Investigation into the circumstances surrounding the death of a man at HMP Blakenhurst (now Hewell) in August 2007

Report by the Prisons and Probation Ombudsman for England and Wales

July 2008

This is the report of an investigation into the circumstances surrounding the death of a man who was a prisoner at HMP Blakenhurst (now Hewell). He died in August 2007 whilst located in the segregation unit at Hewell. The post mortem report indicates that he died from a cerebral haemorrhage (a burst blood vessel within the skull, close to the brain). The man was 39 years of age when he died.

I would like to extend my personal condolences to the man's family and friends for their loss. The loss of a loved one at any time is difficult, but especially so when they are relatively young, die suddenly and are in custody.

This investigation was carried out by one of my colleagues. A clinical review (for which I am most grateful) was undertaken on behalf of the local Primary Care Trust. I would also like to thank the Governor of HMP Hewell and his staff, for their help and co-operation during this investigation.

In addition to the one recommendation I make in this report, I am pleased to draw attention to the good work undertaken by staff at the prison in trying to resuscitate the man. I make no criticism of them for not realising the significance of his heavy snoring on the night of his death.

Stephen Shaw CBE
Prisons and Probation Ombudsman **July 2008**

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SUMMARY

The man arrived in prison on 17 May 2007. He died on 18 August whilst in the segregation unit at HMP Hewell.

The man had pleaded guilty to assault charges and was awaiting Crown Court proceedings against him in Bristol. Due to overcrowding in the south of the country, the man was sent to Hewell from Bristol Magistrates Court until his Crown Court appearance date, which was scheduled for 28 August.

On 11 August, the man threw the contents of his breakfast tray at a member of staff on his residential unit. This led to him being restrained by staff and resulted in a disciplinary hearing against him. This in turn meant he was to be confined to the segregation unit for a 14 day period. His stay on the unit was uneventful for the first few days.

During one night in August, staff heard loud snoring coming from his cell. They checked on the man and found him lying on the floor with his head under the bed. They thought he was fast asleep. Unbeknown to staff, the man had suffered a cerebral haemorrhage and had collapsed. Night staff assumed that because he was snoring, he must be alive and well.

When staff came to unlock the man in the morning, they found him under his bed but he was not breathing. They attempted resuscitation and called an ambulance, but a doctor on site pronounced the man dead at 9.25am.

THE INVESTIGATION PROCESS

1. My investigator visited HMP Hewell on 28 August 2007. He was given access to the man's prison records and visited the segregation area where he was resident at the time of his death. My investigator also reviewed CCTV footage of the incident on 11 August 2007 that led to the man being in the segregation unit in the first place. Notices of my investigation for staff and prisoners were already on display at various points throughout the prison.

2. During this initial visit my investigator also met the Chair of the local Independent Monitoring Board (IMB). The IMB member told my investigator that the man had been seen on a routine IMB visit to the segregation unit on 15 August and the record showed that he was feeling well and had no problems or concerns at that time. My investigator also met with the local Prison Officers' Association committee member who expressed his desire to help in any way he could.

3. The local Primary Care Trust was asked to undertake a clinical review of the care that the man received in the short time he was in custody. They appointed a doctor to undertake this review on their behalf. The doctor was asked to look at the process of reception screening, the entries in the man's clinical record and the quality of these entries. The clinical review was also to consider if there might have been any early warning signs of the man's condition or circumstances that may have contributed to his spontaneous cerebral haemorrhage.

4. One of my Family Liaison Officers contacted the man's family. On 6 November, my Family Liaison Officer and investigator visited the family at their home. The visit allowed the family the opportunity to discuss the purpose of the investigation and to raise concerns or questions that they would like explored and addressed. The family raised a number of issues which are addressed later in this report. I know my investigator and Family Liaison Officer have endeavoured to answer all of the questions raised throughout this investigation by the family. I hope this report goes some way to reassuring them that the man's condition came out of the blue and was completely unpredictable and unpreventable.

