PRISONS AND PROBATION OMBUDSMAN
for England and Wales
Independent investigations

A Report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

Investigation into the death of a man at HMP Coldingley in July 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 Coldingley in July 2013. He died of a heart attack. He was 45 years old. I offer my condolences to his family and friends.

A review of the clinical care the man received at the prison was conducted. Coldingley cooperated fully with the investigation.

The man had reported chest pains several months before his death. They were thought to be linked to an episode of hypermania and were not followed up in accordance with national clinical guidelines. Apart from this single episode, he made no further complaints of chest pain.

One afternoon in July, the man suddenly became unwell while working in the prison print shop. His symptoms indicated that he had taken illegal drugs and, when questioned by friends and healthcare staff, he admitted that he had smoked spice, a synthetic form of cannabis which staff at Coldingley acknowledge was a problem at the prison. He would not allow healthcare staff to examine him. An ambulance was called but he then refused to go to hospital. He returned to his cell and was locked in for the evening. At about 7.00pm, he was found unresponsive in his cell. Attempts by prison staff and paramedics to resuscitate him were unsuccessful.

The man had undiagnosed serious underlying heart conditions which the clinical reviewer concludes could have caused a heart attack at any time. It is unfortunate, therefore, that when he first presented with chest pains in November, these were not followed up appropriately. On the day of his death, he did not report any symptoms of chest pain and it was not unreasonable for prison and healthcare staff to consider that his symptoms were the result of drug misuse. However, despite concern over his health, no proper arrangements were made to monitor him after the healthcare staff and the first ambulance crew left the prison. There were also credible accounts from prisoners that staff could have done more to assist him. Moreover, the emergency response was poor and the prison had failed to implement mandatory national procedures for emergencies. This meant that when his condition became critical, there was a delay in starting resuscitation and calling an ambulance.

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 **June 2014**

CONTENTS

SUMMARY

1. The man was convicted of assault in July 2009 and released on licence in April 2010. He was recalled to prison in July 2010 and transferred to Coldingley on 6 September 2012. He had a long history of drug misuse and participated in a relapse prevention programme at Coldingley. However, his erratic behaviour indicated that he had continued to take illegal drugs and he was diagnosed with drug-induced psychosis. He was assessed as physically fit but he remained under the care of the mental health team and a psychiatrist who prescribed olanzapine, an anti-psychotic medication.

2. In November 2012, the man reported chest pains. He had an electrocardiogram, which was normal, but the clinical reviewer is concerned that healthcare staff did not physically examine him or refer him for further cardiovascular tests in line with national clinical guidelines. The pains were attributed to an episode of hypermania and did not recur.

3. During the afternoon of 18 July 2013, while working in the print workshop, the man became unwell with what appeared to be symptoms of drug misuse and admitted that he had taken spice, a synthetic form of cannabis. An ambulance was called, but he refused medical intervention and was abusive and threatening to healthcare staff and paramedics. He initially agreed to go to hospital, but then declined when he discovered that he would be handcuffed. He refused to go to hospital, but would not sign a medical disclaimer which paramedics completed. This was not brought to the attention of the nurse and doctor on duty who believed he had gone to hospital, so no further medical advice was given about monitoring him and none was sought.

4. The man was locked in his cell at around 6.00pm and checked twice. On the second occasion at around 7.00pm, an officer found him lying on his back on the cell floor. He did not radio an emergency code but went to the wing office to get the custodial manager. They both returned to the cell and started cardiopulmonary resuscitation, but there was a delay in requesting an ambulance. The attempts to resuscitate him were unsuccessful and he was pronounced dead at 8.40pm. A post-mortem examination discovered that the cause of death was a heart attack.

5. The man admitted that he had taken spice on 18 July, so it is understandable that staff assumed that he was suffering from the effects of substance misuse and handled the incident accordingly. However, more effective monitoring and observations by wing staff and healthcare staff should have been implemented once he decided against going to hospital. A number of prisoners expressed serious concerns and gave credible accounts that staff did not monitor him adequately and disregarded their requests to help them. When he was found unresponsive, resuscitation should have begun immediately. National instructions for emergency incidents and the use of emergency codes were not followed, leading to a delay in obtaining emergency equipment and calling an ambulance.

THE INVESTIGATION PROCESS

6. Notices were issued at Coldingley, announcing the investigation to staff and prisoners and inviting anyone with relevant information to contact the investigator. She received two letters and a telephone call from prisoners.

7. The investigator visited Coldingley on 25 July. She met the Governor and spoke to staff involved in the man's care. She visited the residential wing where he had lived and spoke to prisoners, including those who had already contacted her. She also went to the print workshop where he had worked and spoke to several prisoners who had worked with him on the day of his death. She examined relevant prison records. She interviewed staff and prisoners at Coldingley in October and November. She gave initial feedback to the Governor on the emerging findings of the investigation.

8. NHS England Kent and Medway Team commissioned a clinical reviewer to review the man's clinical care in custody. He attended the interviews of some of the healthcare staff.

