Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of a man, a prisoner at HMP Highpoint, in July 2014

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.

The man died at HMP Highpoint on 1 July 2014, of a blood clot in the lung caused by fragments of broken pacemaker wires. I offer my condolences to his family and friends.

The man had a heart condition, causing an irregular heartbeat, which was initially managed by a pacemaker. He twice removed his pacemaker on his own, in 2010 and 2012. Surgeons removed most of the wires left in his heart, but a fragment remained. The man consistently refused to take his prescribed medication. On 30 June 2014, he refused to go to hospital when he became unwell because he was unhappy with the escort arrangements. He died the next day. I am satisfied that the man received a good standard of active and consistent care at Highpoint, even though he declined treatment. However, I am concerned that, while it was the man's decision not to go to hospital on 30 June, this decision was influenced by security arrangements, which were based on erroneous information and unjustified.

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 **October 2015**

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Summary

Events

1. On 5 February 1996, the man was sentenced to life imprisonment for murder. The man had a heart condition causing an irregular heartbeat. He had a pacemaker to help manage this.

2. The man frequently refused medical treatment and in 2010, he removed his pacemaker leaving some residual broken wires. In 2011, surgeons removed some wires from the man's heart and replaced the pacemaker. A small fragment of wires remained but a cardiologist considered this did not need further attention. The man removed his pacemaker again in 2012. His cardiologist decided not to replace it and instead, manage the man's heart condition with medication.

3. On 13 May 2013, the man transferred to HMP Highpoint. He did not take his medication as prescribed and often refused to go to hospital for treatment. Healthcare staff were satisfied that he had the mental capacity to understand the risks involved in refusing treatment.

4. On Monday 30 June 2014, the man reported feeling unwell and his heart rate was very low. He was pale, dizzy, and had difficulty breathing. Paramedics attended and said he should go to hospital.

5. The man was unhappy with the security arrangements a manager decided should be used for the hospital escort, which included three officers and the use of double handcuffs. For this reason, he refused to go to hospital, contrary to medical advice. A prison GP did not review the man on Tuesday 1 July, but a nurse arranged a GP appointment for the next day.

6. At 11.30am on 1 July, the man collected his lunch as normal and an officer locked him back in his cell at 12.00pm. At 1.30pm, an officer unlocked the cell and noted he was asleep. He checked him again a few minutes later and noted he had moved and was breathing. At 4.00pm, the same officer checked him again and found him unresponsive. The officer telephoned healthcare staff for help and called the control room to ask for an ambulance. Nurses and paramedics attended but were unable to resuscitate him. At 4.26pm, a paramedic pronounced the man's death. A post-mortem examination found that the man had died from blood clots blocking arteries from the heart to the lung caused by the presence of broken pacemaker wires.

Findings

7. We are concerned that when the man refused to go to hospital on 30 June, the escort risk assessment was based on incorrect information and there was no healthcare input into the assessment. However, we recognise that the man often refused to go to hospital when advised. Despite the higher than necessary security, he made an informed decision not to go. It is not possible to know whether a hospital admission would have prevented his death, or whether he would have complied with other arrangements, but the decision to use double handcuffs was not justified.

8. The man died from complications relating to a heart condition exacerbated by his own actions in removing his pacemaker and his consistent refusal of medication and treatment. Overall, we are satisfied that the clinical care offered to him was good and equivalent to that he could have expected to receive in the community. Staff at Highpoint could not have prevented his death.

Recommendations

- The Governor should ensure that risk assessments for prisoners being taken to hospital fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. The use of double handcuffs for category C prisoners should be exceptional and fully justified in writing.

The Investigation Process

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

10. The investigator obtained copies of relevant extracts from the man's prison and medical records.

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

12. The investigator and clinical reviewer interviewed six members of staff at Highpoint on 22 April 2015. The investigator also interviewed two prisoners. She interviewed a further three members of staff by telephone.

13. We informed HM Coroner for Greater Suffolk of the investigation. We have sent the coroner a copy of this report. Our investigation was suspended for several months while we waited for the results of the post-mortem and toxicology tests and the outcome of a police investigation into the man's death. We regret the consequent delay in issuing this report.

14. One of the Ombudsman's family liaison officers contacted a friend of the man's and his brother, to explain the investigation and to ask if they had any matters they wanted the investigation to consider. The man's brother asked us to consider whether the man had received an appropriate standard of healthcare at the prison.

15. The initial report was shared with the Prison Service. There were no factual inaccuracies and the action plan has been added to the end of the report.

