

A Report by the
Prisons and
Probation
Ombudsman
Nigel Newcomen CBE

**Investigation into the death of a man at HMP
Highpoint in August 2013**

Our Vision

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

This is the investigation report into the death of a man at HMP Highpoint in August 2013. He was 44 years old. His cause of death was found at post-mortem to be acute myocardial infarction (a heart attack). I offer my condolences to his family and friends.

A clinical reviewer reviewed the clinical care the man received in prison. HMP Highpoint cooperated fully with the investigation.

The man had suffered a heart attack in 2009, while living in the community. He had also been diagnosed with diabetes and paranoid schizophrenia. The clinical reviewer found that his cardiac disease, high cholesterol levels and diabetes should have been monitored more closely. More robust follow-up might have helped reduce some of his health risks, although the clinical reviewer also noted that he was not always compliant with treatment and medication.

As in other recent deaths at Highpoint, there was a delay in discovering the man's death due to procedural failings during the morning unlocking of prisoners. When he was found, staff attempted resuscitation even though it was clear that he had died some hours previously.

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

Nigel Newcomen CBE
Prisons and Probation Ombudsman

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SUMMARY

1. On 25 February 2013, the man was sentenced to 14 months imprisonment and was sent to HMP Chelmsford. He had suffered a heart attack in 2009. He also had diabetes and long standing mental health problems, which were treated by fortnightly injections of antipsychotic medication.
2. In April 2013, the man transferred to Highpoint. In June, he moved to HMP Hollesley Bay, an open prison where his mental health deteriorated. As Hollesley Bay did not have mental health cover at weekends, he transferred back to Highpoint three weeks later. No further concerns about his health were identified over the following months.
3. On a morning in August 2013, a roll check was completed at 6.30am and cells were unlocked at around 9.00am. Neither officer involved obtained any form of response from the man. When he did not collect his lunch, an officer asked another prisoner to check if he wanted something to eat. He was then discovered dead in bed.
4. A post-mortem examination found that, the man's cause of death was acute myocardial infarction (a heart attack). The examination also found that he had significant narrowing of his coronary arteries.
5. The clinical reviewer concluded that there was inadequate assessment and monitoring of the man's cardiac disease, high cholesterol levels and diabetes in prison but it was impossible to determine whether follow-up care would have reduced his risk of death. The investigation found that the officer who unlocked him on the morning of the incident did not follow local and national guidelines to ensure the welfare of prisoners at that time and that a member of staff unnecessarily attempted resuscitation when it was clear that he had been dead for some time.

THE INVESTIGATION PROCESS

6. Notices were issued to staff and prisoners at Highpoint, informing them of the investigation and inviting them to contact the investigator if they wished to be involved. No one responded.
7. The investigator visited HMP Highpoint on 14 August 2013 and met the deputy governor, the Head of Safer Prisons and Equality and a senior nurse. He obtained copies of the man's prison and health records. He subsequently interviewed five members of staff at the prison.
8. The investigator wrote to HM Coroner to inform him of the Ombudsman's investigation and a copy of this report has been sent to him.
9. NHS England (East Anglia Area Team) appointed a clinical reviewer to review the clinical care the man received at Highpoint.
10. One of the Ombudsman's family liaison officers contacted the man's parents to inform them of the investigation and offer the opportunity to identify issues for the investigation to consider. They said that their son had previously had a heart attack and had been fitted with stents. They asked whether he had been able to use the prison gym and whether he had an appropriate diet. He had access to the gym at Highpoint and was able to select from a prison menu which included healthy choices.
11. The family received a copy of the draft report under the review process. The man's sister said that the family were concerned to read the investigation findings which they said they would pursue at the inquest into her brother's death.

HMP HIGHPOINT

12. HMP Highpoint is on two sites, Highpoint South which was the original HMP Highpoint and Highpoint North, which was previously known as HMP Edmunds Hill. Highpoint is a prison for medium security risk category C adult male prisoners. The man was based at Highpoint South.
13. General healthcare services at HMP Highpoint are provided by Care UK. Mental health services are provided by the Norfolk and Suffolk Mental Health NHS Foundation Trust.

HM Inspectorate of Prisons

14. The Inspectorate's last published report on Highpoint followed an inspection in September 2012. Inspectors found that the care of patients with lifelong conditions was underdeveloped and that the prisons approach to health promotion was not systematic. Prisoners with mental health problems told inspectors that they felt well supported by the mental health team.

