Investigation into the circumstances surrounding the death of a man on 29 April 2011, while in the custody of HMP Coldingley

Report by the Prisons and Probation Ombudsman for England and Wales

April 2012

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.

This is the report of an investigation into the death of a prisoner at HMP Coldingley who died on 29 April 2011. A fellow prisoner raised concerns having discovered the man unresponsive after morning unlock. A post mortem recorded the man's death as being due to natural causes, as a consequence of a heart attack. He was 64 years old. I offer my sincere condolences to the man's family and to all those affected by his death.

The investigation was undertaken by one of my senior investigators. I would like to thank the Governor of Coldingley and his staff for their assistance during the investigation. I apologise that the report has been delayed.

A clinical review into the man's medical care at Coldingley was commissioned from Surrey Primary Care Trust. They appointed a doctor to conduct the review. The review concludes that the man's clinical care was satisfactory. The clinical reviewer made four recommendations, three of which we endorse. These relate to provision of paper records, consideration of outstanding hospital appointments when a prisoner is transferred and ensuring that information is sought from a prisoner's General Practitioner when they arrive in custody. The other recommendation made by the clinical reviewer relates to suggested actions for the Coroner to consider.

During the investigation evidence came to light that a prison visitor had raised concerns about the man's wellbeing. She apparently informed staff about her concerns and opened a self-harm monitoring document. No trace could be found of the prison visitor's visit or the self-harm monitoring documentation in the records held by Coldingley. This is clearly unsatisfactory and requires investigation. It is also unsatisfactory that, when the man was unlocked on the day of his death, staff made no attempt to check on his condition and some time passed before he was discovered. This lapse would not have affected the sad outcome in the man's case, as he had died some time previously, but unlock routines require improvement.

The recommendations made in the draft report has been accepted by HMP Coldingley. I have included the prison's response to the recommendations at the end of this report.

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

SUMMARY

1. A man was born in 1947. He was 64 years old when he died on 29 April 2011 at HMP Coldingley. The man died of natural causes as a consequence of a heart attack caused by heart disease.

2. On 26 July 2007, the man was sentenced at Crown Court to an indeterminate sentence prison sentence for public protection (a life sentence where a prisoner has to serve a set number of years (the tariff) before they can be considered for release by the Parole Board) and was given a tariff of two years and seven months. He arrived at HMP Woodhill on the same day. The man was later held at HMP Wellingborough, HMP Coldingley and HMP High Down before he returned to HMP Coldingley on 26 January 2011.

3. During the man's first reception health screening interview, at Coldingley, it was recorded that he had history of heart disease (he had a stroke in 2003), had left sided weakness, walked with a stick, short-term memory loss and dyslexia (a learning disability that can affect a person's ability to read and spell words). The man was also a smoker. He was offered and declined assistance to help him stop smoking.

4. A few days before his death, the man was visited by a prison visitor. She was concerned about the man's low mood and informed staff about her concerns. The prison visitor opened a self-harm observation and support document. However, there is no record of her visit to the prison around this time and staff could not find a record of self-harm observation and support procedures being implemented.

5. The man's cell was unlocked around 8.40am on 29 April. The member of staff who unlocked the cell did not check to see if he was awake and did not enter his cell. Just after 9.15am, one of the diversity and disability orderlies approached staff as he was unable to rouse the man when he went to clean his cell. Officers went to the man's cell and were also unable to rouse him. Assistance was requested from healthcare and a nurse attempted to resuscitate the man. Unfortunately, her attempts to resuscitate him were unsuccessful. An ambulance was called and paramedics pronounced death at 9.40am.

6. The clinical review carried out on behalf of Surrey Primary Care Trust considered both the care provided for the man throughout his time in prison and the emergency response when he was discovered. In the clinical reviewer's view, the general standard of care given to the man was satisfactory and that his care while he was at Coldingley was "exemplary". The clinical reviewer has made four recommendations, one of which relates to the actions taken by the Coroner following a death in custody, which is outside of the Ombudsman's remit. We endorse the other three recommendations which relate to the provision of paper records to both the investigator and clinical review, seeking information from a prisoner's General Practitioner when they arrive in custody and consideration of outstanding hospital appointments when a prisoner is transferred to another prison.

7. We make a further three recommendations. When a cell door is unlocked, the member of staff should interact with the prisoner to ensure that there are no immediate medical issues that may need attention. We are also concerned that there is no record of the prison visitor's visit to the prison and that the self-harm monitoring documentation cannot be located.

