Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man at HMP High Down on 21 January 2015

A report by the Prisons and Probation Ombudsman Nigel Newcomen CBE

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Our Vision

To carry out independent investigations to make custody and community supervision safer and fairer.

Our Values

We are:

Impartial: *we do not take sides*
Respectful: *we are considerate and courteous*
Inclusive: *we value diversity*
Dedicated: *we are determined and focused*
Fair: *we are honest and act with integrity*

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The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out **independent** investigations, such as this, into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

My office carries out investigations to understand what happened and identify how the organisations whose actions we oversee can improve their work in the future.

This is the investigation report into the death of a man from multiple organ failure on 21 January 2015, while a prisoner at HMP High Down. He was 66 years old. I offer my condolences to his family and friends.

I am satisfied that the man received a generally good standard of health care at the prison and that staff at High Down could not have done anything to prevent his death. However, I am concerned that some of his physical care needs were not met as his health deteriorated and that he was restrained for some days in hospital without justification. When he was seriously ill it took too long to notify his family.

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 **January 2016**

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Summary

Events

1. On 6 October 2014, the man was remanded to HMP High Down, charged with sexual offences.

2. The man had many chronic health problems, including type 2 diabetes, high blood pressure and obesity. Healthcare staff completed full and comprehensive initial health screens and care plans to monitor his health.

3. Between 7 December 2014 and January 2015, the man reported feeling unwell several times. His symptoms included vomiting after eating, dizziness, headaches, constipation and deteriorating eyesight. Prison doctors initially prescribed antibiotics and stomach acid suppressants. They later diagnosed dehydration, oral thrush and an inner ear infection. On 13 January, a GP was called to see him, who was lying in bed in his own faeces. He said that he had taken laxatives. The doctor considered that although his blood pressure was slightly high, his observations were stable and he appeared well. She advised that he should continue his medication and ask staff to help him clean up.

4. The next day, 14 January, the man collapsed in his cell. A nurse and a doctor were on the wing and examined his quickly. They found him pale, dehydrated and unable to speak. The nurse used an emergency code red rather than code blue, which we would have expected. An ambulance was called quickly and took him to hospital. Officers did not use restraints as healthcare staff had indicated that his condition was life-threatening and he could not move. He was admitted to hospital and later that day he was restrained by an escort chain. He remained restrained until 17 January.

5. Hospital doctors were unsure what was wrong with the man and completed a number of tests. By 18 January, he was almost completely unresponsive. No one from the prison had contacted his family so the hospital informed them of his serious condition. On 19 January, a scan revealed abdominal bleeding and a CT scan on 21 January found he had bleeding on his brain. Later that day, his family agreed that life support should be withdrawn. He died at 4.24pm.

Findings

6. We agree with the clinical reviewer's findings that the man's death was not preventable, but we are concerned that his physical care needs were not met during his last few days at the prison. Although the nurse did not use the standard medical emergency code for the circumstances, there was no delay in the emergency response.

7. We found no evidence to support the decision to restrain the man in hospital between 14 and 17 January, which was contrary to healthcare advice. We are also concerned that no one from the prison contacted his family to let them know that he was seriously ill when he was taken to hospital.

Recommendations

- The Governor and Head of Healthcare should ensure that there is a coordinated multi-disciplinary approach to meeting the needs of prisoners with complex physical, mental and social care needs.

- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. All decisions should be fully documented.

- The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.

The Investigation Process

8. The investigator issued notices to staff and prisoners at HMP High Down informing them of the investigation and asking anyone with relevant information to contact her. Several prisoners responded and asked to be interviewed.

9. The investigator obtained copies of relevant extracts from the man's prison and medical records. She interviewed four members of staff and a group of four prisoners at High Down in March 2015.

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

11. We informed HM Coroner for Surrey of the investigation who provided the cause of death. We have sent the coroner a copy of this report.

12. One of the Ombudsman's family liaison officers contacted the man's sister, his nominated next of kin, to explain the investigation. She said that she would like to know more about the healthcare that her brother had received.

13. The initial report was shared with the Prison Service. They did not identify any factual inaccuracies.

14. The man's sister received a copy of the initial report. She raised a number of questions that do not impact on the factual accuracy of this report and have been addressed through separate correspondence.