5. My investigator contacted Her Majesty's Coroner to inform him of the nature and scope of my investigation and to request a copy of the Post Mortem report. On 27 November, the Coroner held a pre-inquest hearing, for which my investigator supplied an initial report. Upon completion of my investigation, a copy of my report will be sent to the Coroner to assist him in his enquiries into the man's death.

HMP HEWELL

6. Hewell is a local prison, built in 1993, which serves many courts in the West Midlands area. It was originally built to be run as a private prison, but the contract for running it was won in 2001 by the Prison Service and it operates now under a Service Level Agreement (SLA). Following the addition of two new house blocks in 2006, it currently has a capacity of 1,060.

7. Ms Anne Owers (Her Majesty's Chief Inspector of Prisons) said in her 2005 report that Hewell is 'a well run and stable local prison'. Her only areas of concern were around the culture of providing a service under an SLA. She felt this could lead the establishment to concentrate on the 'must do' deliverables of the SLA. There was a danger that the less quantifiable elements of personal contact with prisoners would sometimes be missed. That having been said, Ms Owers was full of praise for the way the management team at the prison had shown remarkable initiative in meeting some of these difficulties.

8. The part of Ms Owers's report covering the segregation unit said

> '*There was a large segregation unit with a relaxed atmosphere. The unit was not overused. Communal areas were clean but individual cells were dirty and smelly. Prisoners spoke well of the unit staff and said their basic regime entitlements were met. However, there were few written entries on prisoner history sheets and these were of little value with no evidence of reintegration planning. Prisoners here had no access to physical education, and little take-up of education or work*.'

In respect of the adjudication process the report went on to say

> '*Adjudication procedures were correctly followed and investigations were usually thorough, although there were exceptions. There were tariffs, which were adhered to, and well-attended quarterly standards meetings. The adjudication room was suitable, but prisoners were given uncomfortable chairs. Writing materials and prison rules were not issued routinely*.'

9. Hewell has a full time nursing and medical service with a 21 bedded in-patient facility and 24 hour nursing cover. They provide a primary care service with the support of local GP's and visiting psychiatric services from the local Mental Health NHS Trust. They have a team of 50 nursing staff with a skill mix of both Registered General and Registered Mental Health Nurses at various grades.

KEY FINDINGS

10. The man first arrived at Hewell on 17 May 2007 from Bristol Magistrates Court. He was remanded into custody having pleaded guilty to charges of Actual Bodily Harm (ABH). Because HMP Bristol was overcrowded, he was transferred to Hewell awaiting sentence at Bristol Crown Court. He was due to appear in court again on 28 August.

11. When the man arrived at Hewell he was seen by nursing staff who undertook the initial reception screening. They found him to be a fit young man who did not smoke, drink excessively or take drugs. He was passed fit to work and participate in normal prison routines. He reported to nursing staff that he was not on any medication and that he had not seen his own GP for some time, nor did he have any outstanding hospital appointments.

12. Aside from this routine interaction with the nursing team, the man had only one other contact with them when he asked for paracetamol on 24 May. There is no detail about this episode of illness, but it appears to be the only time the man requested any medication during his time at Hewell.

13. On 11 August, the man was involved in an altercation with a member of the discipline staff on his house block. It is reported on prison form F256 (Record of Adjudication Hearing) that when the man came down for breakfast he threw the contents of his breakfast tray at an officer. This was unprovoked and at variance with the way staff would have expected the man to behave. The 'Use of Force' forms (Annex A used to record when staff have to use force) say that the man was initially ordered to return to his landing. However he started to go up the stairs and then stopped and held firm to the railings at first step level. He was therefore restrained and removed to the segregation unit. Initially the man put up quite a struggle but eventually staff gained control of him and he was placed in handcuffs. Once staff gained control, the man became compliant and walked to the segregation unit with just two members of staff supporting him. This is evident from staff interviews and the CCTV footage that my investigator has viewed.

14. The usual procedure of removing a prisoner to the segregation unit for an initial cooling off period was followed in this instance. The man was originally admitted at approximately 9.15 am. At approximately 3.00pm segregation staff prepared to move the man back to his unit but he refused to leave. He was warned that he would be put on a disciplinary charge if he did not leave the segregation unit. He continued to refuse to leave and therefore was charged with 'Disobeys any lawful order'.