16. The man's family received a copy of the draft report. They pointed out a factual inaccuracy. This report has been amended accordingly.

Background Information

HMP Highpoint

17. HMP Highpoint is a medium security prison on two sites: Highpoint South, which was the original HMP Highpoint, and Highpoint North, which was previously known as HMP Edmunds Hill. Highpoint holds up to 1,325 men. Care UK provides general and mental healthcare services from 8.00am to 6.15pm Monday to Friday, and from 8.30am to 6.00pm on weekends.

HM Inspectorate of Prisons

18. The most recent published inspection of HMP Highpoint was in September 2012. Inspectors reported that, while there were some problems, the prison largely provided a decent and safe environment. Primary health services were reasonable, although the rate of non-attendance at many clinics was too high. Inspectors noted that interactions between nurses and patients were professional and good-natured. Care UK clinical managers and GPs were available out of hours.

Independent Monitoring Board

19. 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 2014, the IMB reported that nurse-led clinics were provided for a variety of conditions such as asthma, blood borne viruses and diabetes. The waiting time to see a GP was an average of 6 days but emergencies were seen the same day. There was an average of 17 complaints about healthcare each month, which the Head of Healthcare dealt with.

Previous deaths at HMP Highpoint

20. The man was the third person to die from natural causes at Highpoint since 2013. We have previously made recommendations about the need for appropriate risk assessments to justify the use of restraints for hospital escorts.

Key Events

21. On 5 February 1996, the man was sentenced to life imprisonment. He had Wolff-Parkinson-White syndrome, a heart condition, which causes an irregular heartbeat. Symptoms include collapse and shortness of breath. The man had a pacemaker to help regulate his heart rate. He was also diagnosed with a borderline personality disorder.

22. The man often refused medical treatment and in 2010, he removed his pacemaker. Surgeons replaced this, but in 2012, he removed his pacemaker again using a plastic knife. On this occasion, his hospital consultant refused to replace the pacemaker and explained to the man that the onus was on him to manage his heart condition by taking prescribed medication.

23. On 15 April 2013, while he was at HMP Wayland the man asked for mental health support. Three days later, a mental health nurse went to see him, but he declined any help or further interaction with mental health staff.

24. On 13 May 2013, the man transferred to HMP Highpoint. Nurse A noted the man's heart condition and medications. These included bisoprolol (to slow down the activity of the heart), ramipril and simvastatin (for high blood pressure and cholesterol), and warfarin (to lower the blood clotting levels). The man wore a heart rate monitor on his wrist and had regular blood tests to monitor the effectiveness of the anti-clotting medication.

25. The man did not comply with his medication or blood tests. Prison doctors saw him frequently to discuss and try to resolve the issue without success. He often signed medical disclaimers confirming he did not want to receive treatment. On 20 August, a psychiatric nurse, Nurse B saw the man to assess his capacity to refuse medication and treatment. He refused to speak to her so she was unable to complete the assessment. However, healthcare staff considered he had capacity to understand the risks involved in refusing treatment.

26. On 30 October, a prison GP, Dr A, wrote to the man's cardiologist explaining that the man's heart condition was proving difficult to manage. Despite refusing to take his prescribed medication, the man complained of intermittent sweating with chest pain. Sometimes the man would agree to go to hospital but would then often refuse treatment or discharge himself before hospital staff could assess him fully. The doctor asked advice on how best to manage the man's condition and enquired about the removal of pacemaker wires that the man believed were the source of his problems.

27. The cardiologist replied on 31 January 2014, confirming that on 12 October 2011 some pacemaker leads were removed from the man's heart. A small fragment was left but needed no further attention. The cardiologist asked for a recent electrocardiogram test (ECG to measure the electrical activity of the heart) so he could further assess the man's condition. The man refused to have an ECG test until 15 March. The results were then sent to the cardiologist.

28. On 25 April, the man told a prison pharmacist that he had not taken any of his heart medication since January. Later that day, a prison GP, Dr B, spoke to the man who agreed to start taking his medication again.

29. On 10 June, the man said he felt unwell with shortness of breath. A prison GP, Dr C, examined him and noted he had a sharp stabbing pain in his right lung area, looked grey and was sweating. He diagnosed possible pneumonia with right sided pleurisy (inflammation of the lining of the lung). The man refused to go to hospital, but agreed to take antibiotics. The doctor asked prison staff to observe the man overnight and to call an ambulance if his condition deteriorated. The man's symptoms improved and on 18 June, Dr B noted that the man said he was feeling a lot better.

