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 in September 2011 at HMP High Down

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 report of the investigation into the death of a man, in September 2011, while a prisoner at HMP High Down. He died of a heart attack. I offer my condolences to his family and friends.

The investigation was carried out by two investigators, with full cooperation of HMP High Down. A clinical reviewer was appointed to review the clinical care the man received at High Down. I am sorry that an associated police investigation has meant that this report has been delayed.

The man had been at High Down since February 2011, and had shown no symptoms of heart disease. At 6.50am in September, he alerted staff that he had chest pains. A nurse assessed him and thought he had had a panic attack. Arrangements were made for the day nurse to assess him again later that morning. Before this assessment took place, the man was discovered unresponsive in his cell at 9.20am. Efforts to resuscitate him were unsuccessful and he was pronounced dead at 10.50am.

The clinical reviewer considers that a full assessment should have taken place when the man first complained of chest pain, and an ambulance called. It is disappointing that staff did not seek a response from the man when he was unlocked later that morning, especially as this is an issue which we raised in the investigation into a previous death at High Down. Other aspects of the emergency response were also weak, in particular nurses who responded to the man's heart attack were not confident enough in resuscitation techniques, although the clinical reviewer recognises that prison officers made good efforts.

The post-mortem examination and further consideration by a specialist heart consultant concluded that the man could have had a fatal heart attack at any time and it seems unlikely that his death could have been prevented. Nevertheless, there is a need for healthcare staff at High Down to ensure they follow national and local guidelines for those presenting with chest pain.

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 **May 2013**

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SUMMARY

1. The man was remanded into custody on 11 February 2011 and taken to HMP High Down. He had no known physical health problems. He told staff that he had suffered from depression, but was not on medication. He was a smoker and had a history of drug misuse.

2. At 6.50am on the morning of September, the man pressed his cell bell because he was experiencing chest pains. An emergency code was used to alert the duty night nurse, who thought he had had a panic attack, and gave him ibuprofen. The nurse said that she would arrange for an electrocardiogram (ECG – which measures the electrical activity of the heart to help with diagnosis) and that he should press his cell bell again if he felt unwell in the interim.

3. The nurse told the oncoming day nurses that an ECG was required, although it is not clear how urgent she said it was. The officer who unlocked the man's cell at about 7.45am for an exercise period did not get a response and locked his cell again without checking on his welfare. At 9.20am an administrative officer went to the man's cell as he had not turned up for a stress management course he was scheduled to attend. The man was unresponsive, so she alerted officers, who called a second emergency code. While healthcare staff made their way to the man's cell, officers began cardiopulmonary resuscitation (CPR) and an ambulance was requested.

4. During resuscitation, there were some difficulties with equipment when it was first thought that the oxygen was not working correctly, although the valve had simply not been turned on. Paramedics arrived, followed by a second paramedic crew and an air ambulance. Resuscitation was continued, but the man was eventually pronounced dead at 10.50am.

5. As with all deaths in custody, the police were called and carried out preliminary enquiries. The police were concerned that the actions of staff might have contributed to the man's death, and asked that we suspend our investigation while they pursued this. The post-mortem investigation and an independent cardiologist report concluded that staff's actions did not contribute to the man's death.

6. We agree with the clinical reviewer that clinical guidance must be followed when a prisoner complains of chest pains, handovers should be clear, and well documented, and nurses should be confident in the use of emergency equipment. We are also critical of the failure to get a response from the man when he was unlocked, an issue we have identified in the investigation of a previous death at High Down.

THE INVESTIGATION PROCESS

7. The Ombudsman was notified of the man's death in September 2011. The first investigator issued notices to staff and prisoners informing them of the investigation and asking anyone who had relevant information to contact him. No responses were received.

8. HM Coroner for Surrey was informed of the investigation. A post-mortem report was received in September 2012, and concluded that the man died from coronary heart disease, which might have been hastened by illicit drug use. A copy of the investigation report has been sent to the Coroner to assist his enquiries.

9. A clinical reviewer was appointed to review the clinical care the man received at High Down. The clinical reviewer was given the man's medical record. The clinical review was received on 19 November 2012.

10. The investigator visited High Down on 12 October 2011, and obtained the man's prison and health records. He met the investigation liaison officer, the safer custody team, the prison's family liaison officer (FLO), and the Head of Healthcare.