Independent Monitoring Board

15. Each prison in England and Wales has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure prisoners are treated fairly and decently. In their 2012 annual report, the Board commended staff for their commitment in running a safe and decent establishment. The Board noted that Care UK became responsible for the delivery of health services in September 2011. It had taken some time to restructure services which were now embedded, including some nurse led clinics for prisoners with life long conditions. Gym staff ran a well man clinic.

Previous deaths at Highpoint

16. There have been six deaths at Highpoint, including that of the man's, in the two years preceding his death. In two deaths in February and April 2013, checks when unlocking cells were inadequate. In one of the cases, staff attempted to resuscitate the prisoner even though rigor mortis was clearly established when he was discovered.

KEY EVENTS

17. The man was born in April 1969. He had various convictions dating back many years and had served several short prison sentences. On 25 February 2013, he was sentenced to 14 months imprisonment for multiple counts of criminal damage to vehicles and was taken to HMP Chelmsford.
18. The nurse who carried out his healthcare reception screen, noted that the man had had a heart attack several years before for which he had been prescribed aspirin. (His heart attack had been in 2009 and he had had a stent fitted.) He smoked, but this was not recorded during his reception screening.
19. The man had diabetes, for which he was prescribed metformin. He had also been diagnosed with paranoid schizophrenia and received fortnightly injections of risperidone (antipsychotic medication). When he arrived he had missed his last two doses in the community. His records indicate that he had spent about six periods in mental health units after being sectioned under the Mental Health Act. His records indicated that he did not always take his prescribed medication or cooperate with diagnostic and preventative interventions and treatments for his cardiac disease.
20. On 17 April, the man transferred from Chelmsford to HMP Highpoint. At a reception health assessment, his past and existing clinical conditions were again listed and it was noted that he did not self-monitor his blood sugar levels. A few days later, a series of blood test results were noted in his records which, on a number of measures, were above the levels recommended by the National Institute for Health and Care Excellence (NICE). In particular, two measures for cholesterol were slightly above recommended levels.
21. An entry in the man's clinical records on 12 June, reported that he had claimed to have been born a hermaphrodite and had arranged for some female clothing to be sent to him. In a telephone call with a nurse at Highpoint that afternoon, his community psychiatric nurse explained that his comments about gender confusion were early warning signs of deterioration in his mental health.
22. The man remained at Highpoint for just under two months. On 13 June, he transferred to HMP Hollesley Bay, an open prison. He was weighed when he arrived and his weight had increased by almost 11 kilograms since he had last been weighed on 17 April. No enquiries were made about the reasons for this weight gain.
23. The man became mentally unwell. As Hollesley Bay did not have mental health cover at weekends, it was thought inappropriate and unsafe for him to remain there so he returned to Highpoint on 5 July,
24. A consultant psychiatrist and two mental health nurses assessed the man on 18 July and discussed the possibility of admitting him to hospital under the Mental Health Act. He objected strongly to the suggestion, as he said he would not be allowed to smoke in hospital. The clinicians increased his dose of risperidone and agreed that he did not require immediate hospital admission, but he would be assessed again if he became unstable. On 8 August, a nurse gave him his fortnightly depot risperidone injection.

25. Prison officers' entries in the man's records were generally brief so the investigator asked several staff about their dealings with him. An officer said that he was a very quiet prisoner who only spoke to staff when cells were unlocked and at mealtimes. He did not mix much with other prisoners and preferred to spend his time alone in his cell.
26. At about 6.30am a few days later, an operational support officer started a roll check (count) of the prisoners on Handley Unit 5 where the man lived. He told the investigator that he had worked at Highpoint for 13 years and had been on permanent night duty for the last 12. He explained that if prisoners were not subject to special monitoring, his practice was to check only that each prisoner was present and seemingly well. If that were the case, he would not seek a response to confirm they were alive. He could not recall checking him that morning, so assumed he had seen nothing unusual.
27. Officer A unlocked the man's cell at around 9.00am that morning. She told the investigator that on weekdays, cells are unlocked at about 8.45am and she ensures that prisoners are awake to attend work and education courses. However, at the weekend, prisoners often lie-in and her understanding was that she was not required to obtain a response from prisoners who seemed to be sleeping. Instead, her weekend practice in the four years she had been an officer was to look into the cell, check that the prisoner was present and that there was nothing apparently untoward and to then unlock the door and move onto the next cell. When she unlocked his cell he appeared to be asleep and she did not notice anything untoward.
28. The man was not checked during the remainder of the morning and no one saw him. At midday, Officer A was checking prisoners collecting their lunch. As he had not appeared, she asked another prisoner to go to his cell to see if he wanted lunch. The prisoner then called to her to come to the cell quickly. Initially she thought that he was asleep, but then noticed he was blue. She asked the other prisoner to press the landing alarm button and radioed a code blue emergency to indicate a prisoner with breathing difficulties, or unconscious.
29. Two officers responded immediately to the landing alarm and Officer A told them that she believed that the man was dead. Officer B had previously been a student nurse. When interviewed, he said that he checked the man and he had no pulse, his body was very cold and rigor mortis was evident. He decided that attempting resuscitation would be futile so he locked the cell and told Officer A that the other prisoners should be locked in their cells too.
30. A Senior Officer (SO) responded to the code blue alarm and went into the cell. He noted that the man was not breathing, had no pulse and was very cold. A nurse also arrived and checked him. He also noted rigor mortis and told the officers that it was apparent that he had been dead for some time. The nurse agreed that it was not appropriate to attempt resuscitation.
31. Despite this advice, the SO started chest compressions but, due to the affects of rigor mortis, he could not open the man's mouth to give oxygen. Nevertheless, he continued chest compressions until paramedics arrived around 15 minutes later and pronounced death. He explained to the investigator

