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 High Down in January 2014

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 in January 2014 at HMP High Down. He was 66 years old and died from ischaemic heart disease. I offer my condolences to his family and friends.

A clinical reviewer assessed the clinical care the man received at High Down. The prison cooperated fully with the investigation.

When the man arrived at High Down in November 2010 he had several long standing medical conditions for which he was prescribed appropriate medication and was regularly reviewed. While at High Down he had several episodes of dizziness and chest pain which were investigated but nothing abnormal found. During the afternoon of 20 January 2014, he collapsed on the way back from his job in the prison. Despite the best efforts of healthcare staff and paramedics he could not be resuscitated.

The man's death was sudden and unexpected and I agree with the clinical reviewer that his medical care at High Down was equivalent to that he could have expected to receive in the community. However, I am concerned that his daughter was informed of his death by telephone rather than in person, as is best practice.

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 **August 2014**
Prisons and Probation Ombudsman

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SUMMARY

1. The man was sentenced to eight years in prison in November 2010 and sent to HMP High Down. He had several long standing medical conditions, including type 2 diabetes and hypertension, for which he received medication. Healthcare staff saw him frequently, particularly to manage his diabetes.

2. While he was at High Down, the man experienced several episodes of dizziness and sickness and GPs prescribed appropriate medication. He also complained of chest pains on several occasions. Each time he had an electrocardiogram test and the results were normal.

3. At approximately 2.55pm in January 2014, the man collapsed on the way back from his job in the prison's restaurant. Emergency assistance was required and nurses arrived quickly. Nurses attempted cardiopulmonary resuscitation, but he could not be resuscitated. Paramedics attended and took over the resuscitation attempt. At 3.59pm, they pronounced him dead.

4. The clinical reviewer found that the man's medical care was of a satisfactory standard and equal to that he could have expected in the community. He commended nurses who attempted to resuscitate him for acting appropriately and professionally.

5. After the man died, we are concerned that his daughter was informed by telephone rather than in person, as is best practice. We make one recommendation about this.

THE INVESTIGATION PROCESS

6. 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. No one responded.

7. The investigator obtained copies of the man's prison medical records and relevant extracts from his prison record. She visited High Down on 30 January 2014 and spoke to the Head of Healthcare and a member of the Independent Monitoring Board. She interviewed four members of staff on 24 March at High Down. She gave the Governor initial written feedback about the investigation.

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

9. We informed HM Coroner for Surrey of the investigation, who provided the results of the post-mortem report. We have sent the Coroner a copy of this investigation report.

10. One of the Ombudsman's family liaison officers contacted the man's daughter to explain the investigation. She had some questions about the management of his diabetes. As this was not directly related to the cause of his death we have dealt with this in separate correspondence.

11. The man's family received a copy of the draft report. They raised a number of issues that do not impact on the factual accuracy of this report and have been addressed through separate correspondence. The prison considered our draft report and recommendation and has accepted this. The prison has also submitted an action plan detailing what they have done to address the issue we raised and this is included at the end of the report.

HMP HIGH DOWN

12. HMP High Down is a local prison near Sutton which holds around 1,100 men. NHS Surrey commissions healthcare services at the prison which are provided by Virgin Care Services. There is a 22 bed inpatient unit.

HM Inspectorate of Prisons

13. The last inspection of High Down was in July 2011. The Inspectorate found that healthcare provision was very good and supported by an impressive level and quality of staff. Prisoners were generally satisfied with their access to healthcare services. However, inspectors noted that there was a need to cater better for prisoners whose needs differed from the population as a whole because of their age, nationality or disability.

Independent Monitoring Board

14. 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 recently published annual report for the year to November 2013, the IMB commented that the year had seen an uneasy relationship between the prison and healthcare providers. The new Governor and new Commissioner had put a different emphasis on the way healthcare should operate in the prison setting compared to the past. This had resulted in some friction as adaptations were made. However, the Board judged that the delivery of healthcare by Virgin Care Services and the team of medical and nursing staff was a very high standard.