11. Surrey Police conducted an investigation to determine if the actions of staff had contributed to the man's death. While the police investigation was ongoing this investigation was suspended in line with our agreement with the police. On 14 September 2012, following the submission of the post-mortem report and a report by a heart specialist, Surrey Police concluded that criminal proceedings would not be pursued so the PPO investigation resumed.

12. With the agreement of the police, the investigator conducted interviews at High Down on 9 and 10 February and 20 March 2012 with seventeen members of staff and two prisoners. The clinical reviewer joined him for clinical interviews. The case was subsequently transferred to a second investigator to complete the investigation. The second investigator had a telephone conversation with two additional members of staff on 26 October 2012.

13. On 8 November 2012, after the conclusion of the police investigation, the second investigator and the clinical reviewer met the patient safety and risk manager for Surrey NHS, the primary care clinical lead at High Down and a lay member of Surrey NHS to discuss the circumstances of the man's death and the identified issues.

14. One of the Ombudsman's family liaison officers (FLO) contacted the man's brother in October 2011, and explained the purpose and scope of the investigation. Another FLO contacted the man's brother on 9 October 2012, when our investigation resumed. The man's family raised the following issues.

- Why was the man not properly assessed when he first told staff that he had chest pains? The man's family feel the omission to do this was unacceptable and a failure in the duty of care.

- Did the man go onto the exercise yard at 8.15am on the morning that he died?

- Why was the man not checked between 7.15am and 9.20am when staff knew that he had been unwell?

- Was there any CCTV (closed circuit television) available? (This matter is dealt with in separate correspondence. It appears that CCTV coverage was mislaid in the coroner's office. We have relied on a detailed time line completed by the police.)

15. The man's family received a copy of the draft report as part of the consultation period.

HMP HIGH DOWN

16. HMP High Down is a local prison for adult males, and takes prisoners from Croydon and Guildford Crown Courts and surrounding magistrates' Courts. At the time of the investigation High Down could hold up to 1,103 sentenced and remand prisoners.

17. Healthcare services at the prison are commissioned by Surrey NHS and provided by Surrey Community Health. There is a 23 bed inpatient unit, plus a 12 bed "step down" unit for prisoners requiring less intensive care.

HM Inspectorate of Prisons (HMIP)

18. The last inspection of High Down was in July 2011. The Inspectorate considered that that healthcare was very good:

> "The health care team was large, multidisciplinary and well led, and there had been an impressive investment in the skill mix and the quality of staffing."

19. The Inspectorate reported that emergency equipment was widely available throughout the prison and appropriate checks were recorded daily. Unfortunately, the findings of this investigation are at odds with the positive conclusions of the inspection report.

Independent Monitoring Board (IMB)

20. Each prison has an Independent Monitoring Board of unpaid volunteers from the local community who monitor all aspects of prison life to help ensure that proper standards of care and decency are maintained. The most recent IMB annual report for High Down covers the year to November 2011. The IMB agreed with the Inspectorate that healthcare provision at High Down was good, and that an investment in nurse training has led to a greater retention of healthcare staff.

Previous deaths at High Down

21. The man's death was one of four in 2011, three of which were deaths due to natural causes. In one of these investigations, we commented on the need for officers to satisfy themselves of the safety of prisoners when they unlock cells and we repeat the related recommendation in this report.

KEY EVENTS

22. The man was born in 1974 and lived in Crawley. He appeared at Guildford Magistrates' Court on 11 February 2011, when he was remanded into custody and taken to HMP High Down.

23. During his initial health screen at the prison, the man said that he had no health problems, but had suffered from depression in the past. He said that he drank very little alcohol, smoked cigarettes and had a history of drug misuse. He had had a full course of hepatitis vaccinations and blood tests to check his immunity. There were no notable episodes of ill health. The man saw the dentist and was treated twice for dental abscesses, the last of which was on 3 August.

24. As part of his custodial plan, the man was referred to the Prison SMART course (Stress Management and Rehabilitative Training), which was delivered in a group room on his wing. The course was run over four consecutive days. The man started the course on the morning of 26 September.

Events in September

25. In September at about 6.50 am, the man rang his emergency cell bell. Officer A and Officer B had just arrived on the houseblock to collect prisoners for court and Officer A went to the man's cell to check the problem. The man told him that he had chest pain and pins and needles running down his left arm and a pain in his jaw. The officer asked Officer B to radio a 'code red' (an emergency medical code for potentially life threatening situations at High Down).