15. The man pleaded guilty to a charge of 'uses threatening abusive or insulting words or behaviour' at his adjudication held on 13 August, which related to the incident with the officer. (Adjudication is a prison disciplinary hearing. It is an internal prison process and is strictly governed in the manner in which it is conducted.) I have examined the adjudication file in the man's case and find that he was dealt with fairly, appropriately and correctly. He also pleaded guilty to a second charge of disobeying any lawful order.

16. On the first adjudication the man was given a punishment of 14 days cellular confinement and 14 days forfeiture of privileges including 14 days without tobacco or being able to spend any private cash. On the second charge of disobeying any lawful order, the man was given a similar 14 days forfeiture of privileges plus 14 days without association and 14 days stoppage of earnings at 80%. This latter punishment was suspended for three months. What this meant for the man was that he would stay in the segregation unit for 14 days without being able to spend any private cash. He would then be sent back to ordinary location. No other punishment would be given to him provided he did not break any more rules within a three month period.

17. The man gave as his reason for refusing to leave the segregation unit that he wanted to leave Hewell and did not want to be on his house block until he was due to go to court on 28 August. He gave no explanation for throwing food at the officer. However, wing history sheets (a record of daily events particular to the man), record that on 6 August another officer noted '*Behaviour has shown deterioration over the past few days, saying "I wanna go down seg". Displays poor and childish attitude when challenged*'.

18. Whilst in the segregation unit the man was seen each day by healthcare staff who recorded that he had no problems. Although this is likely to be a rudimentary appraisal by healthcare staff, he would have been seen in person each time. The man was also visited by the duty governor each day, and the Independent Monitoring Board. There were no reports of any concerns.

19. During one night in August, the man was reported to be snoring very loudly. The night officer was about to do her hourly observation rounds in the segregation unit at approximately 3.00am when she heard a loud snoring noise coming from the man's cell. She approached the cell and looked through the observation flap. At first she could not see the man because he was lying on the floor under his bed. The officer was at first surprised by this, but then took stock and came to the conclusion that the man was breathing (as evidenced by his snoring) and some prisoners prefer sleeping on the floor. She therefore concluded that the man was indeed in a deep sleep and therefore must be comfortable in this position. He had his head under the bed and she did not think he had fallen or was hurt.

20. The man continued this loud snoring throughout the night. As other prisoners started waking up in the early morning, some of them complained about the man's snoring. The officer asked them to be tolerant towards the man, telling them that she was not willing to wake him from his sleep. The officer was visited at approximately 6.30am by another officer who was issuing paperwork to the various areas of the prison. This officer recalls hearing the man snoring as he entered the segregation unit and commenting to the night officer. Both officers visited the man's cell and looked through the observation flap. The man was still in exactly the same position (lying on his back under the bed snoring). The other officer then went about his duties.

21. At approximately 7.20am another officer arrived on the segregation unit to take over duties from the night officer. He also was aware when he arrived of someone snoring loudly on the unit. When he did his rounds with the night officer he established that the person responsible for the snoring was the man. The day officer also undertook a visual observation of the man in his cell. He confirmed the night officer's description of the man lying on his back under his bed snoring.

22. The day officer remembered thinking that perhaps the man was sleeping under his bed to get away from day light (the cells do not have curtains at the windows) or perhaps he had a bad back and needed a firm surface to sleep on. He also concluded that because the man was snoring, he was still breathing and therefore was alive and well. The day officer remembered that the man was still snoring when other day staff took over from him (although he can not remember at exactly what time that was).

23. During that morning of August, day staff on the segregation unit were visited by the Orderly Officer. It is part of his duties to visit each part of the prison to ensure that all is running smoothly. Although the Orderly Officer can not recall exactly what time he arrived at the segregation unit he recalls hearing the man snoring loudly when he arrived. He remembers commenting to staff on the unit 'He's snoring like a good'un'. Day staff cannot recall at what time the man stopped snoring – his ceasing to snore did not register with them.