that his understanding was that resuscitation should be attempted until a doctor or paramedic pronounced the person's death and that he would "never forgive" himself if he did not try.

32. Staff attended a debrief to discuss their involvement in the emergency and were seen by a member of the care team. Checks were made on prisoners thought to be at risk of self-harm or suicide in case they had been adversely affected by the man's death.
33. At 2.30pm, two of Highpoint's family liaison officers, a chaplain and an officer, left the prison to drive to his parents' home. They arrived at around 5.00pm and broke the news. They told them that the prison would assist with funeral expenses and offered them the opportunity to visit the prison if they wished. The man's parents said that they would break the news to their grandson. They subsequently asked the chaplain to conduct the funeral service.
34. A post-mortem examination found the man had severe narrowing of the arteries of his heart and his cause of death was acute myocardial infarction (a heart attack).

ISSUES

The man's clinical care

35. The clinical reviewer is critical of some aspects of the man's care and treatment during his final period in custody. Her conclusions are explained in detail in her report but the aspects of care about which she is most concerned are the assessment and monitoring of his chronic health conditions:
- The man gave differing accounts of his past medical history but the discrepancies were not fully checked and validated. If healthcare staff had checked his previous history, they would have found that he had not been offered the usual follow-up or cardiac rehabilitation after his heart attack in 2009.
 - There was limited evidence that the man had received lifestyle advice about regular physical exercise, smoking cessation or advice about good diet and dietary intake, which would have been recommended to help his diabetes and heart condition.
 - The man's cholesterol levels were above the range recommended by NICE but there was no evidence of care plans to deal with either this condition, or his cardiac disease and no provision of advice and information about the possible long-term consequences of these conditions.
36. The clinical reviewer has made a series of recommendations to address the deficiencies in clinical management highlighted in these aspects of the man's care and additional recommendations about improving record keeping.
37. The clinical reviewer describes the man's standard of healthcare as inadequate because of the lack of systematic follow up and monitoring of his conditions. However, she concludes that it is not possible to know with certainty that his risk of death would have been reduced, even if he had received all appropriate follow-up. She notes that he often did not cooperate with treatment and advice. Toxicology tests indicated that he had not taken his medication, to reduce the risk of further heart related problems as prescribed. The post-mortem report confirmed that he had significant underlying cardiac disease at the time of his death. We make the following recommendation:

The Head of Healthcare should ensure that prisoners with known cardiovascular risk factors and identified life long conditions receive appropriate treatment and advice and are monitored in line with NICE best practice guidelines.

Morning roll checks and unlocking cells

38. At about 6.30am on the day of the incident, the officer support grade began a morning roll check on Handley Unit 5. He then signed to confirm that he had counted 119 prisoners and that there was nothing untoward to report.

