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 a man in August 2014 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 investigation report into the death of a man who died of heart failure in August 2014, at HMP High Down. I offer my condolences to his family and friends.

One of our investigators carried out the investigation. A clinical reviewer was, appointed, to review the clinical care the man received at High Down. The prison cooperated fully with the investigation. The investigation was suspended for some time until the results of the post-mortem and toxicology tests were received to confirm the cause of death. I am sorry for the consequent delay in issuing this report.

In October 2013, the man was remanded to High Down and, in January 2014, he was sentenced to ten years in prison. On the morning of the man's death, an officer unlocked the man's cell but did not check his wellbeing at the time. About six minutes later, prisoner A found the man unresponsive in his bed and alerted staff. Officers did not administer any basic life support, but waited until nurses arrived. Paramedics and a hospital critical care team attended and continued emergency treatment. Shortly afterwards, a doctor pronounced the man dead.

I am satisfied that healthcare staff at the prison could not have predicted or prevented the man's death. However, I am concerned that the officer who unlocked the man that morning did not check on his welfare. While the man might already have been dead, this meant that a potential opportunity for earlier emergency intervention was missed. I have raised this matter with the prison before. I am also concerned that there was a delay in beginning basic life support. It is crucial in cases of cardiac arrest that this is attempted as soon as possible.

The 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 2015**

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SUMMARY

1. The man was remanded to HMP High Down on 24 October 2013. He appeared fit and healthy and healthcare staff identified no concerns at a reception health screen. He was sentenced to ten years in prison on 17 January 2014. Apart from seeing a prison GP for eczema, he had little contact with healthcare staff.

2. On 12 August at 8.50am, an officer unlocked the man's cell but did not try to get a response from him. At 8.56am, prisoner A, found the man in bed and unresponsive. He said that he had tried, very briefly, to resuscitate him, but thought that he had died. He asked another prisoner to alert staff. Officers arrived a minute later and radioed an emergency code blue (which indicates situations such as when a prisoner is not breathing or unresponsive). The control room called an ambulance immediately. The officers did not attempt cardiopulmonary resuscitation.

3. At 9.03am, a healthcare assistant attended with an emergency bag. He could not find a pulse and noted that the man's lips and fingers looked blue, an indicator of low oxygen levels in the blood. At about the same time, nurses arrived with oxygen and a defibrillator. The defibrillator did not detect a shockable heart rhythm and stiffness in his head and jaw suggested that rigor mortis was beginning. Although nurses noted that the man's body was mostly cold, they noted some warmth on his chest and stomach. At about 9.06am, they therefore decided to attempt resuscitation.

4. Nurses gave the man oxygen. On the fourth round, the defibrillator indicated they should administer a shock, after which the nurses continued cardiopulmonary resuscitation. The defibrillator did not find any further heart rhythm. Paramedics arrived and continued with the resuscitation attempt until a hospital critical care team arrived. At 9.48am, a doctor from the team confirmed that the man had died.

5. The man's death was sudden and unexpected and would have been difficult to predict or prevent. However, we are concerned that the officer who unlocked the man's cell that morning did not check his welfare and that there was a delay beginning cardiopulmonary resuscitation. Although it seems likely that the man had died, resuscitation should be attempted as quickly as possible, unless there are clear signs that to do so would be futile. We make two recommendations.

THE INVESTIGATION PROCESS

6. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and inviting anyone with relevant information to contact her. One prisoner responded.

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison records. She interviewed prisoner A and three members of staff at High Down in October and subsequently interviewed two more staff by telephone. We have been unable to interview the officer who unlocked the man's cell on 12 August. The investigator informed the Governor of her initial findings.

8. NHS England commissioned a clinical reviewer to review the man's clinical care at the prison.

9. We informed HM Coroner for Surrey of the investigation, who provided the post-mortem report. We have sent the Coroner a copy of this investigation report. The investigation was suspended for a period while we waited for the results of the post-mortem and toxicology tests. We regret the consequent delay in issuing this report.

10. One of the Ombudsman's family liaison officers wrote to the man's sister, his nominated next of kin, on 23 November, to explain the investigation, but she did not reply.

11. The man's family received a copy of the draft report. They did not make any comments. The prison also received a copy of the draft report and the response to the recommendations has been added to the end of the report.

HMP HIGH DOWN

12. HMP High Down is a local prison near Sutton, which holds around 1,100 men. Virgin Care provides healthcare services at the prison. There is a 22 bed inpatient unit

HM Inspectorate of Prisons

13. The report of a recent inspection of HMP High Down in January 2015 has not yet been published. At the previous inspection in July 2011, the Inspectorate found that the healthcare provision was very good, with an impressive level and quality of staff. Prisoners were generally satisfied with their access to healthcare services.