24. One of the day staff on duty in the segregation unit recalled that there was a slight delay that morning in serving breakfast to the prisoners on the unit. She described the usual process in the segregation unit of visiting each cell in turn and giving the occupant his breakfast. She recalled that when they started this process, the man was not snoring. This officer thought this was likely to be somewhere between 8.30am and 8.45am.

25. Staff on the unit came to give the man his breakfast at 9.10am. The officer opened the cell door observation flap. She saw the man lying on the floor under his bed. She had not seen him like this earlier and therefore her immediate reaction was that something was wrong. She entered the cell and tried to pull him out from under the bed at the same time as alerting her colleagues to come and help. One member of staff (it is not clear who) immediately and responded by raising the alarm over the radio, calling for medical assistance, another started chest compressions. A female officer went to get emergency equipment that is kept on the unit to aid this process (an airway for mouth to mouth resuscitation). Before she could return, the healthcare team had arrived (at 9.14am). A Nurse took over giving breaths via a mask while a male officer continued chest compressions. A paramedic ambulance was called for via the communications centre. The nurse and male officer continued cardio pulmonary resuscitation (CPR) and suctioning of fluid from the man's airways. The prison doctor arrived. After CPR had been attempted for 15 minutes it was evident that the man was dead. The doctor certified death at 9.25am.

26. The paramedics used their own equipment when they arrived at 9.26am but they confirmed that there was no heart beat present and there were therefore no further attempts at resuscitation.

ISSUES

27. On 11 August, the man was restrained using Control and Restraint techniques after he had thrown food at a member of staff. The man's action was unprovoked and unexpected. I have read the man's earlier prison records and note from those that on 26 October 2005, whilst at HMP Dartmoor, he did exactly the same thing. On that occasion he threw his meal at an officer in an unprovoked attack which resulted in him being removed to the segregation unit. An officer wrote in the man's wing record at Hewell that the man wanted to go to the segregation unit. I have no information to suggest why this might be. The man claimed in his adjudication hearing not to know why he threw his meal at the officer, but also said he wanted to come off his house block unit.

28. When the man was restrained my investigation reveals that proper procedures were followed in line with Prison Service Order (PSO) 1600. Staff tried initially to de-escalate the situation by sending the man back to his cell. The man refused to go as instructed, leaving staff little choice but to restrain him. In accordance with procedure, the technique of one member of staff taking control of the left arm, one taking control of the right arm and one member of staff taking control of the head was followed. Several officers were involved in restraining the man, with some staff needing to be assisted by fresh staff because the man put up such a struggle.

29. My investigator enquired if during the course of this restraint the man had banged his head. It was reported consistently by staff present that he had not banged his head. He also enquired whether batons had been drawn and used during the restraint. No batons were drawn or used.

30. It was apparent from interviews that the man had initially been quite vigorous in his struggles with staff. After a short time he became compliant, allowing himself to be handcuffed and led away to the segregation unit. PSO 1600 permits the use of ratchet handcuffs 'temporarily if it is necessary to remove a prisoner from one part of the establishment to another (e.g. relocation to a cell or the segregation unit)'. The guidance goes on to say that this can be done 'whether the prisoner is reasonably compliant but it is not judged safe enough to permit the prisoner to walk completely independently to the relocation venue'. I judge the prison's actions in the man's case to have been justified.

31. The man's initial restraint was not captured on CCTV but his removal to the segregation unit was. The CCTV footage does not appear to show that the man was under any duress or in any discomfort. It is therefore highly unlikely that he suffered any significant injury from this episode of restraint. The man was also seen by healthcare staff on his arrival in the segregation unit and no injuries were recorded.

32. The man was later due to leave the segregation unit, but he refused. For this, and throwing food at the officer, he was placed on report and adjudicated on 13 August. He pleaded guilty to both charges.