THE INVESTIGATION PROCESS

8. The investigator was formally notified of the man's death on 3 May 2011. Notices were subsequently issued to both staff and prisoners at HMP Coldingley to inform them of the investigation process and asking anyone who had information relevant to the investigation to contact the investigator. One prisoner asked to be seen. The investigator also studied all the relevant prison records relating to the man which included his main prison record and his medical records.

9. A clinical review was commissioned from Surrey Primary Care Trust into the medical care provided for the man during his time in custody. The purpose of the review was to establish whether the care which the man received in prison was comparable with that he would have been offered in the community and to identify any points of learning. A doctor was appointed to lead the clinical review. We are grateful for his report which was received on 19 January 2012 and is annexed to this investigation report.

10. We apologise for the delay in issuing the draft report. This was due to work pressures at the Ombudsman's office and the late receipt of the clinical review.

11. The investigator contacted Her Majesty's Coroner to inform him of the nature and scope of the investigation and to request a copy of the post mortem report. Upon completion, this report will be sent to the Coroner to assist his enquiries into the man's death.

12. One of our family liaison officers contacted the man's family. They were informed about the purpose of the investigation and offered the chance to raise any concerns or questions that they wanted to be addressed. The family had concerns about the man's healthcare in previous prisons. The family were very complimentary of staff and care at Coldingley and the memorial service that was arranged. However, the family were concerned about the man having in-possession medication due to his mental health. We have attempted to address these issues within the report. We hope that this helps the man's family to understand the events leading up to his death. The family received the draft report as part of the consultation period, the investigator and family liaison officer met with the man's wife to discuss the draft report. We would like to thank her for taking the time to read and for providing thorough comments on the report.

13. The investigator visited HMP Coldingley on 6 May and spoke to the Deputy Governor, a member of the Independent Monitoring Board at Coldingley as well as other staff involved in the care of the man. He returned to Coldingley on 29 June to interview two prisoners, a diversity and disability orderly and one of the man's friends. Mr Del-Greco returned again on 12 July to conduct joint interviews with the clinical reviewer. Transcripts of these interviews are attached to this report.

14. After completing the interviews, the investigator discussed the emerging issues with the Governor, on 12 July, and later confirmed his findings in writing.

HMP COLDINGLEY

15. HMP Coldingley was opened in 1969 and in 1993 it was re-designated as Category C[1] training prison. The prison is organised into five residential wings, the majority in single cells, with a small number of shared cells. Four of the wings have electronic unlocking night time sanitation (this is when the cell door unlocks for a limited time to allow the prisoner to go to the toilet) and one, built 2009, has integral sanitation.

16. There is no in-patient healthcare facility at Coldingley. Prisoners with increased healthcare needs are transferred to nearby prisons with appropriate facilities. There is a Healthcare centre which operates services parallel to a GP surgery, also offering a walk-in clinic and treatment for minor injuries

17. The investigator reviewed the Ombudsman's report into the one earlier death at HMP Coldingley. The previous death was also due to natural causes. There are no similarities between that death and the man's.

Diversity and disability orderlies

18. Diversity and disability orderlies are specially selected prisoners. They assist with the induction of new prisoners when they arrive at Coldingley, promote good relations between different racial groups and assist prisoners who have need of additional assistance due to their disabilities. The role also involves cleaning cells, collecting meals and assisting with movements around the prison for prisoners with mobility problems.

Official Prison Visitors

19. Official Prison Visitors (OPVs) are independent volunteers appointed by prison establishments, who visit prisons in order to offer friendship to prisoners. They are neither paid civil servants, nor religious volunteers. Any prisoner may apply for an OPV, whether or not he/she has visits from family members or friends. A prisoner is not required to surrender a visiting order to receive a visit from an OPV. OPVs visit all categories of prisoner, whatever their circumstances and may visit more than one prisoner. OPVs are encouraged to operate in such a way that they are included in the general life of the prison, meeting needs which are quite distinct from, for example, those met by probation volunteers or chaplains' assistants.

Multi-Agency Public Protection Arrangements

20. Multi-Agency Public Protection Arrangements (MAPPA) support the assessment and management of the most serious sexual and violent offenders.

[1] On arrival into prison, all adult male prisoners are classified on reception into prison and put into one of four security categories based on the likelihood of escape and the risk to the public if they did escape. The categories are: Category A: prisoners who would be highly dangerous to the public, police or national security if they were to escape. Category B: prisoners for whom the highest security conditions are not necessary, but for whom escape needs to be made very difficult. Category C: prisoners who cannot be trusted in open conditions but who are unlikely to make a determined escape attempt. Category D: open conditions, prisoners who can be trusted not to try and escape. The man was categorised as a Category C prisoner.

The aim of MAPPA is to ensure that a risk management plan that is drawn up for the most serious offenders and benefits from the information, skills and resources provided by the individual agencies co-ordinated through MAPPA.