9. We informed HM Coroner for Surrey of our investigation who provided the results of the post-mortem examination and toxicology report. We have sent a copy of this report to the Coroner.

10. One of the Ombudsman's family liaison officers contacted the man's mother, on 15 August, to explain the purpose of the investigation and invite her to raise matters that she wished the investigation to consider. She asked what medication had been prescribed to her son and whether rumours from prisoners that he had been denied a drink of water were true.

11. The man's family received a copy of the draft report. His mother said it had been distressing to learn of the full sequence of events leading to her son's death. She said the report had revealed a lack of care and more notice should have been taken of his health.

HMP COLDINGLEY

12. HMP Coldingley opened in 1969. It is a category C working prison on the outskirts of Woking, Surrey and holds up to 513 men. It has mostly single cells. Those in the four original wings, A-D, have no integral sanitation or running water and prisoners access services on the landing by an electronic unlock system.

13. Virgin Care provides health services at the prison between 7.30am and 6.30pm on weekdays and a limited service at weekends. Doctors from a local practice provide a daily GP service and there is a team of primary care and mental health nurses. There are no inpatient facilities. ThamesDoc provides an out of hours service.

HM Inspectorate of Prisons

14. The Inspectorate conducted an unannounced inspection of Coldingley in April 2013. Inspectors found it to be a safe prison and prisoners in crisis were well cared for, although they acknowledged that the living accommodation was poor and sanitary arrangements antiquated.

15. Healthcare provision had improved since the previous inspection in June 2010. Prisoners had good access to high quality healthcare services and were satisfied with their care. Provision for those with drug and alcohol problems was good and the drug services team offered a wide range of support. Drug supply reduction measures were found to be appropriate and the average mandatory drug testing rate was less than the target of 8 per cent, although there had been a recent increase and inspectors noted that attempts to bring in new psycho-active substances such as enhanced forms of cannabis were a constant challenge. Inspectors considered that staff-prisoner relationships were reasonable but many prisoners complained of dismissive or uncaring behaviour.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community to help ensure that prisoners are treated fairly and decently. In their annual report for 2011-12, the Board was critical of the lack of in-cell sanitation and the electronic cell unlocking system, which they considered to be unreliable.

Previous deaths at HMP Coldingley

17. The man was the third prisoner to die at Coldingley since the Ombudsman became responsible for investigating deaths in custody. All three deaths were due to natural causes. The previous death was also due to a heart attack, but there was no similarity in the circumstances.

KEY EVENTS

12. The man was born in February 1968. He was convicted of assault against his partner in July 2009 and received an extended sentence of five years, comprising two years imprisonment and an extension period of three years under supervision in the community. He had a number of previous convictions, often linked to his longstanding history of alcohol and drug misuse. It was not his first time in prison.

13. After his release on licence on 1 April 2010, the man was recalled to prison on 27 July 2010, after abusive and threatening behaviour to a member of the public while under the influence of alcohol. He was taken to HMP Winchester and moved to HMP Huntercombe in December 2010.

14. The man transferred to HMP Coldingley on 6 September 2012. A reception health screen identified some past mental health problems but no existing physical conditions. He had been prescribed olanzapine (an antipsychotic) but had stopped taking it. He did not want to take part in a smoking cessation programme. He was referred to the prison's drug services agency for a relapse prevention programme. He subsequently attended group sessions and monthly one to one sessions with a member of the drug service team.

15. On 15 October, the mental health manager conducted a mental health assessment commissioned by the Parole Board. He noted a history of cannabis misuse and physically threatening behaviour. He concluded that there was no current evidence of a mental health disorder, but considered that the man had suffered drug-induced psychosis.

16. On the morning of 30 November, wing staff were concerned about the man's mental state and asked the mental health team to review him. At an appointment that morning, he told the nurse manager that he had suffered chest pains the previous evening. She carried out an electrocardiogram (ECG - a test to record the heart's electrical activity which can be used to detect whether someone has had a heart attack). The ECG test was normal.

17. After the ECG, the man told a prison GP that he felt as if his chest was caving in. The doctor prescribed olanzapine and zoplicone (to aid sleep). He also arranged urine tests and referred him to the psychiatrist. That afternoon a community psychiatric nurse assessed him, who repeated what he had told the doctor about the feeling in his chest and said that he had suffered two heart attacks since arriving on E wing on 27 November. He believed that the chest pains had been caused by other people having bad thoughts about him and he had not slept well because he thought he would die. He behaved strangely in both appointments that day and the nurse agreed that the mental health team would continue to monitor and support him. It was assumed that the chest pains were linked to his episode of hypermania and no further cardiovascular tests or examinations took place. In the following days, wing staff and other prisoners reported that he had been acting strangely, such as howling like a dog and eating food off the cell floor.