39. An order to staff dated 14 August 2013, issued by the Governor of Highpoint stated:
- “... Any member of staff ... carrying out a roll check or when opening any cell/room door after a patrol period ... MUST completely satisfy themselves that the cell occupants are responsive, this may be by detecting clear bodily movement [that is] a limb move, verbal response or obvious breathing ...”
40. The officer confirmed at interview that his practice at the morning roll check in his 12 years of night duty was to obtain responses only from those prisoners receiving additional support under the suicide and self-harm prevention procedures. He said that his practice had not changed since the issue of the Governor’s order. He added that obtaining responses from all prisoners during the morning roll check would not be welcomed by prisoners, particularly during the winter. However, we note that the order does not require active responses unless there is no sign of bodily movement or breathing.
41. Prison Service Instruction 10/2011 which came into effect on 1 April 2011 states that:
- “Reports from the Prisons and Probation Ombudsman on deaths in custody have identified cases in which a prisoner has died overnight ... but staff unlocking them have not noticed that the prisoner had died. This is not acceptable...
- “[Differing] arrangements will depend on the local regime, but there need to be clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock ... Where prisoners are not necessarily expected to leave their cell, staff will need to check on their well-being, for example by obtaining a response during the unlock process.”
42. The next check was at around 9.00am, when Officer A unlocked the man’s door. On a weekday, she said she ensured that prisoners were awake to attend work or education courses. However, at weekends prisoners were allowed to sleep late, so she did not obtain responses provided that all appeared well. This had been her practice throughout the four years she had worked as a landing officer.
43. The Governor’s order for action when unlocking cells reflects the Prison Service Instruction. In an investigation after a previous death at Highpoint on a Sunday morning in February 2013, we recommended that the correct procedures should be followed when unlocking cells. The recommendation was made in July and a Governor’s order was issued on 14 August 2013. We therefore make no further recommendation about this.

The emergency response

44. The evidence indicates that the man had been dead for some considerable time when he was discovered: he was not breathing, he had no pulse and several staff, including a nurse, reported that rigor mortis was evident. In view of this, the investigator asked the SO why he had attempted resuscitation. The SO acknowledged that both Officer B and the nurse had advised him that the man

was dead, but he thought that resuscitation should always be attempted until a doctor or a paramedic pronounced death.

45. European Resuscitation Guidelines 2010 state that, “Resuscitation is inappropriate and should not be provided when there is clear evidence that it would be futile ...”. While the SO protected other staff from involvement in attempting resuscitation, he was not sufficiently confident to decide that any effort would be futile so he continued delivering chest compressions until instructed to stop by ambulance paramedics. This is somewhat surprising given that all staff who examined him agreed that rigor mortis had set in. Staff present included a nurse and his advice to the SO was that he had been dead for some time.
46. The latest version of Highpoint’s contingency plans on actions to be taken by staff attending an apparent death in custody includes the following actions:

“Try [to] determine the type of injury / illness and follow emergency first aid procedures appropriate to injury and your ability.

“If the prisoner had used a ligature ... cut the ligature [and if] the prisoner is not breathing, attempt artificial respiration.”

We make the following recommendation:

The Governor should ensure that all staff receive guidance about the circumstances in which resuscitation is not appropriate and that the contingency plans on actions following apparent death in custody are revised accordingly.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that prisoners with known cardiovascular risk factors and identified life long conditions receive appropriate treatment and advice and are monitored in line with NICE best practice guidelines.
2. The Governor should ensure that all staff receive guidance about the circumstances in which resuscitation is not appropriate and that the contingency plans on actions following apparent death in custody are revised accordingly.

ACTION PLAN: The Man – HMP Highpoint

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and Function Responsible	Progress (to be updated after 6 months)
1	The Head of Healthcare should ensure that prisoners with known cardiovascular risk factors and identified life long conditions receive appropriate treatment and advice and are monitored in line with NICE best practice guidelines.	Accepted	Healthcare is in the process of reviewing its systems, to ensure SystemOne is fully utilised for its chronic disease management and to ensure that staff use NICE guidelines when seeing and treating patients with known cardiovascular risk factors and identified life long conditions. This will be fully implemented with staff training included by the end of February 2014.	28/02/2014 Head of Healthcare	
2	The Governor should ensure that all staff receive guidance about the circumstances in which resuscitation is not appropriate and that the contingency plans on actions following apparent death in custody are revised accordingly.	Accepted	<p>This requires consultation between the Governor and Care UK, taking into consideration the different guidance available to both groups (clinical and non-clinical). A meeting is taking place to provide staff with appropriate guidelines.</p> <p>Separately, in addition to the instructions contained in PSI 64/2011, NOMS will be developing further guidance in conjunction with NHS England for emergency response to include the non-resuscitation of prisoners where there are clear signs of rigor mortis. This will be issued to all prisons.</p>	<p>28/02/2014 Head of Healthcare</p> <p>Ongoing</p> <p>NOMS Equality, Rights & Decency Group and NHS England</p>	