26. Nurse A was the duty night nurse who responded to the emergency call (radio call sign Hotel 2). Officer A opened the man's cell and the nurse assessed him there. Shortly afterwards, she was joined by Healthcare Assistant (HCA). The nurse checked the man's blood pressure (BP) and pulse, which were normal (BP was 140/80 pulse was 60 beats per minute). She took a brief history from the man, who told her that his pains had started at about 2.00am, he had never had pains like this before and he was not taking any medication. He also told her that he was attending a course for stress management.

27. The man told Nurse A that his symptoms were improving, he was not cold and clammy and his observations were normal, so she concluded that he was probably having a panic attack. She said she reassured him, gave him two ibuprofen tablets for the pain and said she would arrange a follow up appointment with the prison GP and an ECG later that morning. Officer C wrote on the man's wing history sheet:

> "nurse believes that he [the man] had a panic attack and chest pains were a result of that. Hotel 2 attended [Nurse A], might have an ECG later today".

28. Officer C locked the man's door at approximately 7.10am, but did not speak to him because he knew he had just been seen by the nurse and thought he needed to rest. The officer returned to the wing office. Oncoming officers were briefed about the night shift at 7.30am, including details of the man's chest pains.

29. Nurse A told the investigator that she had intended to collect the ECG machine and return to assess the man. She left his cell at about 7.10am and went to check his records. By that time, the day shift was arriving and the nurse asked Nurse B to carry out the man's ECG because she was about to finish her shift.

30. Nurse B was assigned to dispense medication that morning on houseblock one, where the man was, and left to start her duties. The nurse told the investigator that she did not think the man's ECG was urgent. After Nurse B had gone to houseblock one, Nurse A asked Nurse C to send Nurse B an electronic message to remind her about the ECG. Nurse C sent the message, but Nurse B did not read it because she was dispensing medications. Nurse A left High Down at 7.50am, an hour after the man had first alerted staff to his chest pain.

31. The HCA began unlocking cells on the man's spur at approximately 7.45 am and asked each prisoner if they wanted to go out on exercise or be 'banged up' (locked back in their cells). If he received no response, he locked the cell door. The HCA had no specific recollection of opening the man's cell, but he did not go out for exercise. After prisoners returned from exercise, he locked them back in their cells. Although CCTV evidence was not made available to the investigator as it had been misplaced, a written timeline of events provided by Surrey Police who had viewed the CCTV footage, verifies that the man never left his cell.

32. Between 8.45am and 9.00am, the HCA opened the doors of those people listed to go to work or full time education. The doors of prisoners attending the SMART course were not unlocked at this point.

33. The administrative officer for the SMART course went to the main office on houseblock one as the man had not turned up for the course. Officer C told her that he was probably sleeping as he had not been well. The administrative officer went to the man's cell, looked through the observation window and saw the man lying in bed. She got no response when she knocked on the door and ran to the office to raise the alarm. (She did not carry a cell key). She saw the HCA on the way and asked him to check the man. The HCA unlocked the cell and, when he got no response, he touched the man on the forehead and wrist and realised that he was cold. The HCA asked the administrative officer to raise the alarm as he did not have a radio.

34. The administrative officer pressed the general alarm bell outside the cell at 9.22am (usually used when staff are needed in the event of disorder on the wing). The HCA left the cell and called to Officer D that it was not a general

alarm but a ‘code red’ and that medical staff were needed urgently. Officer D called a code red, and an ambulance was requested.

35. Officer E, and Officer C moved the man on to the floor to start CPR. Nurse B was already on the houseblock and heard an officer say that somebody was not breathing. She collected the emergency medical bag, which contained a defibrillator and oxygen and met Nurse B (radio sign Hotel 2, the responding emergency nurse), on her way to the man’s cell. They were shortly joined by Nurse D.

36. Nurse B passed oxygen and a face mask to the officers administering CPR. She was told that the oxygen was not working. While officers continued with resuscitation, the nurse ran to a different houseblock to collect a second emergency bag, but on her return was told that the original oxygen cylinder had in fact been working, but had not been switched on correctly. The officers requested a defibrillator and the nurse passed this into the cell and then went to get the duty prison doctor from the healthcare centre.

37. While waiting for the ambulance and prison doctor, CPR continued. Nurse D took over administering oxygen, but Nurse C was not able to do CPR because of a medical condition. She relayed instructions and attached the defibrillator to the man after reading through the instructions. The defibrillator indicated that there was no shockable heart rhythm, and advised continuing CPR.