21. There are three levels of MAPPA:

- Level three - Anyone subject to level three is considered as being the highest risk case, where more than one agency will take responsibility for the management of the person concerned.
- Level two - As with level three, anyone who has been identified as falling into the level two heading would be managed by more than one agency, very often limited to probation and the police. However, it is possible to involve more agencies if the circumstances warrant it.
- Level one - An offender on level one MAPPA is normally managed by a single agency. This is the lowest monitoring procedure available under the MAPPA system.

When the man arrived in custody he was assessed as MAPPA Level 2.

Assessment, Care in Custody and Teamwork

22. The Assessment, Care in Custody and Teamwork (ACCT) system monitors and supports prisoners who are assessed as at risk of suicide or self-harm. It is a flexible, prisoner-centred assessment and care planning system, which aims to identify individual needs and offer personalised care and support before, during and after crisis, in a safe and caring environment. Once placed on ACCT support, the prisoner is observed at intervals determined by their perceived level of risk. The observations continue during the day and the night. Additional support is offered from Listeners[2], personal officers[3] and other staff. Amongst other things, the ACCT guidance states that prisoners should be cared for in a safe environment. The arrangements are reviewed regularly by a multi disciplinary meeting, which should include the prisoner

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23. If a member of staff has reason to believe that a prisoner is at risk of self-harm or suicide, he or she must open an ACCT form straightaway. The following further actions must follow:

- A ‘Concern and Keep Safe’ form must be opened immediately. The purpose of this form is to determine the main issues causing the prisoner to be at risk of self-harm or suicide.

- An immediate action plan must be compiled within one hour of the ACCT form being opened. The purpose of the immediate action plan is to consider and record the most appropriate environment and regime required to support the at-risk prisoner prior to the first case review. The plan should be drawn up within an hour of the ACCT form being opened.

[2] Listeners support prisoners who may be at risk of suicide and/or self-harm. They are trained, selected and supported by Samaritans to offer confidential emotional support, 24 hours a day, to fellow prisoners in distress
[3] Each prisoner is allocated a personal officer, who is the first point of contact for them.

- An assessment interview must be conducted with the at-risk prisoner by a trained assessor within 24 hours of the ACCT form being opened. The purpose of this interview is to examine in depth the reasons behind the risk posed by the prisoner. The details of the assessment then inform the initial case review.

- An initial case review must be conducted within 24 hours of the ACCT form being opened. The review panel must, in conjunction with the at-risk prisoner, agree a care and management plan - or 'care map' - setting out goals or the prisoner to achieve, with the help of staff, in order to reduce his risk.

- Thereafter, regular multi-disciplinary case reviews must be convened, each involving the at-risk prisoner, so that his risk can be monitored and his care map updated.

The ACCT form can be closed once those involved in the prisoner's care, as well as the prisoner himself, are content that the risk has reduced to the point where formal monitoring procedures are no longer necessary. However, in such cases, a post-closure review, once again involving the prisoner and a multi-disciplinary panel, must be convened within an appropriate interval.

Independent Monitoring Board

24. Each prison has an Independent Monitoring Board (IMB) appointed by the Secretary of State for Justice. IMB members are independent and unpaid. They monitor day-to-day life in their prison and ensure that proper standards of care and decency are maintained. The most recent annual report published by the IMB at Coldingley covers the period from August 2010 to July to August 2011. The report does not comment on any issues relevant to this investigation.

25. The IMB confirmed that the man had not made any applications to them while he was at Coldingley.

HM Chief Inspector of Prisons

26. The last inspection of HMP Coldingley by the HM Chief Inspector of Prisons was between 7 and 11 June 2010. The Chief Inspector noted that: "Despite a more challenging population requiring a greater focus on security, the prison was a safe place … It is quite clear Coldingley is going in the right direction". During our investigator's visits, he observed this calm environment and the positive attitude of those prisoners and staff he had informal contact with.

27. In relation to the healthcare facilities the Chief Inspector reported that: "The newly refurbished health care centre was a good facility for the treatment and care of patients, and was well managed with well organised clinics". Although there some was criticism of general health services prisoners interviewed

during the inspection were positive about “the attitude and professionalism” of the healthcare staff.

KEY EVENTS

28. The man was born in 1947 in London. He was 64 years old when he died on 29 April 2011 at HMP Coldingley.

29. The man was convicted of committing arson recklessly and he was sentenced on 26 July 2007 at Crown Court to an indeterminate prison sentence for public protection (IPP)[4] and was given a tariff of two years and seven months. This was not his first time in prison as he had previously been convicted of arson in 1991 when he was sentenced to 18 months imprisonment. He arrived at HMP Woodhill on the same day as he was sentenced. The man was later held at HMP Wellingborough, HMP Coldingley and HMP High Down before he returned to HMP Coldingley on 26 January 2011. When the man arrived in custody he was assessed as MAPPA Level 2.