30. At around 4.30pm on 30 June, Nurse C saw the man who was finding it difficult to breathe. He was pale and dizzy and his wrist heart rate monitor showed a low heart rate of 46. (A normal heart rate for an adult is between 60-110 beats per minute.) The nurse took some time to convince the man that he needed to go to hospital and requested an ambulance at 4.57pm.

31. At 5.00pm, Nurse D took over the man's care from Nurse C, when her shift finished. Paramedics arrived and carried out an ECG, which showed the man had an atrial flutter (an abnormal heart rhythm) and needed to go to hospital. Officer A, Officer B and Officer C were detailed to escort him and took him to the ambulance. They restrained the man with double handcuffs. (This means the prisoner's hands are handcuffed in front of him and one wrist is attached to a prison officer by an additional set of handcuffs).

32. The man was unhappy about the level of escort and the use of double handcuffs. He refused to go to hospital and asked to go back to his cell. A prison manager, A, who had authorised the security arrangements, spoke to the man in the ambulance and tried to convince him to go to hospital and that the level of security was appropriate. The man continued to refuse to go and signed a medical disclaimer, so Officer A took the man back to his cell.

33. The man threw his medication in the bin in his cell and said he did not need it any more. Officer A retrieved the medication and arranged for it to be held in the orderly officer's safe with a view to returning it to healthcare staff in the morning. The man remained in his cell and did not complain of feeling unwell during the night.

34. The next morning, after hearing that the man had refused to go to hospital the evening before, Nurse C made an appointment for him to see Dr B the next day, 2 July.

35. At 11.30am, the man collected his lunch and an officer locked him in his cell at 12.00pm. At 1.30pm, Officer A unlocked the man's cell. The man was asleep so he continued to unlock the rest of the landing and then went back to the man's cell a few minutes later. The man had moved position and appeared to be breathing.

36. As he knew about the man's poor health, Officer A went back to the man's cell at around 4.00pm to check on him. He was concerned that the man was still in bed and went into the cell and found the man unresponsive. The officer radio did not work due to a poor signal on the wing so he ran to the wing office to telephone healthcare staff and asked them to come immediately. At 4.02pm, he called the prison's control room who immediately called an ambulance.

37. At 4.05pm, Nurse E and Nurse C arrived. They noted that the man was pale and had no pulse. Officer A helped to move him to the floor and the nurses started cardiopulmonary resuscitation. They attached a defibrillator, which showed no shockable heart rhythm and continued chest compressions. Paramedics arrived at 4.20pm and continued to attempt resuscitation. The man did not respond and, at 4.26pm, a paramedic pronounced his death.

Contact with the man's family

38. The prison chaplain, acted as the prison's family liaison officer. He could not contact the man's nominated next of kin, as the phone number the man had given was out of service and there was no address recorded. No relationship was given and she was listed as 'official other' on the record. At 6.55pm, the chaplain, contacted a close friend, who had visited the man a number of times, and informed him that the man had died.

39. On 15 July, police located two of the man's half brothers. The chaplain contacted them that day and offered support. The man's funeral was on 8 August 2014 and the prison paid the costs in line with national guidance.

Support for prisoners and staff

40. After the man's death, a prison manager debriefed the staff involved in the emergency response to allow them to discuss any issues arising and to offer support. The staff care team also offered support.

41. The prison posted notices informing other prisoners of the man'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 the man's death.

Post-mortem report

42. A post-mortem examination found that the man died from pulmonary thromboembolic disease (blood clots that develop over time blocking arteries from the heart to the lung that in turn reduce lung function) caused by the presence of broken pacing (pacemaker) wires with complete heart block (abnormal electrical pulses in the heart causing it to beat more slowly).

Findings

Clinical care

43. The man had Wolff-Parkinson-White syndrome, which was initially managed with a pacemaker. The clinical reviewer explained that, the presence of a pacemaker and the associated wires increase the risk of infection and blood clots. Doctors prescribed warfarin to reduce the risk of blood clots, but the medication is only effective if taken regularly. The man frequently declined his medication and the associated blood tests to monitor the clotting levels.

44. The man removed his pacemaker twice, leaving broken pacing wires in place. Although surgeons removed most of these, a small fragment remained. The presence of old pacing wires in the heart increases the risk of blood clots forming. The cardiologist was aware of the presence of the fragment of wires but advised no further treatment. The clinical reviewer noted that in some cases operative removal can be achieved, but the process can be risky, including death. The prison healthcare team appropriately followed the management advice of the cardiology team.

