell. As a result, at 8.00pm, the nurse and the doctor (a substance misuse doctor covering reception that day) carried out the first reception healthscreen together. (The purpose of the healthscreen is to identify any immediate physical or mental health needs requiring referral to the doctor or other specialist service.) The nurse was interviewed as part of this investigation and the doctor provided a written report of her contact with the man.

19. The man told the staff he was not registered with a doctor in the community, had no outstanding medical appointments and was not currently being prescribed any medication. He said he had not received any physical injuries in the few days prior to coming to prison and denied having any physical health problems.
20. The reception nurse asked him how much alcohol he usually drank and he told her that he consumed about two bottles of vodka and several cans of strong lager each day. He denied using any drugs in the past month. The nurse recorded that the man had received ten mg of diazepam while in police custody, but that he currently felt "terrible". The man said he had suffered with depression about ten years ago and had been prescribed anti-depressants. He said he had no thoughts of harming himself.
21. The nurse wrote that the man was nauseous and had been sick on his arrival at High Down. She noted that he was clearly withdrawing from alcohol and had tremors in both hands, was visibly shaking and felt hot and sweaty.
22. In interview, the nurse described the man as physically very unwell. She remembered that he was quite distressed during the healthscreen interview, particularly when he talked about the death of his father. The man told the two healthcare staff that he drank alcohol because he was unable to come to terms with his offence. The man said he began drinking in the morning and would continue to drink throughout the day.
23. The nurse explained to the investigator that she took the man's blood pressure, which was "slightly high" and his pulse rate was fast. She said that patients withdrawing from alcohol often have high blood pressure and that, in fact, the man's was lower than she might have expected. She was a little concerned about his pulse rate but thought this might be due to the stress of being recalled to prison. She and the doctor concluded that he did not need to be taken to hospital for treatment but should be admitted to the prison inpatients' unit, where he could be checked by nurses during the night.
24. The doctor and the nurse agreed that the man needed to begin an alcohol detoxification programme and he was given 30 mg of chlordiazepoxide while in reception. Chlordiazepoxide is a benzodiazepine, commonly used to help alleviate the effects of alcohol withdrawal. It is a sedative drug, which helps to reduce anxiety. At High Down, the alcohol detoxification programme involves the prisoner being prescribed a reducing dose of chlordiazepoxide over a ten day period. The man was also prescribed thiamine and vitamin B. (Heavy alcohol users are commonly prescribed these as part of their alcohol detoxification programme.) The nurse remembered that she helped the man to drink two glasses of water, and encouraged him to drink plenty during the night. The nurse was asked whether the man complained of any chest pain or appeared short of breath during her assessment, and she said that he had not.
25. Following the healthscreen, the nurse completed the healthcare section of the CSRA. She concluded that the man posed a low risk to other prisoners but that he would have a single cell in the inpatients' unit anyway.