30. During the man's first reception health screening interview (this interview highlights any immediate mental or physical health problems requiring referral to the doctor or other specialist service), at Coldingley, it was recorded that he had history of heart disease (he had a stroke in 2003), left sided weakness, walked with a stick, short-term memory loss and dyslexia. The man was a smoker but chose not to accept help to stop.

31. On 20 December 2007, the man was granted enhanced prisoner status. The Incentive and Earned Privileges Scheme (IEPS) was introduced to prisons in 1995. It is designed to encourage prisoners to progress through their sentence plan, to undertake hard work or other purposeful activity and create a better and safer environment for prisoners and staff. There are three levels under IEPS – basic, standard and enhanced – with all new prisoners initially being on standard level. Changes to that level will then depend on their conduct and progress through their sentence plan.

32. During the morning of 1 March 2010, the man was taken to hospital for an outpatient appointment. He returned to High Down on the same day.

33. Just over two weeks later, on 19 March, the man was taken to hospital for an outpatient appointment. He returned to prison later that same day. He returned to hospital again on 4 May for a consultation.

34. The Parole Board held a hearing on 14 May to consider the man's case.[5] The Board decided that he was not suitable for release on licence or transfer to open conditions. The Board concluded that the man was not suitable for open conditions until he had "completed the appropriate [offending behaviour] work" The Board encouraged the man to "engage with this work, as soon as his health will allow it, in order to make progress before his next [parole] review."

35. The man appealed against the Parole Board's decision and they informed him that his appeal was unsuccessful in a letter dated 10 June. The Parole Board

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[5] The Parole Board is an independent body that works with its criminal justice partners to protect the public by risk assessing prisoners to decide whether they can be safely released into the community.

acknowledged that the man had experienced health problems since 2003 after he suffered a stroke. However, they drew attention to the fact this offence had occurred after this date. The Parole Board wrote:

> "While your newly diagnosed health problems may have some impact on risk and ability to take part in offending behaviour work, the key issue is whether the risk you pose can be safely managed outside closed conditions. You remain at more than minimal risk of causing serious harm and there is no justification for an oral hearing at this stage."

36. During the morning of 14 June, the man was again taken to hospital for an outpatient appointment. He returned to the prison later that same day. On 13 July, a referral was made by the man's cardiologist for him to attend hospital for consideration of an implantable cardioverter defibrillator (a small battery powered electrical impulse generator which can be implanted in people to assist with heart rhythm problems). His first appointment was for 3.15pm on 18 August but, due to paperwork being lost in the security department, he was not ready to leave until 3.00pm. He therefore did not attend the appointment as, by the time he arrived at the hospital, the consultant had left. A new appointment was made for 3 November but on the day the man refused to attend and signed a disclaimer. He wrote: "The prison keeps mucking up my paperwork and last time we had to come back without being seen". A further appointment was made for 15 December but the man was unable to attend as he was an inpatient in hospital at the time. A fourth appointment was scheduled for 26 January 2011.

37. A letter dated 22 September, from the Public Protection Casework Section of the National Offender Management Service (NOMS), informed the man that the Secretary of State agreed with the view of the Parole Board (not to consider release on life licence or recommend transfer to open conditions) and considered the following risk factors were outstanding and required further work in closed conditions:

    - Domestic violence/relationships
    - Cognitive deficits
    - Arson/fire setting

38. On 23 September, a mini mental state examination (MMSE, or Folstein test, is a brief 30-point questionnaire test that is used to screen for cognitive impairment[6]) was conducted. The man scored 15/22 usually it is scored out of 30 but due to his dyslexia his maximal achievable score was only 22. This suggested that had mild to moderate impairment of cognition.

39. On 13 December, the man was admitted to hospital with acute coronary syndrome (heart problems). He returned to High Down two days later.

[6] Cognitively-impaired people have difficulty with one or more of the basic functions of their brain, such as perception, memory, concentration and reasoning skills. Common causes of cognitive impairment include Alzheimer's disease and related dementias, stroke, brain injury, Parkinson's disease and brain tumour.

40. On 26 January 2011, the man transferred to Coldingley (the same day as had an appointment at hospital which he was consequently unable to attend). He was initially held on C wing and moved to E wing on 24 February.