18. A psychiatrist assessed the man on 3 December. He concluded that, although his urine screens for illicit drugs had tested negative, his condition was possibly psychotic behaviour induced by the use of “legal highs” (drugs that can be purchased legally, but can cause a hallucinogenic effect and cannot generally be detected through urine screens). He advised him to continue with his existing medication.

19. Later that day, the man had an appointment with the psychiatric nurse, who asked about his previously reported “heart attacks”. He said there had been no further heart pains and again attributed the previous pain to people thinking bad thoughts about him. He continued to see the mental health team and the psychiatrist and no one reported any strange behaviour for the next few months.

20. At an appointment with a doctor on 21 May 2013, the man asked to stop taking olanzapine. The doctor reduced his prescription and, on 4 June, the psychiatrist prescribed a reduction programme over four weeks.

21. Towards the end of June and in early July, there were further reports of the man exhibiting inappropriate and strange behaviour. This included a report from an instructor in the print shop that he had been behaving strangely at work. Healthcare staff established that he had not been taking his medication as prescribed and this led to a requirement for him to be supervised while taking his medication.

22. On 16 July, the man saw the smoking cessation advisor. He told her that he had been smoking for 37 years. She gave him advice and nicotine replacement therapy patches.

23. A few days later the man had an appointment with a doctor, who recorded that he had not attended the healthcare centre to take his medication as he felt he did not need it. He told her that his strange behaviour was just “mucking around”.

24. That afternoon, the man went to work in the print shop. His instructor told the investigator that he had a good relationship with him, who he described as a jovial person. Although he had previously seen him acting strangely, on that day he had behaved normally.

25. Prisoner A, who worked with the man in the print shop, told the investigator that prisoners often smoked tobacco or drugs in the workshop toilets. At around 2.30pm he saw him go into the toilet. He came out five or ten minutes later and sat next to him. The prisoner recognised that he was showing signs of hallucination, paranoia and dehydration. His eyes were dilated, he was shaking and sweating and he had turned pale. He became subdued and introverted and did not respond to questions from others.

26. From personal experience of the symptoms, Prisoner A believed that the man had taken spice, a synthetic cannabinoid. He told him that if he did not feel well, he should lie on the floor and staff would let him go to the healthcare

centre for treatment. He did not want to do that. He said all he needed was a cup of tea and he made one. His quiet demeanour continued for around an hour and he then started wandering around, looking agitated and unfocussed. The investigator spoke to several prisoners who had been at work in the print shop that day, who also said it was obvious to them that he had taken something. He said that in the weeks before his death, the man had told him he intended to obtain some spice. By the time they finished work at 4.30pm, he was more lucid and conscious.

27. At about 4.45pm, while prisoners were returning from work to their wings and going to the dining halls, a supervising officer saw the man crouching against a wall, holding his stomach. When she went to see if he was all right, he ran away and vomited in the corridor. She asked an officer to radio an amber alert (which indicates an urgent, but not life-threatening emergency) at 4.50pm. He ran into the association area, of B wing where he lived.

28. According to Prisoner B, who was in the B wing association room, the man was pacing up and down, holding his head in his hands and crouching like an animal on his haunches. Prisoner C said he had asked Officer A, who was at the door of the association room, if he could help but the officer replied that he did not care what he did. The prisoner went into the association room and asked him if he was all right. He noticed that he was sweating profusely. The man asked him for help and told him he had smoked some spice 'pure' from a pipe. He gave him some water to drink and poured some over his head. He said that although prisoners had asked officers to do something to help, the officers thought he was just “playing up”.

29. When interviewed, Officer A denied the remark attributed to him. Both he and Officer B explained that they had advised others not to get involved as the man was unwell and it was a difficult situation. However, they had allowed a prisoner (presumed to be Prisoner C) to get the man some water. Officer A said that he repeatedly said he was all right. Officer B said that they had decided to keep him in the association room to avoid making a spectacle and allowing a crowd of prisoners to form. He said that a number of them were outside the association room, looking in through the large glass windows and laughing at him.

30. In response to the amber alert, a nurse and an associate practitioner (equivalent to a healthcare assistant) went to the association room. The nurse asked the man if he was all right and if she could assess him. He declined politely and said that he was fine. When she persisted and asked to carry out some basic observations, he became agitated and swore at her. The associate practitioner, who knew him from past consultations, thought this was out of character. They left the association room and continued to observe him through the windows.

31. At 4.55pm, the nurse asked for a member of the mental health team to go and speak to the man. The psychiatric nurse had already gone home but a mental health support worker went to the room. She knew him from mental health consultations and had a good rapport with him. She noticed that he was

breathing heavily. At first, he spoke to her but when she tried to discuss what he had taken he swore at her and asked her to leave. The nurse then asked for a doctor to attend. One of the sessional prison GPs, who was conducting a clinic in the prison, arrived at about 5.00pm. However, he refused to see her. She was satisfied that he was walking and talking and she got the impression that his clinical observations were stable, so she did not persist, but said she was happy to see him if needed and returned to resume her clinic. The nurse remained concerned about his condition and asked officers to call an ambulance.