45. The post-mortem examination found that the man had developed a blood clot in his lung. The clinical reviewer noted that a blood clot in the lung can often mimic a chest infection. The man was diagnosed with a chest infection earlier in June 2014 that responded to antibiotics.

46. When the man became unwell on 30 June and refused to go to hospital he was not monitored during the night as there are no healthcare staff on duty at night at Highpoint. The next morning, when Nurse C discovered that the man had refused to go to hospital the night before, she made an appointment for him to see a GP the next day, 2 July. In these circumstances, we would have expected a clinician to have reviewed him on 1 July. The Head of Healthcare told us that since the man's death she has introduced a policy to ensure that all prisoners now receive an automatic nurse triage, and an emergency doctor's appointment if required, after they have refused treatment or when they on return from hospital. We therefore do not make a recommendation about this.

47. The man died because of complications relating to his heart condition. These were exacerbated by his frequent refusal to take medication or accept treatment. Toxicology tests indicate that when the man died, he was not taking any of his prescribed medication. He was aware of the severity of his heart condition and the risks associated with refusing treatment. Healthcare staff were satisfied he had the mental capacity to make decisions about his treatment. The clinical reviewer considered that the man was offered proactive, interventional care consistently, even though he declined treatment. We are satisfied that the man received a standard of healthcare that was equivalent to that he could have expected to receive in the community.

Restraints, security and escorts

48. 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.

49. On 30 June, when paramedics indicated that the man should go to hospital, an operational support grade and the head of residency and safety completed an escort risk assessment. The operational support grade gathered background information about the man from the prison computer system to allow the head of residency and safety to make a decision about the level of security required for the escort.

50. The risk assessment form showed that the man was on the enhanced level of the incentives and earned privileges scheme and had 43 recent adjudications (disciplinary charges). The head of residency and safety, told us that when he saw this and previous risk assessments, he decided that three officers should escort him using double handcuffs. He completed the escort documents and indicated that the man was a medium risk to the public and of escape. The risk of hostage taking and risk of outside assistance sections were not completed.

51. Healthcare staff noted that there were no medical objections to the use of restraints but added nothing further. We would have expected additional information about how or whether his health condition at the time affected his risk of escape, in line with guidance in a 2007 High Court judgment about the use of restraints for prisoners needing hospital treatment.

52. We reviewed the man's prison record and could not find any evidence of the 43 recent adjudications recorded on the escort risk assessment. Prison manager, A, confirmed that the man had no adjudications against him while he was at Highpoint; his last had been at HMP Wayland in May 2013. We are surprised that the head of residency and safety did not identify that it was implausible in the extreme that a prisoner with 43 recent adjudications would be rewarded by being on the enhanced level of the incentives and earned privileges scheme, which is designed to encourage and recognise good behaviour. Nor did he review this when the man made representations against the level of security.

53. We looked at previous escort risk assessments for the man at Highpoint, which the head of residency and safety said he took into account. These showed that he was previously escorted by two officers and the level of restraint was either a single handcuff or an escort chain (a long chain with a light handcuff at each end, one of which is attached to the prisoner and the other to an officer). During these escorts, the man was described as "polite throughout to prison and medical staff". It is therefore unclear to us what information the head of residency and safety and the operational support grade viewed before completing the escort risk assessment on 30 June, but it is apparent that this did not relate to the man.

54. Double handcuffing is usually required for moving high-risk prisoners in security categories A or B, in good health. When, exceptionally, double cuffs are used for a category C prisoner like the man, the Prison Service requires that reasons should be recorded in writing. We are not satisfied that the head of residency and safety gave sufficient reasons to justify this exceptional decision. Even if the information about the adjudications had been correct, there was nothing to connect them with an increased risk of escape and the head of residency and

safety did not assess the man as a high risk of escape, which might have merited additional security precautions.

55. Public protection is fundamental, but the risk assessment on 30 June was fundamentally flawed and the level of security was disproportionate to the assessed level of risk. This was particularly unfortunate as, until the additional security measures were imposed, the man appears to have been prepared to attend hospital for treatment. We cannot know whether this affected the outcome for the man and recognise that ultimately, it was his decision not to go to hospital, even if the escort risk assessment was unsound. We make the following recommendation:

The Governor should ensure that risk assessments for prisoners being taken to hospital fully take into account the health of a prisoner and are based on the actual risk the prisoner presents at the time. The use of double handcuffs for category C prisoners should be exceptional and fully justified in writing.