Background Information

HMP High Down

15. HMP High Down is a local prison near Sutton, in Surrey, which holds approximately 1,100 men. Healthcare is provided by Virgin Care and, at the time of the man's death, local GPs from Cheam Family Practice provided GP services. Care UK provides out of hours cover. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

16. The most recent inspection of HMP High Down was in January 2015. Inspectors found that healthcare services were good but staff shortages resulted in the cancellation of too many appointments. Staff provided good care in the inpatient unit but prisoners there spent too much time locked in their cells.

Independent Monitoring Board

17. Each prison 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 recent published report for the year to December 2014, the IMB reported that healthcare provision at High Down compared well with other prisons.

Previous deaths at HMP High Down

18. The man was the eighth prisoner to die from natural causes in the custody of High Down since January 2013. We have raised the issue of unjustified use of restraints before.

Key Events

19. The man was remanded to HMP High Down on 6 October 2014, charged with sexual offences. At an initial health assessment a healthcare assistant noted that he had type 2 diabetes and had high blood pressure. He weighed 125.5kg, which was morbidly obese.

20. In October, the man attended chronic diseases clinic and had blood tests, which showed liver damage and a high sugar level. A nurse manager reviewed him and completed a comprehensive diabetic care plan, including instructions for healthcare and prison staff. On 20 October, a specialist diabetic nurse from the hospital prescribed weight loss medication.

21. At an appointment for a Hepatitis B vaccination on 22 November, the man told a nurse that he was experiencing numbness in his hand. A GP examined him on 28 November and referred him to orthopaedics to investigate potential nerve injury. He noted that the man had lost 10kg and that he looked well.

22. On 7 December, a nurse referred the man to a GP, as he said he was vomiting every day. She reviewed him the next day and prescribed prochlorperazine to help with vomiting after food. A GP reviewed him on 15 December and prescribed clarithromycin (antibiotics) and omeprazole (to treat excess stomach acid).

23. The man's sickness did not improve. On 22 December, a GP considered he might be dehydrated, prescribed medication for oral thrush and requested blood tests. On 27 December, he fainted when he was collecting his medication. A nurse examined him and gave him a cup of water to help bring his blood pressure up to the normal range. On 29 December, a GP reviewed the blood test results, which showed a slightly raised white blood cell count, which he attributed to a mild infection.

24. On 3 January 2015, a nurse referred the man to the GP, as he reported deteriorating eyesight, headaches and dizziness. On 9 January, a GP assessed him and diagnosed acute labyrinthitis (inner ear infection) and constipation. On 11 January, a nurse arranged a number of tests that had been requested. He was found to have blood in his urine, but there is no record that this was followed up.

25. A GP reviewed the man on 12 January, as he had a poor appetite and had been constipated for two weeks. He noted that the man weighed 88.8kg, a loss of 36.7kg since he had arrived, three months earlier. He adjusted his diabetic medication.

26. The next day, a GP was called to review the man after wing staff found him in bed lying in his own faeces. He said that he had taken laxatives. She noted that his observations were stable. She told the investigator that his blood pressure was a little high but when she read his notes from the previous day, she saw that his blood pressure medication had been reduced and was satisfied with this. She advised him to shower and noted that his current medication should continue. She told prison officers that he was well and advised them to make sure that he had help to get to the showers and to call back if there were any

problems. There is no evidence that anyone helped him to clean up his cell or take care of his personal hygiene.

27. On the morning of 14 January, at around 10.30am, a nurse was on the man's wing when some prisoners who were cleaning on the wing, told her that he was on the floor in his locked cell. She told the investigator that she looked into his cell and he was on the floor, but she could see that he was breathing and blinking. Officers unlocked the cell and she and a GP, who was also on the wing, went in to examine him.

28. The man was unable to respond verbally but could nod and shake his head. The nurse said that he was very pale, appeared to be very dehydrated and looked to have severe oral thrush. There were faeces in the cell. The GP told the investigator that the man's pulse was very weak and he was very cold. He thought the faeces in the cell were from the previous day. The nurse asked officers to radio an emergency code red (an emergency medical code used to indicate loss of blood, burns or suspected fracture). She told the investigator that she did not feel a code blue, which is used in circumstances such as when a prisoner is unconscious, not breathing or is having breathing difficulties was appropriate because she and the doctor were with him. (We are satisfied that this did not affect the emergency response.)