32. The man asked if he could go back to his cell and it was considered he was fit to do so. Prisoner D saw him struggling to go up the stairs. He noticed that he was sweating and he then went to have a drink and splash water on his face from a sink where prisoners washed their eating utensils. He heard him say that he was not feeling well and said that he looked pale and had difficulty breathing. Prisoners were being locked up and he said he heard Officers A and B tell him that he had to be locked into his cell. (Although the prisoner attributed the timing of these events to the lunchtime period, he was describing what took place later that day.)

33. The nurse went to the man's cell and asked him if he had taken anything. He told her he had smoked some spice and she informed him that she had called an ambulance. He was unhappy about this and then asked for a drink of water. She asked officers to get him some water and continued to observe him through the observation flap in his cell door. The cell door was not locked, but she stood outside because he was being aggressive. Officer B left a jug of water in his cell.

34. Ambulance service records show that an ambulance was called at 5.05pm and arrived at the prison 26 minutes later. By this time, the man had left his cell and gone down to the ground floor of B wing. The paramedics reached him at 5.40pm and the nurse tried to persuade him to allow them to examine him. Initially he refused, but then he agreed to allow some observations to be taken. While the paramedics were setting up their equipment, he again became agitated. He allowed them to measure his blood pressure and take a pulse reading, but then refused further assessments. They recorded that he was pale, sweaty and clammy and that he was very uncooperative and abusive. She suggested that they take him to hospital. He agreed to this so she asked wing staff to arrange for him to be accompanied.

35. The nurse then returned to the healthcare centre. She recorded that the man was initially coherent and communicating but subsequently said he was having trouble breathing. She had no further contact with him. She noticed the ambulance on her way out of the prison at about 6.45pm. (He had subsequently refused to go to hospital but she was unaware of that.)

36. A custodial manager arranged for escorts to accompany the man to hospital. However, when they attempted to handcuff him, he refused and said he would not go to hospital if he had to be handcuffed. He became agitated and aggressive again. He told the manager that he was also concerned that the

association period for other prisoners on his wing would be cancelled if staff had to escort him as there would not be enough staff on duty. The manager explained that B wing's association period would not be cancelled as he had found staff from elsewhere in the prison to escort him.

37. Officer B contacted the associate practitioner in the healthcare centre to ask for a disclaimer form for the man to sign as he had refused to go to hospital. A healthcare Sister who was not on duty but happened to be in the prison briefly to meet colleagues, offered to take the form to the wing. Paramedics completed the form, but he refused to sign it. Neither the associate practitioner nor the Sister told the doctor or any of the other healthcare staff, that he had changed his mind and refused to go to hospital.

38. The duty governor discussed the situation with the custodial manager and they agreed that the man should be locked in his cell during the patrol period (when all prisoners are locked in their cells) but would then be unlocked for association. However, because of his erratic behaviour, the manager thought he might be danger to staff or other prisoners and instructed that he should remain locked in his cell that evening. The manager maintains that he told the duty governor about this decision, but the duty governor told the investigator that he was unaware of it. During his interview, Prisoner C mentioned that after the man had collapsed, he had overheard the duty governor asking an officer why he had been locked in his cell. The duty governor said that if he had been consulted, he would have considered other options such as a safer or gated cell.

39. The duty governor asked Officer B to keep an eye on the man. He did not specify how frequently he should be checked, but told the investigator that he expected it to be about every twenty minutes. The officer thought every 30 minutes would be adequate. The wings have closed-circuit television, but the camera lens on B wing had been vandalised so it was not possible for the investigator to check when his cell was visited.

40. The cells on B wing were automatically unlocked for association at 6.10pm but the man remained locked in his cell. Officer B said that it was hectic that evening, as the prisoners had feared association would be curtailed to allow staff to take him to hospital. As a result, prisoners took the opportunity to ask officers to deal with enquiries while they could. Although the officers explained that escorts would come from another wing, the prisoners were not convinced of this. He said he went to see him about ten minutes after the cells had been unlocked, which would have been about 6.20pm. He did not go into his cell, but looked through the observation flap and saw him kneeling on his bed with his head in his hands, breathing strongly. He said that he did not respond to him calling to him. The officer, the custodial manager and prisoners gave differing accounts of what happened next.

41. Officer B said he returned to the B wing office on the ground floor and began to write the incident reports and answer queries from other prisoners about general issues. He telephoned the custodial manager to report that the man's condition was the same. They then discussed whether to start Assessment,

Care in Custody and Teamwork (ACCT) suicide and self-harm prevention procedures. Although they did not regard his actions as an act of self-harm, they considered the process would be the best way of monitoring him during the night (although, the self-harm box on the form was later ticked). As he was very busy, the custodial manager agreed to open it and estimated that he left his own office in E wing to come to the B wing office to begin completing the ACCT plan between 6.45pm and 7.00pm.