38. The duty doctor arrived at the man’s cell, checked for a pulse, and advised staff to continue CPR until paramedics arrived. The first crew of paramedics arrived at 9.40am. At 9.43am a second crew arrived. While they completed their assessment, officers and nurses continued to administer CPR. Nurse E and Nurse Practitioner F had also attended the incident and took over CPR from the officers.

39. The paramedics requested an air ambulance at 9.52am, which arrived at the prison at 10.24am. In the meantime, paramedics continued resuscitation attempts, but the man was pronounced dead at 10.50 am.

Support for prisoners

40. The Governor issued notices to let prisoners know of the man’s death and the support that was available to them. All prisoners subject to suicide prevention monitoring were reviewed. Samaritans visited houseblock one that afternoon to provide additional support to prisoners if required. The prison held a memorial service for the man on 17 October 2011.

Liaison with the man’s family

41. The man had nominated his brother as his next of kin. A prison chaplain, was assigned as the prison family liaison officer (FLO) and, together with the Imam and a prison manager, she went to the man’s brother’s home to break the news. The man’s brother was not at home but was telephoned to return and then informed of his brother’s death.

42. The prison FLO maintained contact with the man's family over the next few days. The prison offered financial assistance with the funeral costs and ensured that all of the man's property was returned. The prison arranged for the man's family to visit High Down on 6 October when they had the opportunity to see where he lived and meet his friends. The man's family also attended the memorial and prayer service held on 17 October. At his family's request, the man's funeral, which was held on 18 October, was conducted by the prison chaplain and the Imam.

Support for staff

43. The prison care team (staff trained to support other staff following an incident) were alerted at 9.40 am that they were required on houseblock one. Two members of the team went to provide support.

44. The duty governor held a hot debrief with staff directly involved with the incident. (A hot debrief is a meeting immediately after an incident, designed to reassure staff, and provide them with support).

Post-mortem report

45. The doctor who undertook the post-mortem examination on 30 September 2011 concluded the man died of coronary heart disease. The post-mortem report was not completed until 3 July 2012.

46. As well as the post-mortem examination, the man's heart was separately examined on 17 October 2011, by a heart specialist. The heart specialist concluded that the man died of a heart attack, which could have occurred at any time. The specialist considered that the damage to his heart was linked to the man's history of illicit drug use.

ISSUES

Clinical care

Nurse A's assessment

47. Nurse A examined the man when he complained chest pain at 6.50am. She found his observations were normal and he told her that his symptoms were getting better. She concluded that the man had experienced a panic attack. She told the investigator that she thought he was stable when she left him, but intended to check his records and carry out an ECG. Instead, she handed over to nurses arriving for their shift. At interview she said that she was aware that there was a chest pain protocol, but was not familiar with its content.

48. Surrey Community Health (including High Down) have devised their own guidance for healthcare professionals on the emergency treatment of chest pain if a cardiac event cannot be excluded. This says:

> "Check immediately if chest pain is current or when the last episode was, particularly if in the last 12 hours.
>
> Check if the chest pain may be cardiac. Consider:
>
> - History of pain
> - Any cardiovascular risk factors
> - History of ischaemic heart disease and previous treatment
> - Previous investigations for chest pain
>
> Check if any of the following symptoms of ischaemia are present. These may indicate an Acute Coronary Syndrome (ACS).
>
> - Pain in the chest and/or other areas (e.g. arms, back, jaw) lasting longer than 15 minutes
> - Chest pain with nausea and vomiting, marked sweating or breathlessness, or haemodynamic instability
> - New onset chest pain or abrupt deterioration in stable angina, with recurrent pain occurring frequently with little or no exertion and often lasting longer than 15 minutes.
> - Central chest pain may not be the main symptom.
>
> Immediate management of suspected ACS
>
> - Call 999 for an ambulance ready for transfer to Accident and Emergency.
> - Give Glyceryl Trinitrate (GTN) as pain relief
> - Give a single loading dose of Aspirin 300mg"

49. We agree with the clinical reviewer that Nurse A should have requested an ambulance for the man. Failing that, she should have carried out an ECG

immediately herself and consulted his records. We are also concerned that the nurses coming on duty also did not appear to follow the protocol. At interview, Nurse C and Nurse B remembered Nurse A telling them that the man needed an ECG that morning. Nurse A told the investigator she had expressed the urgency of the ECG, but Nurse C and Nurse B said that they did not know it was urgent. There is no record of the handover, apart from the email that Nurse C sent on Nurse A's behalf, that was not read until after the man's death. We make the following recommendations:

The Head of Healthcare should ensure that all staff follow the guidance in relation to chest pain and request an ambulance without delay.