26. The nurse told the investigators that she took the man to the inpatients unit herself. Although she could not remember which nurse she had handed his care over to, she remembered that she asked that he be placed in a gated cell (when the cell is secured with a gate, rather than a solid door) so that staff could check him more easily during the night. She also asked nursing staff to check his blood pressure later. There is no note of her handover in the man's medical record and no mention of his blood pressure being read again. The nurse explained that, whilst she could ask the nurses on duty to carry out such checks, it is for them to decide when to do so. However, the nursing staff interviewed agreed that it was difficult to make these checks during the night, when prisoners were locked in their cells, as the nursing staff do not carry cell keys.
27. The man was given a further 30 mg of chlordiazepoxide at 9.00pm. At 7.00am the following day, a nurse working on the inpatients' unit noted that he was "pleasant and talkative", had slept soundly and that there were "no problems". A few hours later a second inpatients' nurse recorded that the man was "generally settled". This nurse recorded that he was showing signs of alcohol withdrawal and the doctor would examine him that afternoon. However, there is no record of any examination taking place. A second prison doctor a substance misuse specialist doctor at the prison, was also interviewed during the investigation. She said that she had reviewed the man's file and confirmed that he was not assessed by a doctor on 11 December.
28. During the day, the man received four 30mg doses of chlordiazepoxide – once in the morning, at noon, in the afternoon and evening. He also received another dose of thiamine and vitamin B. The reception nurse said that she saw the man smoking in the prison garden that day. She described him as "fine and smiling" and said she was surprised to see that he was no longer shaking (indicating that he was being prescribed the correct dose of chlordiazepoxide). The man thanked the nurse for her help the previous day. She said she had no reason to have any concerns about him.
29. At 7.50pm, a third inpatients' unit nurse made an entry in the man's medical records noting that he was showing clear signs of withdrawing from alcohol. The nurse advised him to remain in bed, but recorded that he was "very restless and fidgety". The investigator spoke to this nurse by telephone during the course of the investigation. The man told her he was thirsty so she got a cup of water for him. She said that he did not mention feeling unwell or having any other concerns. The nurse said that staff on the inpatients' unit are used to treating patients who are withdrawing from alcohol. She asked the nurse who had made the 7.00am entry, who was on duty that night, to check him overnight. She agreed to check him every half an hour.
30. During a routine check the nurse became concerned about the man. She noticed that he had been in the same position in bed for more than an hour. She tried calling his name and splashing him with water through the cell gate but he did not wake. The nurse asked an officer, who was also working on inpatients that night, for his opinion. The officer also tried calling to the man through the observation hatch in the cell door, but he did not respond. At this point, they

used a radio and asked the assist orderly officer (who was second in charge of the prison that night) to attend.

31. The assist orderly officer also tried to rouse the man by calling through the gate. When he still did not respond, she unlocked the cell and the nurse and officer went in. The nurse checked the man for a pulse or signs of breathing, but found neither. The assist orderly officer used her radio to alert the prison to a "Code Red" (the call sign used to indicate a medical emergency) and to ask that an ambulance be called. Another nurse who was working in the outpatients' department that night, arrived and the two nurses began delivering cardio pulmonary resuscitation (CPR).
32. The nurse working on the inpatients' unit that night has since left her employment at High Down and attempts to contact her by telephone have been unsuccessful. However, the outpatients' nurse was interviewed. He explained that the nurses on duty at night do not carry cell keys. A governor grade member of staff said that officers working on the inpatients' unit carry a sealed pouch containing a cell key. In an emergency, the officer should break the sealed pouch and open the cell door. If it is not an emergency, staff should call for the night orderly officer (in charge of the prison) or the assist orderly officer to unlock the cell for them.
33. The outpatients' nurse said that, on going into the cell and although the inpatients' nurse had already done so, he too checked the man for a pulse or any signs of breathing. On finding none, he and the inpatients' nurse began CPR. The nurse said that healthcare staff at High Down have refresher heart start training annually, but that he last received the training in December 2008.
34. The paramedics arrived at 1.03am. They checked the man for signs of life and took a reading of the electrical output of his heart. At 1.14am, they pronounced that he had died.
35. Following the man's death, prison staff travelled to the address he had provided for his next of kin, a friend. There was no response at the address, but later that day, staff managed to speak to the friend and inform her of the man's death. Attempts by the prison and the Coroner's office to trace members of the man's family have, to date, been unsuccessful. Prison staff arranged the man's funeral.
36. On 12 December, the duty governor, issued a notice to prisoners informing them of the man's death. They were reminded that the Listeners (prisoners trained and supported by the Samaritans to offer a confidential listening service) and Samaritans' telephone were available. Prisoners were encouraged to talk to staff if they required any support.
37. In the early hours of the morning of 12 December, the deputy governor held a hot debrief. (This is a meeting for all members of staff involved in a serious incident to share their experiences. It is a requirement of Prison Service Order 2710.)
38. The post mortem concluded that the man died of coronary heart disease, as a result of significant narrowing of the coronary arteries. There was no evidence to suggest that withdrawing from alcohol was a factor in his death.

