Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Garry Warren a prisoner at HMP Hull on 28 April 2016

A report by the Prisons and Probation Ombudsman
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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*

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 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.

Mr Garry Warren died of a heart attack, thrombosis and emphysema at HMP Hull on 28 April 2016. Mr Warren was 48 years old. I offer my condolences to Mr Warren's family and friends.

The investigation found that the care Mr Warren received was equivalent to that he could have expected to receive in the community. Although Mr Warren's previous medical records do not appear to have been requested, and he did not have an alcohol screening test, this did not affect the outcome for Mr Warren. The prison could neither have predicted, nor prevented, his death.

This version of my report, published on my website, has been amended to remove the names of staff and prisoners involved in my investigation.

Nigel Newcomen CBE
Prisons and Probation Ombudsman **December 2016**

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Events

1. Mr Garry Warren was sentenced to 22 weeks imprisonment for theft on 27 April 2016. He was admitted into HMP Hull on the same day. He had an induction with an officer, and saw a nurse for an initial health screening. He had a history of alcoholism, but denied current dependency on alcohol. Mr Warren signed a sheet in reception to say substance misuse services had seen him but he declined to engage with them.

2. The next morning, at about 8.20am, an officer went to see Mr Warren as part of a basic custody screening but found him unresponsive. As she did not have a radio, she asked another officer to call an emergency code. Other officers and a nurse attended Mr Warren's cell. There were signs that Mr Warren had been dead for some time, and so prison staff and nurses did not attempt resuscitation. A doctor pronounced Mr Warren dead at 8.31am.

Findings

3. The care Mr Warren received was equivalent to that he could have expected to receive in the community. Although it would have been best practice to request his previous medical records and perform an alcohol dependency audit, this was not done. However, this would not have not affected the outcome for Mr Warren.

4. There is no evidence Mr Warren suffered from symptoms of heart disease, or complained of any symptoms, in the day before he died. The emergency response was prompt, and appropriate. We are satisfied that Mr Warren's death could not have been predicted or prevented by the prison.

The Investigation Process

5. The investigator issued notices to staff and prisoners at HMP Hull informing them of the investigation and asking anyone with relevant information to contact her. No one responded.

6. The investigator obtained copies of relevant extracts from Mr Warren's prison and medical records.

7. The investigator interviewed five members of staff over the telephone in May and June 2016.

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

9. We informed HM Coroner for East Riding and Kingston Upon Hull of the investigation. The investigation was suspended for over two months until we received the results of the post-mortem examination. We regret the consequent delay. We have given the coroner a copy of this report.

10. One of the Ombudsman's family liaison officers contacted Mr Warren's mother to explain the investigation and to ask if she had any matters they wanted the investigation to consider. She had no specific concerns for this investigation.

11. Mr Warren's family received a copy of the initial report. They asked for some clarification about officer checks on Mr Warren through the night. This report has been amended accordingly.

12. The initial report was shared with the Prison Service. The Prison Service pointed out some factual inaccuracies and this report has been amended accordingly.

Background Information

HMP Hull

13. HMP Hull is a local prison, which holds up to 1056 men in ten wings. City Healthcare Partnership provides health services at the prison. There is a Wellbeing Unit which was introduced in October 2014 following the closure of the inpatient facility in HMP Hull.

14. The Wellbeing Unit provides an environment to support and progress individuals who are presenting with complex needs which are difficult to meet in the normal prison environment, including a specialist palliative care suite. GP surgeries are held four days a week, with an out of hour's service available at other times.

HM Inspectorate of Prisons

15. The most recent inspection of HMP Hull was in October 2014. Inspectors reported that healthcare services were good. The reception process was well organised. Complete privacy during reception was not available and the inspectorate was not confident all prisoners would have disclosed information that could have been overheard by others. However, prisoners later had private first night interviews with induction staff. The first night accommodation was poor.

Independent Monitoring Board

16. Each prison has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that prisoners are treated fairly and decently. In its latest annual report, for the year to December 2015, the IMB reported that Hull was effectively run and a safe environment. There was a full health screen at reception, which identified immediate risks.

Previous deaths at HMP Hull

17. Mr Warren was the fourth person to die of natural causes since January 2015. There have been two subsequent deaths. We have found no significant similarities between the investigations.

Key Events

18. Mr Garry Warren was sentenced to 22 weeks imprisonment for theft on 27 April 2016. He was admitted into HMP Hull the same day.

19. An officer saw Mr Warren for his induction, and explained the procedures within the prison. Mr Warren had been to Hull before, and said he understood the prison procedures.

20. At his initial health screen that day, a nurse noted that Mr Warren had a history of alcoholism, although Mr Warren reported that he was not currently dependent on alcohol. The nurse reported that he presented with no concerning symptoms and did not appear to be under the influence of any substances. The substance misuse services, Lifeline (who provide treatment for alcohol addiction), are present at reception. It is not noted on the medical records, but the nurse recalled that Mr Warren saw someone from the service, and that he declined help from them for substance misuse issues. Mr Warren signed a sheet in reception, which drug misuse services state was to show he declined intervention.