41. All prisoners are subject to a Cell Sharing Risk Assessment (CSRA) on reception. The CSRA process is designed to assess the risks posed by an individual to other prisoners in a locked cell which includes taking into account the any previous violence or mental health issues. When the man moved to Coldingley his CSRA was recorded as low (no current indication/evidence of risk, suitable for multi-cell location). The man's CSRA was reviewed on 4 April and recorded as standard risk[7].

42. On 28 March, the man attended a review with a prison doctor. The prison doctor noted the previous referrals to hospital and recorded that he had confirmed with administration that the man was waiting for an appointment. There appeared to be no further action taken on this issue. Following the appointment, the prison doctor prescribed isosorbide mononitrate this is in the class of drugs called nitrates that are used for treating and preventing angina. Nitrates are vasodilators (dilators of blood vessels). Blood returning from the body in the veins must be pumped by the heart through the lungs and into the body's arteries against the high pressure in the arteries. In order to accomplish this work, the heart's muscle must produce and use energy ("fuel") which requires oxygen brought to the heart by the blood. Angina pectoris (angina) or "heart pain" is due to an inadequate flow of blood (and oxygen) to the muscle of the heart.

43. On 3 April, a Senior Officer (SO) made an entry in the man's record confirming that the diversity and disability orderlies had been asked to take turns in cleaning the man's cell. After the SO informed the man about the cleaning arrangements he made the following entry:

> "He [the man] has asked for a working task on the wing to which I am looking into, he has been to healthcare to be medically cleared to help out at the E wing hotplate. The Head of Healthcare has given the go ahead verbally but I am yet to receive written confirmation. He [the man] has been made aware of this."

44. In her statement provided to the clinical reviewer in November 2011, a prison visitor wrote that she visited the man "a few days" before his death. During her visit the prison visitor was concerned about the man's wellbeing as he appeared "down in himself and very unhappy and when talking seemed preoccupied". The prison visitor asked an officer (she did not know his name) whether the man was subject to an Assessment, Care in Custody and Teamwork (ACCT) self-harm observation and support plan. As he was not, the

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[7] There are two risk categories, high risk and standard. A high risk prisoner is one for whom there is a clear indication (from evidence) of a high level of risk that they may be severely violent to a cell mate, or that a cell mate may be severely violent to them. A standard risk prisoner is one for whom, based on the evidence available, there is no immediate risk of severe cell violence.

prison visitor completed a ‘Concern and Keep Safe’ form. The purpose of this form is to determine the main issues causing the prisoner to be at risk of self-harm or suicide. This should have triggered an assessment which could have led to regular checks being carried out and recorded.

45. After receipt of the prison visitor’s statement, the investigator asked the prison to confirm her recollection of events. Coldingley had no record of the visit (in either the gatehouse records or in the wing observation book) and the last record of the prison visitor visiting the prison was on 19 April. There was also no trace of the ACCT documentation and no record of it being opened in the self-harm and suicide records held by the prison.

46. When interviewed as part of this investigation, a fellow prisoner and a friend of the man confirmed that he had appeared well on the day before his death. The prisoner said that he had delivered some food to the man shortly before they were locked in the cells on 28 April. He said “I think it was a pie, steak and kidney pie. I said ‘alright, see you in the morning mate’, and sadly [the next day] he was dead”.

47. At around 7.40pm on 28 April, an officer locked the man’s cell door (E1-55). In her statement to the Governor, she confirmed putting her head round the door and seeing the man sitting in his chair watching television. She checked he was alright and he responded: “Yep, yep I’m fine” and she then locked his cell door. There are no records of the man using his cell bell to summon assistance after his cell door was locked. The prison then entered patrol state[8] and the day shift staff on E wing handed over responsibility to two Operational Support Grade (OSG)[9] staff and gave a verbal briefing of any outstanding issues.

48. A roll check[10] was carried out at around 6.40am on 29 April and the officer did not notice anything untoward when he checked that the man was in his cell.

49. At around 8.40am on 29 April, an officer unlocked the man’s cell but she did not look inside or try and gain a response from him. At around 9.15am, a diversity and disability orderly went in to clean the cell but decided not to do so as he found the man unresponsive and thought he could still be asleep. The orderly went to the wing office and informed the SO that he did not wish to clean the man’s cell as he appeared to be asleep, but was not responding. After he spoke to the orderly the SO asked an officer to check on the man.

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[8] After the evening roll call to confirm prisoners are all accounted for, the prison enters what is called patrol state. This is defined as follows: ‘Prisoners are locked up and staff numbers are reduced to the minimum needed to patrol. The main role of staff at this time is to maintain the security of the prison.’

[9] An Operational Support Grade (OSG) is a member of prison staff at a grade below prison officer. They work in many areas of the prison, normally where there is little or no contact with prisoners.