ISSUES

Clinical care

39. In his review, the clinical reviewer considers how staff at High Down assessed and treated the man's alcohol withdrawal symptoms on his arrival at the prison on 10 December. He concludes that the reception doctor and the reception nurse's examination of the man was comprehensive and the man was swiftly placed on an alcohol detoxification programme. The clinical reviewer notes that the doses of chlordiazepoxide were appropriate, as was the man's admittance to the inpatients' unit.
40. During the first reception healthscreen, the man's general physical health was assessed. The reception nurse said that he did not mention experiencing any chest pains (which might have indicated heart disease). However, the second prison doctor explained that the symptoms of alcohol withdrawal might have masked any other physical health problems. Both the reception nurse and the third inpatients' nurse talked to the man on 11 December, when his withdrawal symptoms were being controlled by chlordiazepoxide. The man did not mention pains in his chest or other symptoms which might have revealed his underlying heart problem.
41. According to the clinical reviewer, the medical records are well completed and indicate that the man was appropriately observed. However, when the reception nurse measured the man's blood pressure and pulse in reception, both were high. She said that, during her handover to inpatients' staff, she suggested that the man's blood pressure be checked again. There is no evidence that further readings were taken. No handover notes were made in the man's medical record.

The Head of Healthcare should ensure that inpatients' blood pressure and pulse rate are checked, and the appropriate notes made in the medical records

42. The medical record also indicates that nursing staff believed that the man would be examined by a doctor on 11 December. There is no record of an examination taking place and the prison was not able to confirm whether he was assessed by a doctor. The introduction of an electronic medical records system (expected to take place shortly) should lessen the likelihood of this uncertainty.
43. The Quality and Clinical Governance Manager explained that the PCT expects prisoners admitted to healthcare to be examined by a doctor within 24 hours of admission, which is what happened to the man. I do not believe it likely that, had the man been assessed by a doctor on 11 December, his death would have been prevented. Nevertheless it is unsatisfactory that he was not followed up.

The emergency response

44. The inpatients' nurse checked the man at half hourly intervals during the night of 11 December. She became concerned when she noticed that he had been in

the same position in bed for an hour. She attempted to rouse him, and being unable to do so, asked the officer working on the inpatients' unit to help her. The officer was carrying a cell key in a sealed pouch. However, the two staff chose to call for assistance from the assist night orderly officer rather than open the cell immediately. When the assist night orderly officer arrived, and the man was still not roused, she unlocked and went into the cell.

The man had been admitted to healthcare as an inpatient because he was experiencing severe alcohol withdrawal symptoms, which can be fatal. The staff interviewed as part of the investigation explained that the nurses working on the inpatients' unit are experienced at managing patients withdrawing from alcohol. I do not think that the decision to wait for the assist night orderly officer to arrive before unlocking the man's cell caused a particular delay in providing treatment to the man. However, the Governor and Head of Healthcare might wish to remind staff of the circumstances in which the cell key contained in the sealed pouch should be used.

45. Overall, however, the clinical reviewer concludes that the healthcare staff involved in assessing the man and caring for him as an inpatient showed a commendable level of care and compassion. I am pleased to endorse that finding. I do not think the man's death could have been foreseen or prevented.

CONCLUSION

46. The man had a long history of serious alcohol abuse. On 10 December 2009, he was recalled to High Down under the terms of his life licence because of his problematic drinking. On his arrival at the prison, he was already experiencing alcohol withdrawal symptoms and felt very unwell. His blood pressure and pulse readings were taken and found to be high, both common symptoms of alcohol withdrawal. However, he complained of no chest pains or shortness of breath. He was placed on an alcohol detoxification programme and was admitted to the prison inpatients' unit for close observation.
47. During the night of 11 December, he was found unresponsive in bed. Staff went into his cell and, finding no pulse or signs of breathing, commenced CPR until the paramedics arrived. They confirmed that the man had died. The post mortem revealed coronary heart disease to be the cause of his death.
48. The investigation has found that generally, the man received a good standard of care and was treated with compassion during his short time at High Down. I conclude that his death was not foreseeable. Although I make one recommendation, I do not believe that the omission was a factor in his death.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that inpatients' blood pressure and pulse rate are checked, and the appropriate notes made in the medical records

The Prison Service accepted the recommendation at the draft report stage, noting that:

“Baseline observations should be recorded for anyone being admitted with a physical illness and this is standard procedure. The medical records are now electronic and this makes follow-up on patients easier and not reliant on verbal prompts.”