21. Through the night, prison officers observed Mr Warren on an hourly basis. This is standard procedure for all prisoners on their first night admitted into Hull. Before 3.30am, an officer saw Mr Warren lying on his left and right hand sides, showing that he had moved. However, on three separate occasions after 3.30am, he checked on Mr Warren and noted that he was lying on his front.

22. The next morning, at about 8.20am, a Supervising Officer (SO) went to check Mr Warren because he was on her list for a basic custody screening. (Basic custody screenings in Hull are when a member of staff checks on prisoners who entered custody the day before, and discuss any issues they may have.) This was the first time that Mr Warren had been unlocked that day. She looked through the viewing flap and initially thought Mr Warren was asleep. She called his name but Mr Warren did not respond. She unlocked his cell, entered and called his name again. When Mr Warren still did not respond to his name, she tapped him. She realised that something was wrong and, because she had no radio, she left the cell to ask an officer to radio an emergency code blue. (An emergency code blue indicates a prisoner is unconscious, not breathing or is having breathing difficulties.) The officer came to the cell and called a code blue at 8.23am. He also tried to get a response and, when he touched Mr Warren, noticed he was cold and rigid.

23. Two more officers and a nurse arrived at Mr Warren's cell. After entering his cell, she decided not attempt to resuscitate Mr Warren because there were clear signs of death, and so resuscitation would be futile. Mr Warren's limbs were stiff, suggesting the presence of rigor mortis. A prison GP confirmed Mr Warren's death at 8.31am. Paramedics also attended the scene and agreed that Mr Warren had died.

Contact with Mr Warren's family

24. A family liaison officer went with a colleague, a prison manager, to see Mr Warren's mother, to inform her of his death. Mr Warren's mother was not in, but the prison representatives telephoned her and arranged to meet her immediately.

They told her that Mr Warren had died, and when they met her, they gave her more information and ongoing support.

25. Mr Warren's funeral was on 12 May. The prison contributed towards the cost of the funeral, in line with national protocol.

Support for prisoners and staff

26. After Mr Warren's death, a prison manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

27. The prison posted notices informing other prisoners of Mr Warren's death, and offering support. Staff reviewed all prisoners subject to suicide and self-harm prevention procedures in case they had been adversely affected by Mr Warren's death.

Post-mortem report

28. The post-mortem report concluded that Mr Warren died of severe heart disease, as his arteries had narrowed and one had previously become blocked with a blood clot. There was evidence he had had a previous heart attack. His heart disease could have caused his death at any time. Emphysema also contributed to his death, as it exacerbated the effects of his heart disease and increased the risk of sudden death.

Findings

29. The clinical reviewer concluded that the care Mr Warren received was equivalent to that he could have expected to receive in the community. The initial health screen was thorough. However, it appears Mr Warren's previous medical records were not requested, as should happen following the initial health screen. It would have been best practice to request these to gain a fuller picture of Mr Warren's health history, although it did not affect the outcome for Mr Warren.

30. The sheet Mr Warren signed for Lifeline services when he arrived in the prison has very little information on it. It was not clear that it was to decline engagement with drug or alcohol misuse services. The investigator was told that the sheet was being updated, in order to include more information on prisoners who decline services, as well as those who engage. Therefore we do not make a recommendation here, but the Head of Healthcare should ensure that the updated sheet satisfies the need for more relevant information.

31. The investigation found that there was no evidence Mr Warren suffered from symptoms of heart disease, or complained of any symptoms, in the day before he died. An alcohol audit, to ascertain if Mr Warren needed substance misuse support, was not done. A nurse did not notice any concerns from Mr Warren's appearance and noted that, although Mr Warren had a history of alcoholism, he did not appear to be under the influence of alcohol. Mr Warren had a history of alcohol related seizures, which could have affected his health. It would have been good practice to complete an audit. However, it would not have affected the outcome for Mr Warren.

32. Through the night, an officer checked on Mr Warren, as per standard procedure in Hull for first night prisoners. In his interview, the officer said that when he is concerned about particular prisoners (who have known healthcare issues or are under suicide and self-harm monitoring) and sees them lying on their front during the night, he knocks on the cell door to get a response. This is because it is hard to see if they are breathing. However, he had not been provided with any information that meant he should check Mr Warren more closely, when he saw Mr Warren lying on his front when he made hourly checks after 3.30am. While, with hindsight, the lack of movement from Mr Warren suggests that he died sometime after 3.30am, we consider that it was appropriate for him not to have checked Mr Warren because there were no health or self-harm concerns.

33. When the SO found Mr Warren, the emergency response was prompt and appropriate. The lack of resuscitation was appropriate in the circumstances, as there were clear signs that Mr Warren had died and that resuscitation would be futile. The clinical reviewer confirmed that the European Resuscitation Guidelines 2010 supported her decision. The nurse had completed training in verifying deaths, and was qualified to make this decision.

34. We are satisfied that prison healthcare staff could not have predicted or prevented Mr Warren's death.

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