[10] The roll check is the physical count of the number of prisoners on each wing within a prison. Roll checks occur at specified times during the day, and staff must sign that the roll is correct.

50. In her statement to the Governor, the officer wrote that on arrival at the man's cell she pushed the door open, called his name twice, walked into his cell and then stood by the side of his bed. She recorded that the man was lying on his right hand side facing the door and as she stood there she called his name again. The officer then touched the man's arm, which was cold as she realised that "something was not right" she closed the cell door and then went to the bottom of the stairs and asked for the SO to come down to the ground floor. They then both entered the man's cell.

51. In his statement to the Governor, the SO wrote:

> "I entered the cell and called the man to try and wake him, he did not respond. I touched his cheek and he was cold, I felt for a pulse but could not find one. I then called for medical assistance i.e. code red [prisoner not breathing]. The nurse arrived and said we needed to start CPR [cardio-pulmonary resuscitation][11] which she did, she asked me to get the oxygen out, I was not familiar with the equipment so we swapped roles. We continued to give CPR until the nurse said we should stop. Other members of the Healthcare team arrived and continued to try and assist the man."

52. The nurse and SO were joined by other healthcare staff. Although it appeared that rigor mortis[12] was present the healthcare staff decided to carry out CPR. A defibrillator was connected to the man and CPR continued until paramedics arrived at 9.37am and they took over the man's care. After they had examined the man, the paramedics pronounced death at 9.40am.

53. Following this, the prison put in place its death in custody contingency plan. The police visited the prison and interviewed staff. They found no suspicious circumstances.

54. Staff told the other prisoners of the man's death later that morning. They also asked whether they required any support or wanted to speak to a Listener. All the prisoners on self-harm and suicide monitoring arrangements were reviewed.

55. After a death, prison managers must hold a "hot debrief". This is a meeting of all the staff who were involved in finding and attempting to resuscitate the prisoner. The meeting should focus on reassurance, information sharing and how staff can support each other. The Head of Residence at Coldingley held a hot debrief on 29 April. There were no areas of concern raised at that time but staff were offered support from the prison's care team.

56. After the man died, Coldingley appointed a family liaison officer who visited the man's family, together with a prison chaplain to inform them about his death. He maintained contact with the family and assisted with the funeral

[11] Cardio-pulmonary resuscitation (often described as mouth-to-mouth resuscitation) is a combination of rescue breaths and chest compressions to keep blood and oxygen circulating in the body.
[12] Rigor mortis is a condition of extreme stiffness affecting the arms and legs after death making it virtually impossible to bend the wrists, elbows or knees.

arrangements. Coldingley also offered financial assistance towards the costs of the man’s funeral. A memorial service, conducted by a prison chaplain, took place at Coldingley on 12 May which was well attended by staff and prisoners. The man’s funeral took place on 25 May 2011.

Post mortem

57. The post mortem report records that the man’s death was due to natural causes, as a consequence of a myocardial infarction (heart attack) caused by coronary atheroma (heart disease).

ISSUES

58. As mentioned earlier in the report, the man's family were contacted by one of the Ombudsman's family liaison officers. The family were concerned about the man's medical care while in custody and wanted clarification about the events leading up to the death. We hope that the sequence of events has been addressed within the main body of the report. The man's medical care is considered in detail below. The man's wife received the draft report as part of the consultation period, the investigator and Ombudsman's family liaison officer met with the man's wife to discuss the draft report. I would like to thank her for taking the time to read and comment on the report. The man's wife explained one of her main concerns was the visit carried out by the Official Prison Visitor, the lack of evidence of the visitor being there, the security for the visitor and others, and the missing self-harm and suicide monitoring document that she had apparently opened. The man's wife said that she agrees with the Ombudsman's recommendations, she finds the roll call regime unacceptable, and would like to see senior managers on wings trained in first aid. The man's wife highlighted her concerns about the missing paperwork and missed appointments. The man's wife explained when she visited the man's cell, she was pleased to see he was allocated a disability cell. The man's wife also expressed her thanks to the prison family liaison officer.

Medical care

59. As noted, a review of the man's medical care was undertaken by a doctor on behalf of Surrey Primary Care Trust. From the medical records, it was clear that the man was seen regularly by healthcare staff. In his review, the clinical reviewer noted that in this particular case the man's transfer occurred on the day of an important appointment (which had already been re-arranged on a number of occasions). The clinical reviewer wrote "great care however should be given to making sure that new establishment knows of these appointments and that they diligently follow them up". We agree with his recommendation that when arranging the transfer of a prisoner, consideration should be made of any outstanding outpatient appointments to ensure that these are not missed.