33. The man's punishment for the first offence was to stay confined in the segregation unit for 14 days. For refusing to leave the segregation unit he was given a suspended punishment that would only come into effect if he misbehaved further. The prison's response was measured and not unjust.

34. During the night in August, after the man had been in the segregation unit for a few days, night staff heard him snoring very loudly. On investigation, the night officer discovered the man lying on the floor, under his bed. Staff at Hewell told my investigator this was unusual, but not unique. They are accustomed to receiving prisoners who have lived rough on the streets. They said that some men find prison beds uncomfortable while others are disturbed by light coming through the cell windows. The officers' belief that the man was alive and well was based on his loud snoring. They assumed he was comfortable enough to sleep very well in his present position. No element of blame should be attached to staff for this assumption.

35. As soon as the man was discovered, staff on the scene attempted CPR with one officer undertaking chest compressions. Another officer went to get an airway to facilitate 'mouth to mouth'. The man had fluid around his mouth which was thought to be secretions from his lungs when he was discovered. One officer tried to improvise with a plastic bag in order to undertake mouth to mouth in the absence of an airway. However, medical staff arrived very promptly with proper medical equipment, including airways and suctioning equipment.

36. Staff summoned assistance from the on site doctor and asked for an ambulance to be called. All of these procedures were followed very quickly after the man's discovery. I am pleased to note that healthcare staff and discipline staff from the segregation unit worked quickly and efficiently to try and save the man's life. It is probable that the man had already died by the time they discovered him. However, it is to their credit that they did not give up trying to revive him until a doctor formally pronounced life extinct at 9.25am.

37. The Clinical Review undertaken by the doctor and the Post Mortem Report written by the pathologist make it clear that there was 'no evidence of major trauma and specifically there was no evidence of injury to the skull or scalp'. The clinical reviewer reports that the snoring was the result of airway obstruction and that the man had 'more than likely already had the cerebral haemorrhage and was in fact dying'. The reviewer adds that 'the segregation staff could not have anticipated this' and it is my view also that they could not have been expected to know what was occurring to the man at this time.

38. The man's family have raised the following issues during the course of my investigation.

    1. *Whether the man had a psychiatric assessment during his reception healthcare screening, and if not why not?*

The man had a full first reception screening which includes a rudimentary screen for any mental illness. During this screening prison healthcare staff can refer a patient on to mental health services if they feel the patient needs such a referral. There was no indication from the screening process that the man required more in-depth investigation or referral.

2. *Could the man have been born with any such weakening, given his history of behavioural problems, which could later have caused the cerebral haemorrhage?*

When asked by my investigator, the clinical reviewer said that there was a good chance that the man was born with a weakness or malformation of the blood vessels within his skull. It is not necessarily the case that this would be the cause of any behavioural difficulties. It is the case that this weakness or malformation was the cause of the cerebral haemorrhage. My investigator has provided the man's family with more detailed information about this condition.

3. *Could a previous head injury have led to any weakening in the vessels which later caused the cerebral haemorrhage?*

There is no evidence to suggest that any trauma, recent or previous, was the cause of the cerebral haemorrhage. The Post Mortem report specifically excludes that as a probable cause. My investigator researched the condition and talked with the clinical reviewer about what might have been the cause. It appears the man is likely to have had an aneurism that burst, or an arteriovenous malformation that split. An aneurism is a blood vessel which is thinner and weaker than it should be. It can bulge outward under pressure, like a balloon, and can burst if the pressure is too high. An arteriovenous malformation is where the veins and arteries are connected without the presence of capillary formations that would otherwise reduce pressure on the veins.

4. *Was it possible to determine whether there had been a struggle when the man was arrested?*

There is no evidence to suggest there was a struggle when he was arrested. The only evidence of any struggle was the control and restraint process described elsewhere in this report.

5. *The man had not been able to make a phone call whilst in segregation.*

The family were greatly concerned that they had not had any recent contact with the man. This was in part due to his recent behaviour which had resulted in a punishment of him not being able to spend any of his money on items such as 'phone cards. Although this seems a bit harsh on families, prisons need some sanctions to assist them in maintaining good order and discipline. However, in cases where the prison considers this could cause significant hardship to a person's well being they have the option of allowing a telephone

call. The man could also have written a letter to his family, although it appears from his prison record that he was not someone who wrote letters.