Independent Monitoring Board

14. Each prison in England and Wales has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community, who help ensure that prisoners are treated fairly and decently. In its most recently published annual report, for the year to November 2013, the IMB reported that, despite operating in a very difficult environment, healthcare staff had maintained a high standard of care.

Previous deaths at HMP High Down

15. The man was the twelfth person to die from natural causes at HMP High Down since 2011. In two of these investigations, we were concerned that officers did not check the welfare of prisoners when they unlocked cells. The prison accepted recommendations about this. Following their recent inspection, HM Inspectorate of Prisons informed us that the Governor had issued a notice to staff in response to our recommendations, but officers did not always check prisoners when they unlocked them.

KEY EVENTS

16. On 24 October 2013, the man was remanded to HMP High Down and on 17 January 2014, he received a ten year prison sentence. At his initial reception health screen, nurses noted no previous or current health concerns. His blood pressure and pulse rate were within the normal range. The only other contacts he had with healthcare staff were when he saw a GP, twice, for eczema.

17. At 8.50am on 12 August, Officer unlocked the man's cell. She did not check whether he was all right at the time or attempt to get a response him. At 8.56am, a prisoner, prisoner A, went to the man's cell as he thought it was unusual that he was not out of bed. The cell was in darkness, and the man was in bed. The prisoner called out to him but got no reply. He said he put his hand on the man's forehead, which was cold and that his eyes were rolled back. He told us that he realised the man was dead.

18. Prisoner A said he did chest compressions briefly to try to resuscitate the man and asked another prisoner to alert staff. A minute later, Officer B and Officer A arrived. The prisoner told them that he had attempted cardiopulmonary resuscitation. The officers checked for a pulse but were unable to find one. Officer B radioed an emergency code blue, which is used in circumstances such as when a prisoner has breathing difficulties, is unresponsive or unconscious. As a result, the control room called an ambulance immediately. The officers did not attempt any basic life support and waited outside the cell for help to arrive.

19. A healthcare assistant to the code blue call and arrived at 9.03am with an emergency bag. He assessed the man and could not find a pulse. He noted that he felt cold and his lips and fingers were blue and thought that he was dead. At about the same time, the first nurse on the scene arrived and immediately radioed for the acting head of healthcare to assist. The nurse noted that the man's head and jaw were stiff. A second nurse on the scene arrived with another emergency bag containing oxygen and a defibrillator. A third nurse on the scene arrived at 9.06am. She noted that although the extremities of the man's body were cold, his stomach and chest were still warm. The acting head of healthcare said that, because of this, they decided to attempt resuscitation.

20. The nurses administered oxygen and applied the defibrillator. In a statement, the third nurse on the scene said that, on the fourth round, the defibrillator administered a shock. The nurses continued the resuscitation attempt, but the defibrillator did not find any further shockable heart rhythm. At 9.15am, paramedics arrived and continued with emergency treatment until a hospital critical care team arrived. At 9.48am, a doctor from the team pronounced the man's death.

Support for prisoners and staff

21. A Governor's notice informed prisoners and staff of the man's death and offered support to those who might have been affected. A senior manager debriefed the staff involved in the emergency response and offered support. Staff checked prisoners considered at risk of suicide or self-harm in case they had been adversely affected by the news of the man's death. The prison held a memorial service for the man in the prison chapel on 18 August.

22. Officers supported prisoner A on the day and the prison arranged for him to see a bereavement counsellor.

Notifying the man's next of kin

23. A supervising officer acted as the prison's family liaison officer and she and a senior manager visited the man's sister, his nominated next of kin, later that morning to break the news of his death. She offered support and advice.

24. The man's funeral was on 12 September. The prison contributed to the cost in line with national guidance.

Post-mortem

28. A post-mortem examination concluded that the man died of acute heart failure, aortic regurgitation (leaking of the aortic valve) and aortic dilatation (enlarged blood vessel) and left ventricular (large chamber in the heart) scarring.

ISSUES

Clinical Care

29. The clinical reviewer noted that the symptoms of aortic regurgitation could initially include chest pain, light-headedness or palpitations. As the condition progresses, the symptoms are shortness of breath and swollen ankles. There is no record that the man ever complained of any of these symptoms. The clinical reviewer considered that it is very possible that there would have been no evidence of any heart condition when the man arrived at High Down, and it is significant that his blood pressure was recorded as normal.