Previous deaths at High Down

15. The man's death was one of four deaths from natural causes at High Down since 2013. There are no significant similarities with the circumstances of his death and the other cases.

KEY EVENTS

16. On 27 November 2010, the man was sentenced to eight years in prison for drugs related offences and was sent to HMP High Down. He had a medical history of type 2 diabetes, diabetic retinopathy (damage to the eyes caused by diabetes), high blood pressure and asthma.

17. When the man arrived at the prison, blood tests showed that his diabetes was poorly controlled. His blood pressure was recorded as normal. He was prescribed medication to manage his diabetes and to lower cholesterol. Healthcare staff saw him regularly to monitor his diabetes and blood pressure. He also attended annual retinal screening (following laser treatment for diabetic retinopathy).

18. During 2011, in addition to his diabetic care and blood pressure monitoring, healthcare staff saw the man a number of times when he complained of dizziness and chest pain. On each occasion, an ECG was carried out and the results were normal. A doctor considered the dizziness was due to lanyrinthitis (an inflammation of the inner ear) and prescribed prochlorperazine, a medication to treat dizziness and nausea.

19. At 4.10pm on 15 February 2012, a nurse saw the man, who said that he had been suffering from chest pains since 2.00pm and had taken two aspirin. He said he had stopped taking his regular medication, apart from for his diabetes, because he was experiencing abdominal pain and wind. She recorded his blood pressure and pulse as normal. The results of an ECG were also normal. He was told to contact healthcare if he experienced further symptoms. The next day a prison GP advised him to take his medication as prescribed.

20. On 16 July, a prison GP referred the man to a cardiologist and a consultant ophthalmologist (a specialist in medical and surgical eye problems) for further examination after he reported experiencing dizzy spells.

21. On 3 October, a cardiologist at the hospital examined the man. He found nothing abnormal and said the man was suffering from presyncope (a term used to describe a feeling of dizziness or fainting that does not actually lead to fainting).

22. On 14 December 2012, the man had an abdominal ultrasound to exclude an aortic aneurysm. The results of the scan were normal. During a follow up appointment with the consultant on 27 December, he said his dizzy spells had improved dramatically and no further follow up was arranged.

23. The man started to experience dizziness again throughout March and April 2013. On each occasion his clinical observations and ECG results were normal. On 18 April, a prison GP saw him and noted that he might be suffering from a reoccurrence of lanyrinthitis and prescribed prochlorperazine.

24. Healthcare staff continued to monitor the man's diabetes and blood pressure, which was now satisfactorily controlled. However, his vision continued to deteriorate due to retinopathy. On 6 November, he applied to be registered as partially sighted. There is no further record of him complaining of dizziness or chest pain.

25. At about 2.55pm in January 2014, the restaurant manager was taking the man back to his houseblock from the prison restaurant where he worked as a cleaner, when he suddenly became breathless and collapsed. The manager immediately placed him in the recovery position. A prison officer saw the incident and radioed for assistance from healthcare.

26. A nurse arrived at the scene within seconds and the officer called a code blue (a medical emergency call indicating a prisoner is unconscious or has breathing difficulties). The control room log shows that an ambulance was called at 2.56pm.

27. At about 3.00pm, the emergency response nurse arrived at the scene with an emergency bag (containing basic observation equipment and emergency medication).

28. A nurse also attended and started cardiopulmonary resuscitation (CPR). A defibrillator, suction machine, ECG and large oxygen cylinder were brought to the scene. The defibrillator was attached to the man which initially advised a shock, but after analysing his heart again the defibrillator did not detect a shockable rhythm. Healthcare staff continued with CPR until the paramedics arrived at 3.18pm and took over. Another set of paramedics arrived at approximately 3.30pm. Despite continued efforts to resuscitate him, at 3.59pm paramedics pronounced he had died.