6. *Had the man complained of being unwell whilst in the segregation unit?*

There is no evidence that the man complained of being unwell whilst he was in the segregation unit. He was seen daily by healthcare staff. Additionally he was seen by the duty governor and discipline staff working in the unit. He had occasional visits from the IMB and Chaplaincy. If staff had any concerns regarding the man (or the man had any concerns himself), there would have been ample opportunity for them to be brought to the attention of nursing staff.

7. *Had the man complained to anyone of having any headaches around this time?*

Aside from the one episode of illness requiring administration of two paracetamol on 24 May, there is no suggestion that the man had any medical problems requiring treatment during his time at Hewell. It is not clear for what reason the paracetamol was given.

8. *Did the man have a medical examination when he arrived into custody? Was there anything recorded to indicate whether his blood pressure was raised at this time?*

The man was seen by a nurse on his reception into Hewell. The nurse took and recorded his blood pressure at that time. It is recorded as systolic 136 mmHG, diastolic 81 mmHG (usually recorded as 136/81). Although this reading is slightly raised, it would not constitute cause for concern and it would not be considered as hypertensive (high blood pressure).

9. *Why was the man in solitary confinement?*

I believe paragraphs 16 to 20 of this report give the answer to this.

10. *In which part of the man's head did the haemorrhage occur? Depending on where the bleed occurred, could this have had an effect on his behaviour?*

The Post Mortem report describes the area where the cerebral haemorrhage occurred as 'in the left occipito-parietal area'. This is the left rear of the skull. The Post Mortem does not describe the precise place within the brain where the haemorrhage occurred. As mentioned earlier, it is highly unlikely that this condition would have led to the man's behavioural problems in his early years. This bleed occurred suddenly and catastrophically. It was the result of a weakness that had not affected the man in any way until the fateful moment when the vessel burst.

CONCLUSION

39. A clinical review was undertaken by a doctor on behalf of the local Primary Care Trust (PCT). His summary says 'The man was a non-smoker, did not use drugs, was symmetrical for height and weight and had normal blood pressure. Yet, he still managed to have this disease. The mortality rate for cerebral haemorrhage is high, aneurismal cerebral haemorrhage has a mortality rate estimated to be as high as 65%, with most deaths occurring early in the clinical course. *This case was no exception, and in my opinion could not have been anticipated, or prevented.*' (the doctor's emphasis.)

40. The doctor also says that when staff unlocked the man's cell for breakfast at 9.10am, he had probably already died before the commencement of CPR. Furthermore, the indication is that the man had already had his cerebral haemorrhage when staff heard him snoring heavily in the early hours of a morning in August. Segregation staff could not have anticipated or known this.

41. However, I am aware because of another death I have recently investigated that loud, heavy snoring can be an indicator of a person in poor health. I am minded therefore to make the following recommendation to Offender Health at the Department of Health.

    Offender Health should consider if there is any useful guidance to be issued to staff working in prisons regarding loud heavy snoring coming from people who do not normally snore and who can not be roused.

RECOMMENDATIONS

The following recommendation was made in the draft version of the report. Offender Health has not responded to date to this recommendation.

> Offender Health should consider if there is any useful guidance to be issued to staff working in prisons regarding loud heavy snoring coming from people who do not normally snore and who can not be roused.

Good Practice

I am pleased to note that healthcare staff and discipline staff from the segregation unit worked quickly and efficiently to try and save the life of this man. It is a sad fact that he had probably already passed away by the time they discovered him. However, it is to their credit that they did not give up trying to revive him until a doctor formally pronounced life extinct at 9.25am.

The Coroner's inquest afforded the family the opportunity to raise some of their concerns direct with the PCT and Governor of Hewell. I was very encouraged to learn of this. At the inquest contemporaneous notes were made of the matters raised by the family and I chose to include a copy of these notes with the final version of this report.