    The Governor of HMP Coldingley and the Head of Healthcare should ensure that, when arranging the transfer of a prisoner, checks should be made of any outstanding outpatient appointments to ensure that these are not missed.

60. With regard to the provision of medical records for the clinical reviewer and investigator, the clinical reviewer recommends that in addition to the computerised medical records, all relevant paper records should also be made available. This will ensure that both the clinical reviewer and investigator have all available information when carrying out their duties.

    The Head of Healthcare should ensure that in addition to the computerised medical records, all relevant paper records should also be made available, to fatal incident investigators and clinical reviewers.

61. To improve the quality of the records, in particular with regard to any allergies and past medical conditions and medications, the clinical reviewer recommends that previous General Practitioner records or, at minimum, a summary sheet are scanned into the prison computerised records.

The Head of Healthcare should ensure that previous General Practitioner records or, at minimum, a summary sheet are scanned into the prison computerised records.

62. In his review, the clinical reviewer also recommends that the Coroner considers routinely carrying out toxicology tests when a prisoner dies in custody. This is outside of the remit of this office and we therefore leave this for the consideration of the Coroner.

63. As mentioned above, the man's family were concerned that he had a history of a heart attack and cancer. They said he had a tendency to pass out frequently but did not like to cause a fuss and this could mean he was overlooked. The clinical reviewer finds that records show that the man had regular contact with nurses and prison doctors when he complained of dizziness or chest pains between July and December 2010 while in HMP High Down. These episodes seemed to settle on transfer to HMP Coldingley. The clinical reviewer states that the man did not have cancer. The man was fully investigated by an urologist and found to have enlargement of the prostate gland. He was also diagnosed with lung damage from asbestos exposure but not any cancerous changes.

64. The family were concerned that the man was given his medication in a weekly medicine (dossett) box[13]. As he had cognitive impairment and dyslexia the family felt he became confused and forgot to take his medication at times. They also felt his medication could be stolen by other prisoners (he often had friends and other prisoners in his cell). They claimed that when they challenged nursing staff about this they were told that the nurses were too busy to give his medication daily.

65. The Lead for Prison Health at High Down and Coldingley addressed this in her written response. She wrote that the man was assessed for his suitability for in-possession medication. This included being able to identify relevant medication. The man found it difficult to manage in-possession medication in boxes, therefore he was provided with a dossett box. He always attended the medicine hatch on the house block once a week, on time, when the dossett box needed to be refilled. The man was compliant with his medication. High Down have an in-possession policy, which accords with the view of Her Majesty's Inspectorate of Prisons, that where possible in-possession medication should be the 'norm'. The Lead for Prison Health said that this was not about nurses not having time, this was about giving patients responsibility and greater control. She added that this also enables them to cope better on discharge if

[13] Dossett type boxes have separate compartments for days of the week and/or times of day such as morning, afternoon and evening. If a patient cannot remember if they took their medicines one day they only need to check the box to find out.

they have got used to managing their own medication and is consistent with practice in the general community. The man was not on any medication which could be used recreationally. There is no evidence that his medication had been taken by other prisoners.

66. The man's family said that before he went into prison he had a carer at home and used a walking stick. They understood that when the man went to prison staff took away his walking stick. They wrote to the governor to ask him to allow the man his walking stick, and they understood that this eventually happened. However, the man's family believed that he could only use it in prison, he wasn't allowed it on visits and this meant it impacted on the length of visit due to the man's location and length of time it took him to get to the visits hall.

67. In her response, the Lead of Prison Health wrote that she could find no evidence that the man's walking stick was removed. An entry in his records dated 29 August 2010 states that the man was able to move around well with his stick. Towards the end of his time at High Down, the man had requested to be considered for a walking frame. In order to achieve this, an occupational therapist assessment was needed which the man subsequently refused to engage in. This was therefore not progressed. The investigator could also find no evidence that the man's walking stick was removed.

Assessment, Care in Custody and Teamwork

68. As mentioned above, a few days before his death, the man was visited by a prison visitor. During her visit she was concerned about the man's wellbeing and opened an ACCT suicide and self-harm monitoring plan, by completing a 'Concern and Keep Safe' form. According to the records held by Coldingley, the last record of her visiting the prison was ten days before the man's death, on 19 April, when she attended a meeting. We are concerned that there is no record of her visit to the prison during the following week and that the ACCT documentation cannot be located.

69. We are concerned that there is no record of the visit (from the aspect of both security and health and safety) and that there is no record of any ACCT documentation. While we accept that there is no evidence to suggest the man took his own life, we suggest that the Governor investigates what happened in this case to clarify the sequence of events (and to locate the ACCT documentation). Such an omission is unacceptable and steps should be taken to avoid this happening again.