42. Officer B said that he went to see the man again at around 6.50/6.55pm (before the custodial manager arrived at the B wing office). His condition had worsened. He was lying on the floor, his eyes were glazed and he was staring at the corner of the cell. He surmised that the manager would be in the B wing office by then, so he went back to the office and told him that the man had deteriorated. They both went to the cell where the manager examined him and noticed his breathing was shallow. The officer said he suggested they call an ambulance and the manager agreed.

43. Officer B said he ran through a crowd of prisoners to the office downstairs and asked another officer to telephone the communications room to call an ambulance. (At interview, the officer said that staff in the communications room had asked her questions about the incident before calling the ambulance. As she was unfamiliar with the circumstances, they decided to contact the custodial manager.) Officer B went back to the man's cell. Both he and the custodial manager felt for a pulse, but could not detect one. The officer suggested that they start cardiopulmonary resuscitation (CPR) so they rolled him over, tilted his head back and started chest compressions. After a few sets of compressions, the manager asked for a defibrillator (a portable device that can send an electric shock to try to restore a normal heart rhythm) and radioed for an ambulance to be called.

44. The duty manager's account is that when he went to the B wing office to complete the ACCT document and asked about the man, Officer B told him that he had been kneeling next to his bed with his head in his hands. The officer then went to check again and said they should both go up to cell as he was now lying on his back with one hand under the bed. The manager said he looked through the cell flap, went into the cell and called a code red - to indicate a life-threatening emergency. (There is no record of an emergency call or code red called by the manager in the communication log but the duty governor said that he had heard a code 1.) The manager said he examined the man and found a very faint pulse and he noted that his breathing was shallow. He then instructed Officer B to request an ambulance.

45. Several prisoners described the events differently. Prisoner C told the investigator that he had been concerned about the officers' lack of urgency in attending to the man and his requests for them to check on him. At one point, he said he had said to Officer B, "Get out of your fucking seat, he looks dead".

46. Another prisoner said he had gone to the man's landing to cut another prisoner's hair. He had looked into his cell and saw him slumped between a chair and his bed. Several prisoners called out to staff to help him. Fifteen or

twenty minutes later, when he had finished cutting the other prisoner's hair, he said that the man was still in the same position. His cell bell light had been on throughout. The bell can only be pressed from inside the cell and other prisoners also said they had heard it ringing. The prisoner said he had heard someone talking to him through the cell intercom but he did not hear him reply.

47. Another prisoner said he had been unaware that the man was unwell until he went to the wing office between 6.50pm and 7.00pm, to enquire about his telephone credit. While he was there, a prisoner came into the office and told the custodial manager that the man was on the floor of his cell and needed help. He said that the manager did nothing and continued writing. A male officer then suggested to the manager that they go up to see him, but the manager replied, "I'm busy, I'm writing". The prisoner said he was in the office for five or six minutes. He recalled that the television programme "Emmerdale" was about to start [at 7.00pm] and he did not want to miss it as he watched it regularly. He said that the manager and Officer B went upstairs while he was still in the office and he thought they might have gone to the cell.

48. The investigator asked Officer B about the procedures for calling an ambulance. He said that he was aware that any member of staff could request an ambulance but the communications room would first seek authority from the orderly officer (the officer in charge of the prison). He added, "if you're going to call an ambulance you have to go through the orderly officer, so I needed to get to the orderly officer as quick as possible". (The manager was the orderly officer that evening.) Officer B was carrying a radio but explained that during training, they had been advised that other transmissions can intercept radios and messages can be misunderstood, so staff should confirm such messages by landline.

49. At around 7.10pm, the custodial manager asked for a defibrillator and a supervising officer brought one to the cell. The defibrillator did not advise staff to shock but instructed them to continue chest compressions, which they did until the paramedics arrived. The paramedics asked for the man to be moved out of the cell to enable sufficient room to use their equipment. As there were still a lot of prisoners out for their association period, Officer B locked off the main spur. However, prisoners were still able to see the efforts to revive him.

50. The communications room log shows that the ambulance was called at 7.20pm and arrived at 7.25pm. A second ambulance arrived at 7.32. The paramedics took over the resuscitation attempts but the man could not be revived and was pronounced dead at 8.40pm.

51. The Governor decided not to contact the man's partner as she had been the victim of his offence and, at 9.00pm, the prison asked the police to break the news to his mother. The prison's family liaison officers drove the man's mother to the hospital the next day to identify him. One liaison officer told the investigator that the prison had offered funeral expenses in line with Prison Service instructions. A memorial service was held at the prison.

52. A debrief was held in the early hours of the morning. (There was a delay as another prisoner was taken to hospital that evening after taking spice.) Notices announcing the man's death were put under the door of each cell in B wing the next day and a notice was placed at the gate for staff. The print shop instructor told the investigator that he had felt sidelined by managers as he knew him well and had been shocked at the news of his death, but this had not been acknowledged.