29. Mores nurses attended and gave the man oxygen. They tried to give him medication through his veins but were unable to do so due to poor veins. His breathing was normal, but they could not get a blood pressure reading and his oxygen level and temperature were low. A nurse recorded that he only opened his eyes to speech and moved only in response to pain. Staff moved him onto his bed and covered him in blankets to keep him warm.

30. A 10.34am the prison called an ambulance and paramedics arrived at the cell at 11.01am. (The ambulance service said that on the information they received, they had classified it as a 30-minute response. At 10.52am, they had received a further call to say the man's condition was worsening.) At 12.05pm, he was taken to hospital and arrived at 12.21pm. No restraints were used. Healthcare staff had advised against them, as his condition was life-threatening and he was immobile. However, later that evening, escort staff applied an escort chain in the hospital. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)

31. On 15 January, a Supervising Officer (SO) noted in the man's escort record that a consultant had assessed him and he was able to nod in response to questions, but could not sit up. On 16 January, he had a lumbar puncture (to test for abnormalities of the brain, spinal cord or other parts of the nervous system). The next day, a doctor told the escort officers that the result of this test was abnormal but they were unsure why.

32. Prison healthcare staff frequently contacted the hospital for updates on the man's condition. On 17 January, a nurse told one of the escort officers that they were treating him for encephalopathy (a disease in which the functioning of the brain is affected by a condition such as viral infection or toxins in the blood). The officer contacted a prison manager and got permission to remove restraints.

33. On 18 January, a consultant reported that the man's condition was deteriorating and he was almost completely unresponsive. The consultant asked for his next of kin details and informed his sister that he was seriously ill. No one from the prison had contacted his sister to let her know he was in hospital. Later that day, he was moved to the acute dependency unit and had a tube inserted to help him breathe. He was then moved to the neuro-intensive care unit.

34. At 10.30am on 19 January, doctors informed one of the escort officers that the man would not live more than a few hours and that his family should be informed. His sisters arrived shortly after at 10.50am. His pupils were not responding and a scan of his abdomen revealed internal bleeding.

35. On 21 January, the man had a CT scan, which showed he had a bleed on his brain. The hospital informed his family. His family went to the hospital and after speaking with doctors, they agreed that his life support should be withdrawn. He was pronounced dead at 4.24pm.

Contact with the man's family

36. A SO acted as the prison family liaison officer and on 20 January she contacted the man's sister, who he had named as his next of kin, and explained her role. On 21 January, the SO met the man's and other family members at the hospital. The family did not want to be present when his life support was removed and the SO agreed to telephone his sister to let her know when he died. The SO met his family when they returned to the hospital.

37. The SO continued contact with the man's sister after his death. In line with national policy, the prison contributed to the funeral costs.

Support for prisoners and staff

38. Notices were issued to prisoners and staff at High Down informing them of the man's death and offering support to those who might have been affected.

Post-mortem report

39. After a post-mortem examination, the coroner gave the cause of death as:

1a) multi organ failure and disseminated intravascular coagulation (associated with ischaemic encephalopathy and brain stem haemorrhage)

(all the organs shut down because of generalised blood clots followed by bleeding, specifically the brain was damaged and bleeding into the brain stem (where it joins the spinal cord);

1b) septic shock (severe infection and cardiovascular system collapse);

1c) mesenteric ischemia due to generalised atherosclerosis (poor blood supply to gut from narrowed arteries);

2) left ventricular hypertrophy and myocardial interstitial fibrosis (due to severe coronary artery atheroma) (enlarged heart and damage to heart muscle from prolonged and reduced blood supply as a result of narrowed coronary arteries).

40. The coroner noted that it was not possible to state exactly what had led to the multi-organ failure, but it was probably due to septic shock resulting from mesenteric ischemia (narrowing or blockage of the main arteries, which supply the small intestine with blood).

Findings

Clinical care

41. When the man arrived at High Down, he had significant health problems, including diabetes, high blood pressure and obesity. We are satisfied that, overall, he received a good standard of care for his medical conditions. He had full initial health screens and nurses implemented comprehensive care plans to monitor his chronic diseases. The clinical reviewer considered that the majority of the man's care was comparable to that he could have expected to receive in the community. However, he had some concerns about the management of the man's weight loss in relation to his diabetes. He has made recommendations, which the Head of Healthcare will need to address. As this issue was not directly related to the man's death, we do not repeat them here.