    The Governor of HMP Coldingley should carry out a review of gate security arrangements for visitors to the prison to ensure that all visitors are appropriately recorded.

    The Governor of HMP Coldingley should carry out a review of self-harm and suicide monitoring procedures, to ensure they are being correctly implemented.

The discovery of the man’s death

70. While we could find no written requirement in Coldingley’s local roll check procedures that staff should check prisoners for signs of life when they unlock the cell, we believe that they should ensure the wellbeing of prisoners when they do so. By not checking his wellbeing, the man was left in an open cell unattended for over half an hour. Had the diversity and disability orderly not gone into the man’s cell and raised concerns, it is possible this would have been much longer. While recognising that such a check would not have changed the outcome for the man, this is clearly unacceptable. The Prison Officer Entry Level Training (POELT) manual states:

> “Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead.”

From the interviews and CCTV footage, it is clear that this procedure was not followed.

The Governor of HMP Coldingley should review the procedures for unlocking prisoners and ensure that when a cell door is unlocked the member of staff interacts with the prisoner to ensure that there are no immediate issues that may need attention.

The emergency response

71. Concerns were raised by a prisoner who discovered the man thirty-five minutes after morning unlock. Within a few minutes of this discovery an officer had radioed for and received assistance, an ambulance had been called, and attempts were being made to resuscitate the man. The paramedics arrived 27 minutes after the initial call for help and pronounced death at 9.40am. It appears that the man had been dead for a number of hours before his discovery as rigor mortis was present and he appeared to have died while he slept. From both the paperwork and the investigator’s interviews with staff it appears that, after the man was discovered, all those involved acted quickly but in a professional and considerate manner.

CONCLUSION

72. The man arrived at Coldingley on 26 January 2011. It was discovered, during the morning of 29 April 2011 that the man had passed away during the night. Attempts to resuscitate were carried out, although it did appear that he had been dead for some time.

73. In light of the findings of this investigation and the clinical review, we conclude that the medical care provided to the man was appropriate. However, the clinical reviewer has, however, highlighted certain areas for improvement at Coldingley.

74. We are concerned that when the man's cell was unlocked, observation checks were not carried out which meant a full thirty-five minutes passed before the man was discovered. It also appears that self-harm and suicide monitoring procedures were also not correctly implemented. Although there is no evidence to suggest that the man took his own life, it is still an issue of concern. We make six recommendations.

RECOMMENDATIONS

At the draft report stage, the National Offender Management Service (NOMS) responded to the recommendation. That response is included in italics below the recommendation.

1. The Governor of HMP Coldingley and the Head of Healthcare should ensure that when arranging the transfer of a prisoner, checks should be made of any outstanding outpatient appointments to ensure that these are not missed.

   Partially Accepted: Wherever possible sending establishments are asked to ensure that all medical appointments are communicated prior to transfer; however, the quality of this process is largely dependent upon the information provided by the sending establishment. Unfortunately, if a prisoner is required to move for security reasons or at short notice the prison is not always able to ensure that the checks can be made within a short time frame. However, the prison is advised by other healthcare providers at other establishments when appointments have previously been made to ensure that they continue with the prisoner's continuity of care.

2. The Head of Healthcare should ensure that in addition to the computerised medical records, all relevant paper records should also be made available, to fatal incidents investigators and clinical reviewers.

   Accepted: All paperwork is available as well as clinical reviews upon request.

3. The Head of Healthcare should ensure that previous General Practitioner records or, at minimum, a summary sheet are scanned into the prison computerised records.

   Accepted: All records are scanned into the computer and are available upon request.

4. The Governor of HMP Coldingley should carry out a review of gate security arrangements for visitors to the prison to ensure that all visitors are appropriately recorded.

   Accepted: An internal investigation has been completed regarding a Prison Visitor who initially stated that they came into the establishment several days before a prisoner died of natural causes. The investigation was able to demonstrate that the Prison Visitor was in fact booked into the gate on the day they visited the establishment.

5. The Governor of HMP Coldingley should carry out a review of self-harm and suicide monitoring procedures, to ensure they are being correctly implemented.

   Accepted: As per the recommendation, a review of the monitoring procedures will be carried out on self-harm and HMP Coldingley has a Safer Custody Co-ordinator who oversees all the monitoring systems.

6. The Governor of HMP Coldingley should review the procedures for unlocking prisoners and ensure that when a cell door is unlocked the member of staff interacts with the prisoner to ensure that there are no immediate issues that may need attention.

   Accepted: A review has been completed on the unlocking procedures. As the majority of HMP Coldingley's unlocking system is completed electronically staff have been told to attend the landings after the doors have been unlocked to ensure that any immediate concerns are dealt with.