The Head of Healthcare should ensure that handovers are comprehensive and well recorded to ensure continuity of care.

Resuscitation attempts

50. Officers who first attended the emergency scene started CPR. Nurse B arrived with the emergency bag along with Nurse C who was designated responsibility for Hotel 2. Nurse D, a newly appointed nurse, arrived shortly afterwards. Despite the arrival of the nurses, officers continued with CPR, and one of the most experienced nurses left the scene to get another oxygen cylinder, then left again for the doctor. It is a matter of concern that nurses did not take over resuscitation attempts as soon as they arrived at the cell.

51. During the panel meeting on 8 November 2012, the prison's primary care lead, told the investigator that all the healthcare staff thought that all prison officers were trained in emergency first aid, so understood that they should not take over resuscitation. While prison officers can undertake first aid training, it is not mandatory and not all officers are trained. Officer D was not trained, although he carried out chest compressions well. Nurses eventually took over from him, but some time after their arrival.

The Head of Healthcare should ensure that trained healthcare staff take control of resuscitation as soon as possible in a life threatening situation.

52. Officers had to ask to use the defibrillator, and Nurse C had to read the instructions before she could use it, despite being trained in life support to intermediate level. There was some confusion about whether the oxygen cylinder was working, but it was not being used properly. The post-mortem report and the cardiologist both conclude that resuscitation was unlikely to have prevented the man's death. However, it is a matter of concern that nurses were not confident in the use of emergency equipment, which might make be crucial in the future.

The Head of Healthcare should ensure that healthcare staff are confident in the use of emergency equipment.

Unlock procedures

53. On the morning of 29 September, the HCA unlocked the man's cell at about 7.45am and asked if wanted to go outside for exercise. The officer said he did not recall the man specifically, but assumed he must not have responded, so he locked his cell without enquiring further.

54. Officers are told in their initial training that they should check the safety of prisoners when they unlock cells. Further, Prison Service Instruction (PSI) 10/2011, paragraph 2.3 clarifies the responsibility of the unlocking officer:

> "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."

It is important that prison staff ensure that they gain a response from prisoners when they unlock their cells. We have raised this in a previous investigation and the Governor accepted the related recommendation. In response to the previous recommendation, the safer custody team sent an instruction to wing managers that officers should always greet prisoners when they unlock them in the morning and "try and get a response". The HCA might well have greeted the man that morning, but he still did not discharge his duty under the PSI to check the man's wellbeing or satisfy himself of his safety. Therefore, we repeat the recommendation.

The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

RECOMMENDATIONS

1. The Head of Healthcare should ensure that all staff follow the guidance in relation to chest pain and request an ambulance without delay.

   Accepted - *All staff have been re-trained in the use of Chest Pain protocol. Provision for new staff to be trained as part of the induction process. An ambulance will be called immediately if clinically appropriate following clinical assessment of patient including vital signs and ECG*. Target date: Completed

2. The Head of Healthcare should ensure that handovers are comprehensive and well recorded to ensure continuity of care.

   Accepted - *Handovers are in place at change of shift times in all areas of the healthcare department. SystmOne provides a continuous clinical record of care and will be used in conjunction with handover reports. An audit of medical records is conducted regularly.* Target date: Completed

3. The Head of Healthcare should ensure that trained healthcare staff take control of resuscitation as soon as possible in a life threatening situation.

   Accepted – *All clinical staff attend basic life support and defibrillation as part of their mandatory training and compliance is scrutinised on a quarterly basis and it is part of the performance reporting structure. Staff are aware of their responsibilities in taking charge of a clinical situation.* Target date: Completed

4. The Head of Healthcare should ensure that healthcare staff are confident in the use of emergency equipment.

   Accepted – *All clinical staff attend basic life support and defibrillation as part of their mandatory training and compliance is scrutinised on a quarterly basis and it is part of the performance reporting structure.* Target date: Completed

5. The Governor should ensure that, when a cell door is unlocked, staff satisfy themselves of the safety of the prisoner and that there are no immediate issues that need attention.

   Accepted - *Governor's order to be issued reminding staff that they must ensure the well being of prisoners on morning unlock.* Target date: 28.02.13