53. The post-mortem found that the man's death was due to 1(a) ischaemic heart disease and 1(b) coronary artery atheroma.

ISSUES

Clinical care

54. The clinical reviewer assessed the man's clinical care in prison. He identified several areas for improvement and we repeat those directly relevant to his death. The Head of Healthcare will need to consider the additional recommendations in the report.

Investigation of chest pains

55. When the man transferred to Coldingley in September 2012, he received a reception health screen in which no physical health conditions were identified. The clinical reviewer notes that there was no exploration of underlying risk factors for premature heart disease, which would have enabled healthcare staff to offer advice on primary prevention of heart disease.

56. At the end of November, the man reported chest pains but, as this coincided with an episode of hyper mania (thought to be triggered by drug use), healthcare staff who assessed him assumed that the pains were linked to this. An ECG taken on the day was normal. The clinical reviewer points out that there is no evidence that healthcare staff physically examined the man, but that such an examination could not have predicted a fatal heart attack. He considers that the chest pain might have been angina and says that the expected practice according to the National Institute of Clinical Excellence (NICE) for a patient with chest pain would be a full resting ECG, blood tests and a referral to a rapid access chest pain clinic for investigation of underlying ischaemic heart disease. We consider that staff should have followed the expected process for investigating chest pain. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that prisoners who complain of chest pains are treated in line with NICE guidelines for the assessment and diagnosis of recent onset chest pain.

57. During the events of 18 July, the man said he had no chest pain when asked. The clinical reviewer concludes that his symptoms and actions on 18 July were consistent with suspected drug misuse and did not indicate an acute coronary event at that stage. We are therefore satisfied that staff exercised reasonable judgement in handling the incident as resulting from the effects of substance misuse.

Monitoring and observing the man on 18 July

58. During the afternoon, when he first became ill, the man refused the nurse's attempts to assess him and he became agitated and abusive. The nurse sought assistance from mental health staff and the prison GP on duty and he similarly refused to cooperate with them. As she was still concerned about him, she then asked for an ambulance but he would only allow the paramedics to conduct basic observations. He initially agreed to go to

hospital, but became abusive when officers told him that he would have to be handcuffed. He then refused to go.

59. A disclaimer form was obtained to record the man's refusal to be treated. After the ambulance crew completed it, the healthcare Sister, who was off duty, took it to the healthcare centre to be processed. Neither the associate practitioner, who answered the call requesting the form, nor the Sister, told the nurse, the prison GP or any other healthcare staff on duty that he had not gone to hospital as planned.

60. It is a concern that staff in the healthcare centre who were aware that the man had not gone to hospital did not think to pass this on to their colleagues who might have given further advice about monitoring him. We also consider that prison staff should have actively sought such advice after he refused to go to hospital. It seems that completion of the disclaimer was treated simply as a paper exercise and no consideration was given to the potential consequences of his decision and whether there was a need to put in place alternative monitoring and care. We make the following recommendation:

The Governor and Head of Healthcare should ensure that when a prisoner declines medical treatment, signs a medical disclaimer form or refuses to go to hospital, this is brought to the attention of an appropriate member of healthcare staff so that alternative medical management can be arranged if necessary.

61. Although the man's clinical observations were stable, his condition had been considered sufficiently serious to merit hospital investigation. When he declined to go, the custodial manager decided that he should remain in his locked cell and instructed Officer B to observe him periodically. He did not say how often he should be checked, but told the investigator that he expected it would be every 20 minutes or so. The officer said he checked him at 6.20pm and a second time a few minutes before 7.00pm.

62. The investigator interviewed several prisoners, who were all critical of the handling of the situation and accused staff of inaction. Their accounts are consistent that when they left their cells after they were unlocked at 6.10pm the man was locked in his cell and they did not see an officer on the landing for sometime. By Officer B's account he did not check the man between 6.20pm and just before 7.00pm. The prisoners considered that wing staff and the custodial manager had not been helpful and had been slow in responding to reports about his condition and their requests for help.

63. Wing staff maintained that they had handled the situation professionally and that they were simply trying to manage it in the face of crowds of prisoners during a busy period. When interviewed, Officer B accepted that Prisoner C had told him a few times that the man was "in a bad way" but, as it was a non-specific phrase and staff already knew that he was not well, he did not interpret it to mean that his condition was deteriorating. He said that his checks on him had not been prompted by that prisoner or any other prisoner,

but because he thought 30 minutes was a reasonable interval. However, the interval between the two checks appears to have been closer to 40 minutes.

64. While we have been unable to resolve the conflicting views between staff and prisoners about staff attitudes during the emergency, the overwhelming weight of evidence drawn from the accounts of several credible prisoners suggests that staff did not respond to their appeals to help the man and should have acted more quickly. At least one prisoner was fearful of negative repercussions as a result of speaking out, yet felt compelled to do so.