30. The clinical reviewer was satisfied that staff carried out a comprehensive and timely health screen when the man arrived at High Down. The man said he was fit and well, had not seen a doctor recently and had no significant medical or family history. The clinical reviewer acknowledged that, while there might not have been anything in the man's medical history to suggest any cardiac problem, the prison should have requested his community health records as a matter of course after his initial health screen. She has made a recommendation about this in her review, which the Head of Healthcare will need to address.

Unlocking prisoners

33. Prison officers are expected to check on a prisoner's wellbeing when unlocking cells. The Prison Officer Entry Level Training (POELT) manual states that "Prior to unlock, staff should physically check the presence of the occupants in every cell. You must ensure that you receive a positive response from them by knocking on the door and await a gesture of acknowledgement. If you fail to get a response, you may need to open the cell to check. The purpose of this check is to confirm that the prisoner has not escaped, is ill or dead". Prison Service Instruction 10/2011 also requires prisons to have "clearly understood systems in place for staff to assure themselves of the well being of prisoners during or shortly after unlock."

34. When Officer A unlocked the man's cell on the morning of 12 August, she did not attempt to get a response from him. While we cannot know whether this would have changed the outcome, this was a missed opportunity to check on the man's wellbeing and to begin cardiopulmonary resuscitation sooner, if he was unresponsive at that stage. We do not know when the man went into cardiac arrest, but the clinical reviewer noted that multiple organ failure and death is considered to occur between four and six minutes after a cardiac arrest. It is therefore important that resuscitation is attempted as soon as possible to improve the chance of survival.

35. We have raised with the prison before the importance of staff checking prisoners' safety and welfare when they unlock them. The prison has accepted previous recommendations, yet it appears that this is still not

standard practice at High Down. Managers have issued a notice to staff, but as the Inspectorate of Prisons has also found, more needs to be done to ensure that the correct procedure is followed. The circumstances of the man's death underline the need for this. Checking at unlock is an important for safety and also helps avoid other prisoners having to deal with finding a prisoner dead or seriously ill, which should be the responsibility of staff. We make the following recommendation:

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

Emergency response

36. Prison Service Instruction (PSI) 03/2013 says that a code blue emergency call should be used in a medical emergency, including when a prisoner has chest pain, has difficulty breathing or is unconscious. It directs that when a medical emergency is called over the radio network, an ambulance must be called immediately. We are satisfied that this happened. Officer B arrived at the man's cell at 8.57am, called a code blue and the control room called an ambulance immediately in response. We consider that nurses made appropriate efforts to resuscitate the man, but are concerned that, other than the prisoner, no one attempted basic life support until the nurses arrived.

37. Although the prisoner told the officers he had administered some chest compressions in an attempt to resuscitate the man, neither officer continued this. Officer B told us that she thought that the man was dead. Officer B was not first aid trained and the prison has not been able to confirm whether Officer A was. It was six minutes or so before a healthcare assistant arrived, closely followed by nurses, and at least a further three minutes before nurses started cardiopulmonary resuscitation. We have noted above, the small window of opportunity for successful resuscitation in the case of cardiac arrest. While it is impossible to know whether this would have changed the outcome for the man, we consider that staff first on the scene of such an emergency should begin basic life support. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that, unless there are clear signs of death, staff first on the scene of an emergency, initiate basic life support until qualified health professionals arrive.

RECOMMENDATIONS

1. The Governor should take active steps to ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.

2. The Governor and Head of Healthcare should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that, unless there are clear signs of death, staff first on the scene of an emergency, initiate basic life support until qualified health professionals arrive.

ACTION PLAN: Mr The man – HMP High Down

No	Recommendation	Accepted/Not accepted	Response	Target date for completion and Function Responsible
1	The Governor should take active steps to ensure that, when a cell door is unlocked, staff satisfy themselves of the wellbeing of the prisoner and that there are no immediate issues that need attention.	Accepted	A Governor's Information Notice has been published on two occasions since The man's death detailing the importance of this requirement. This notice will also be distributed every two months as a reminder to staff. Staff have been reminded of this requirement via briefings from unit managers. Ad-hoc CCTV reviews / quality assurance will take place to ensure the correct procedures are followed.	30 March 2015 Safety, and Residential Functions
2	The Governor and Head of Healthcare should ensure that all staff are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity, and that, unless there are clear signs of death, staff first on the scene of an emergency, initiate basic life support until qualified health professionals arrive.	Accepted	Staff awareness of the importance and requirement of this will be raised by the means of notices to staff and staff training via 'first aid trainers' and Health Care professionals These notices will be also be sent out regularly and ongoing training will take place	30 March 2015 Safety, Residential, and Training Functions and Health Care Department