42. The man's health deteriorated rapidly and the hospital was initially unable to diagnose his illness. The clinical reviewer noted that healthcare staff at the prison could not have anticipated or prevented the man's death.

Social care

43. We are concerned that the man did not always receive the level of social care he needed. On 13 January 2015, he was found lying in his faeces and a GP asked prison staff to arrange for help to clean up his cell and manage his personal hygiene. There is no evidence that this was done. When he was found collapsed in his cell the next day, old faeces were present in various parts of his cell, his bed and clothes.

44. Prisoners who spoke to the investigator said that the man had experienced some difficulty collecting his meals and attending the medication hatch for a time but was not given any additional support. It does not appear that there is any formal 'buddy' scheme at High Down, where prisoners are trained to help other prisoners with day-to-day living. He had been unwell for some time and we are concerned that staff did not identify or assist him with his ongoing physical care and day-to-day tasks. We make the following recommendation:

    The Governor and Head of Healthcare should ensure that there is a coordinated multi-disciplinary approach to meeting the needs of prisoners with complex physical, mental and social care needs.

Use of restraints

45. The Prison Service has a duty to protect the public when escorting prisoners outside prison, such as to hospital. It also has a responsibility to balance this by treating prisoners with humanity. The level of restraints used should be necessary in all the circumstances and based on a risk assessment, which considers the risk of escape, the risk to the public and takes into account the prisoner's health and mobility.

46. A judgment in the High Court in 2007, made it clear that prison staff need to distinguish between the prisoner's risk of escape when fit (and the risk to the public in the event of an escape) and the prisoner's risk when suffering from a

serious medical condition. The judgment indicated that prison staff must take into account medical opinion about the prisoner's ability to escape and keep this under review as circumstances change.

47. The man went to hospital on 14 January, as an emergency. On the risk assessment form, a member of healthcare staff noted that his condition was life-threatening, he was immobile and restraints should not be applied. At 11.30am, a prison manager concluded that restraints should not be used due to the man's critical condition.

48. The escort record (which details events at hospital) shows that when the man was taken to hospital, in line with the risk assessment, no restraints were used. A change of escort staff took place at 8.00pm. At 2.30am, there is a note that the escort chain was loosened. The escort log shows that a management check was completed on 15 January, after the restraints had been applied, but no further management checks were recorded. A manager was unable to explain when and why the decision not to restrain the man was revoked, but thought the prison had been told that his condition had improved. There is no documentary evidence of this decision, no record of managerial authority for the use of restraints and no evidence that his condition improved while he was in hospital.

49. Escort officers continued to use the escort chain until the evening of 17 January, when they sought permission to remove the restraints due to the man's poor health. He remained unrestrained until he died on 21 January.

50. Public protection is fundamental, but security measures must be proportionate to a prisoner's individual circumstances, which must be fully considered, taken into account and balanced against the security risks. We do not consider that staff appropriately assessed the man's risk, or fully took into account his poor and unresponsive condition when they reversed the decision not to use restraints. We have made previous recommendations to High Down about the inappropriate use of restraints. We make the following recommendation:

The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position and that assessments fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. All decisions should be fully documented.

Informing the man's family of his admission to hospital

51. On 18 January, a consultant asked an escort officer for the man's next of kin details and contacted his sister to tell her that he was very unwell. No one from the prison had contacted his family to let them know that he was seriously ill in hospital before that and it was not until 20 January that a SO, the family liaison officer, first contacted his sister.

52. Prison Rule 22 says that when "a prisoner dies, becomes seriously ill or, sustains any severe injury or is removed to hospital on account of a mental disorder, the governor shall, if he knows his or her address, at once inform the prisoner's spouse or next of kin, and also any person who the prisoner may reasonably have asked should be informed". This is reflected in Prison Service Instruction

64/2011, which requires prisons to contact the next of kin of prisoners who are seriously ill.

53. When the man was taken to hospital as an emergency on 14 January, he was seriously ill and healthcare staff had indicated that his condition was life-threatening. We consider that, in line with Prison Rules, someone from the prison should have informed his next of kin at that stage. We make the following recommendation:

The Governor should ensure, in line with Prison Rule 22, that the next of kin of seriously ill prisoners are informed as soon as possible so that they are able to visit them in hospital without delay.

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