29. Prisoners and staff were informed of the man's death through a Governor's notice. At 6.30pm, a debrief was held for all staff involved in the emergency incident and staff were offered support from the care team. Prisoners being monitored as at risk of suicide and self-harm were checked in case they had been adversely affected by his death. Other prisoners were also offered support. A memorial service was held in the prison chapel later.

Family liaison

30. The man's next of kin was listed as his daughter. The prison's designated family liaison officer was not on duty but agreed to come into the prison. Meanwhile, an operational manager and a custodial manager decided to inform the man's daughter of his death by telephone. The custodial manager told the investigator this was because prisoners were aware that he had died and there was concern that prisoners or their relatives might inform her before the prison was able to do so. The family liaison log shows that the custodial manager telephoned her at 5.10pm. The family liaison officer contacted her again at 7.55pm. She said she did not want anyone from the prison to visit her that evening and would prefer to come to the prison the next day. She

visited the prison the next day and records show regular communication between them.

31. The funeral took place on 31 January and the prison contributed to the costs in line with national guidance.

Post-mortem

32. A post-mortem examination found the cause of death was ischaemic heart disease, and a coronary artery atheroma (hardening of the arteries).

ISSUES

Clinical care

33. The clinical reviewer concluded that the man's standard of healthcare at the prison was satisfactory and equivalent to that which he could have expected in the community. He suffered from a number of medical conditions for which he received appropriate care and treatment. Healthcare staff saw him frequently to monitor and manage his diabetes and blood pressure.

34. The man's episodes of dizziness and chest pain were appropriately investigated. He was appropriately referred to a cardiologist who found nothing abnormal. The clinical reviewer commented that he did not exhibit any classical symptoms of heart disease or signs of angina. His death was sudden and unexpected and could not have been prevented.

Emergency response

35. The clinical reviewer and the paramedics who attended the prison said that the actions of staff after the man collapsed were commendable and we agree.

36. Both prison and healthcare staff acted swiftly, appropriately and professionally. The correct emergency code was used which ensured an ambulance was called immediately and appropriate emergency equipment was brought to the scene. Prison, healthcare and ambulance staff worked well together to try to save the man. Sadly, despite everyone's best efforts, he could not be resuscitated.

Liaison with the man's family

37. The man was pronounced dead by the paramedics at 3.59pm. At the time of his death the prison's designated family liaison officer was not on duty, but agreed to come into the prison and contact his family. However, the operational manager and custodial manager decided to inform his daughter of his death by telephone. The custodial manager told the investigator that his collapse had been witnessed by other prisoners and he was concerned that his family would be told of his death before the family liaison officer was able to visit in person.

38. PSI 64/2011 states in Chapter 13:

> *"Wherever possible, the FLO and another member of staff must visit in person the next of kin or nominated person to break the news of the death. Time will be of the essence in order to try to ensure that the family do not find out about the death from another source.*

39. The custodial manager, who is also a trained family liaison officer, telephoned the man's daughter at 5.10pm. She lives very near High Down and someone from the prison could easily have visited her shortly after his death to inform

her in person. We consider that it was not appropriate to telephone to break the news of his death and we make the following recommendation:

The Governor should ensure that in the event of a death, prisoners' next of kin are informed quickly and in person by a member of Prison Service staff in line with national guidance.

RECOMMENDATION

The Governor should ensure that in the event of a death, prisoners' next of kin are informed quickly and in person by a member of Prison Service staff in line with national guidance.

ACTION PLAN:

No	Recommendation	Accepted/ Not Accepted	Response	Target date for completion and Function Responsible
1	The Governor should ensure that in the event of a death, prisoners' next of kin are informed quickly and in person by a member of Prison Service staff in line with national guidance.	Accepted	The Senior Management Team and Family Liaison Officers have been briefed to remind them that in the event of a death a prisoner's next of kin should be informed as soon as possible and in person, rather than over the telephone.	Completed Governor HMP High Down