65. The clinical reviewer believes that best practice would have been to review the man and his consumption of water around every 15 minutes. As a layperson, the custodial manager would not have known this but we believe he should have been specific about the frequency of the checks he expected and sought medical advice about the man's continuing care after he decided against going to hospital. Instead he seems to have been diverted by opening an ACCT document which does not appear to have been the appropriate response in the circumstances. We make the following recommendation:

The Governor and Head of Healthcare should ensure that healthcare staff are consulted about monitoring prisoners when there are concerns about their health and that clear documented instructions are given to the officers responsible.

Legitimacy of locking the man in his cell during association

66. The custodial manager consulted the duty governor about keeping the man in his cell but did not comply with the duty governor's instruction to unlock him for association. He explained that he took this decision to ensure the safety of other prisoners and regarded it as a safe place for him and thought the duty governor had agreed to this. When the duty governor attended the emergency incident later, he was surprised to find that he had remained locked in his cell during the association period. He said that he would have preferred to consider alternative options. The account of Prisoner C, who overheard the duty governor asking wing staff why he had been locked up, supports the contention that the duty governor had not authorised the custodial manager to keep him locked in his cell during association.

67. The Governor commissioned an internal disciplinary investigation, which found that the custodial manager did not have the authority under Prison Rules to deny the man association without the authorisation of the duty governor. We therefore make no recommendation about this matter.

Availability and use of spice

68. The man's death was initially thought to have been caused by effects of smoking spice, a synthetic cannabinoid. On the same evening that he died, another prisoner from Coldingley was taken to hospital after using it. Both staff and prisoners said that it was prevalent at Coldingley and the investigator noticed that a number of spice related incidents had been recorded in the

wing observation book. A drug worker said that an increasing number of prisoners had been 'fitting' after taking it.

69. The Head of Security and Intelligence at the prison explained to the investigator that spice is popular as it cannot be detected in urine tests. The prison has custom-made testing kits for spice that are used predominantly for kitchen workers, prisoners working outside the prison and those on some drug programmes. She added that, because the constituent ingredients of the drug changes, it is very difficult to keep abreast of it and the prison frequently sends new samples to the manufacturers of the testing kits. If there is intelligence about dealing in spice, staff conduct targeted cell and area searches.

70. It is difficult to determine whether a prisoner is under the influence of spice as it affects individuals in different ways. The Head of Security said that the prison had issued information to staff about spice and invited them to see what it looks like. They have also issued notices to prisoners about the risks. (A notice about a particular batch of spice was issued to prisoners the day after the man's death.) We are therefore satisfied that Coldingley is taking reasonable steps to address the problem.

71. The clinical reviewer says that documented reports suggest that the ingestion of spice can trigger heart attacks. Although the man had admitted to taking spice on the day of his death, we do not know whether this was a contributory factor or whether it was a coincidence.

72. The post-mortem report explains that no synthetic cannabinoids were detected in the man's post-mortem urine but that identification of such substances is very difficult. The pathologist concludes that, although it is likely that he had used synthetic cannabinoids, he had severe coronary artery atheroma and acute plaque haemorrhage. His death was due to ischaemic heart disease and coronary artery atheroma. The clinical reviewer states that these could have caused a heart attack at any time.

Emergency response codes

73. Prison Service Instruction (PSI) 03/2013 *Medical Emergency Response Codes,* issued in February 2013, contains mandatory instructions for governors to have a protocol to provide guidance on efficiently communicating the nature of a medical emergency, ensuring staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. It explicitly states that all prison staff must be made aware of and understand this instruction and their responsibilities during medical emergencies.

74. Although Officer B was carrying a radio, when he found the man unresponsive he did not radio an emergency code. Instead, he ran down to the office to alert the custodial manager. They both returned to the cell and decided that an ambulance should be called. The officer then went back to office and asked another officer to call the communications room from the landline telephone. The communications room then had to ring the custodial manager

direct to seek further information as the officer was unfamiliar with the circumstances and unable to answer questions about the nature of the incident. The custodial manager said he also called a code red. There is no record of the code red call (and the duty governor said he recalled hearing a code 1) or a record of the request for an ambulance at that point and there is a variation in accounts as to when the request was made.

75. Officer B indicated that an ambulance could only be called with the authority of the orderly officer. Coldingley's local instruction (which appears to have been issued in 2012) states, in the event of a code red emergency, "ambulance to be called by healthcare staff attending the scene, or the orderly officer if outside of healthcare hours". The communications log shows that an ambulance was called at 7.20pm, about 20 minutes after he was found collapsed in his cell. Although the accounts are confused, there was clearly a delay before staff started CPR and a further significant delay in calling the ambulance. If a person is unconscious, it is crucial that resuscitation is started immediately to improve their chances of survival. Vital minutes were lost when the officer went to the office twice instead of using his radio and then in seeking the custodial manager's approval for an ambulance to be called.

76. PSI 03/2013 was issued at the beginning of February 2013 and governors were required to have a medical emergency response code based on the instruction by 28 February 2013. Coldingley did not have such a protocol to ensure no delay in calling an ambulance. We therefore make the following recommendation:

The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Coldingley has a Medical Emergency Response Code protocol which:

- **Provides guidance to staff on efficiently communicating the nature of a medical emergency;**
- **Ensures staff called to the scene bring the relevant equipment; and**
- **Ensures there are no delays in calling, directing or discharging ambulances.**

Cell bells and CCTV cameras

77. Coldingley has two separate systems to enable prisoners to contact staff. The call bell system, effectively an intercom to allow prisoners to speak to the communications room and the cell bell, which has an alarm that sounds on the stairs and outside the wing office. The audible alarm of the cell bell stops after a few minutes, though a light remains on. Neither system records when a bell is pressed, or by whom. Therefore, there is no way of confirming whether prisoners' accounts of the man pressing the bells for help are true.

78. The wings at Coldingley are covered by CCTV, but the camera lens on the man's wing had been damaged so it was impossible to see how frequently he had been monitored. The wing observation book shows that the camera is vandalised frequently. The internal disciplinary investigation examined the issues of cell bells and CCTV cameras and the Governor has accepted the recommendations for improvement. We therefore make no further recommendation.

RECOMMENDATIONS

1. The Governor and Head of Healthcare should ensure that prisoners who complain of chest pains are treated in line with NICE guidelines for the assessment and diagnosis of recent onset chest pain.

2. The Governor and Head of Healthcare should ensure that when a prisoner declines medical treatment, signs a medical disclaimer form or refuses to go to hospital, this is brought to the attention of an appropriate member of healthcare staff so that alternative medical management can be arranged if necessary.

3. The Governor and Head of Healthcare should ensure that healthcare staff are consulted about monitoring prisoners when there are concerns about their health and that clear documented instructions are given to the officers responsible.

4. The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Coldingley has a Medical Emergency Response Code protocol which:

    - Provides guidance to staff on efficiently communicating the nature of a medical emergency;
    - Ensures staff called to the scene bring the relevant equipment; and
    - Ensures there are no delays in calling, directing or discharging ambulances.

DOCUMENTS CONSIDERED BUT NOT ANNEXED

Clinical record
Core record
NOMIS transfer report
Post-mortem report
Forensic toxicology report
Staff statements
B wing observation book
Assessment, care in custody and teamwork (ACCT) plan
South East Coast Ambulance incident report and non-conveyance form
Parole Board correspondence
Probation documents
Control room log
Counselling, Assessment, Referral and Throughcare service (CARATs) records

ACTION PLAN

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function responsible	Progress (to be updated after 6 months)
1	The Governor and Head of Healthcare should ensure that prisoners who complain of chest pains are treated in line with NICE guidelines for the assessment and diagnosis of recent onset chest pain.	Accepted	The Head of Healthcare will ensure that NICE guidelines are followed in all cases of chest pains. Staff have received 1-1 training and the guidelines have been published in the department. In addition two cardiac trained nurses have been employed.	February 2014 Head of Healthcare	
2	The Governor and Head of Healthcare should ensure that when a prisoner declines medical treatment, signs a medical disclaimer form or refuses to go to hospital, this is brought to the attention of an appropriate member of healthcare staff so that alternative medical management can be arranged if necessary.	Accepted	If a prisoner refuses medical treatment during the core day the healthcare department will lead on a case management review immediately with the duty Governor present. A clear flowchart with timescales for holding the meeting will be produced. If it is out of hours the duty Governor will call the out of hours service and ensure that a plan is put in place for the ongoing observations and actions if condition changes. A review will be carried out as soon as practical to ensure that Coldingley remains the most suitable location.	February 2014 Head of Healthcare	
3	The Governor and Head of Healthcare should ensure that healthcare staff are consulted about monitoring prisoners when there are concerns about their health and that clear documented	Accepted	If the prisoner requires 24 hour healthcare then he will be transferred to a more suitable prison. Observations will be arranged and agreed through case management with clear instructions on what to do if condition should change. A flow chart of actions will be produced, published and issued to all	February 2014 Head of Healthcare	

	instructions are given to the officers responsible.		healthcare staff		
4.	The Governor should ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies and that Coldingley has a Medical Emergency Response Code protocol which: • Provides guidance to staff on efficiently communicating the nature of a medical emergency; • Ensures staff called to the scene bring the relevant equipment; and • Ensures there are no delays in calling, directing or discharging ambulances.	Accepted	A clear policy is now in place and staff will sign to say they have read and understood it Healthcare staff will respond with the appropriate equipment when on duty however there is not a 24 hour service. Heart start machines have been procured and will be located within the prison and a notice to staff will be published regarding locations. The first on the scene will summon assistance using the appropriate code and an ambulance will be called by control room staff on receipt of this supported with information from the orderly officer or healthcare member of staff. The orderly officer will ensure that staff are deployed to the gate to escort the vehicle and remain with it until departure.	February 2014 Head of Healthcare	