

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Brian Strotten a prisoner at HMP High Down on 31 December 2015

**A report by the Prisons and Probation Ombudsman
Nigel Newcomen CBE**

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 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 Brian Strotten died on 31 December 2015 in hospital, while a prisoner of HMP High Down. The cause of his death was unascertained. Mr Strotten was 27 years old. I offer my condolences to Mr Strotten's family and friends.

I am concerned that opportunities were missed to check Mr Strotten's health in the week before he was taken to hospital. When Mr Strotten was found unwell in his cell, there was an unexplained delay radioing an emergency code and, therefore, in calling an ambulance. I am also concerned that, when Mr Strotten was taken to hospital, the level of restraint used did not reflect his security risk. I have raised this matter before with HMP High Down and the Governor needs to make sure that managers authorising restraints understand the legal position and follow Prison Service guidance.

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

September 2017

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Summary

Events

1. On 2 October 2015, Mr Brian Strotten had his licence revoked and he was recalled to prison for taking drugs. At HMP High Down, a doctor continued his prescription for antidepressant and indigestion medications. He weighed 78kg.
2. Mr Strotten first reported sickness and diarrhoea on 24 November. On 10 December, a doctor admitted Mr Strotten to the healthcare unit for observation and blood tests. He was discharged on 11 December as his symptoms had stopped and his blood test results were normal, he weighed 78.6kg.
3. On 16 December, Mr Strotten told a nurse that he still felt unwell and she recorded his weight as 69 kg. On 18 December, a doctor reviewed Mr Strotten and was concerned about him as he looked pale, was short of breath and had lost weight. She requested urgent blood tests and suggested that he should be admitted to the healthcare unit, but he preferred to remain on the wing. The blood tests showed that further investigation was needed, but this was not followed up.
4. At 10.14am on 26 December, an officer raised the alarm when he found Mr Strotten unwell in his cell. A nurse responded, found Mr Strotten very unwell and had difficulty taking his observations. She asked for assistance and for officers to radio an emergency code, which would have prompted more healthcare staff to attend and an ambulance to be called. The emergency code was radioed at 10.51am, when an ambulance was called. We have not established the reason for this long delay. Mr Strotten was taken to hospital and officers used double handcuffs to restrain him, even though he was a clearly unwell category C prisoner. Restraints were removed shortly after he arrived at hospital to allow treatment to take place. Officers re-applied handcuffs two hours later, before finally removing them later that afternoon.
5. Mr Strotten's condition deteriorated and he was taken to intensive care where his mother visited him. He was transferred to another hospital the following day. Mr Strotten's family agreed to the withdrawal of life support. He died at 1.55pm on 27 December.

Findings

6. We agree with the clinical reviewer that a sudden loss of weight and abnormal blood test results should have been followed up. We are concerned that there was an unexplained delay radioing an emergency, which resulted in a delay calling an ambulance. Despite Mr Strotten's security category and poor health, double handcuffs were used without adequate justification when he was taken to hospital. We have brought this matter to the Governor's attention before.

Recommendations

- The Head of Healthcare should ensure that:
 - urgent tests are carried out without delay;

- abnormal blood results are promptly and appropriately investigated; and
- prisoners reporting weight loss should be properly monitored to determine the root cause.
- The Governor should ensure that all prison staff understand their responsibilities in a medical emergency and that there is no unnecessary delay in calling an ambulance.
- The Governor should ensure that all staff undertaking risk assessments for prisoners taken to hospital understand the legal position on the use of restraints 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.

The Investigation Process

1. 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.
2. NHS England commissioned a clinical reviewer to review Mr Strotten's clinical care at the prison.
3. The investigator visited High Down on 6 January 2016. She obtained copies of relevant extracts from Mr Strotten's prison and medical records.
4. The investigator interviewed four members of staff at High Down on 26 February and four members of staff on 21 March. She completed one telephone interview on 20 April and another on 27 April. The clinical reviewer joined her for the clinical interviews.
5. We informed HM Coroner for Surrey of the investigation who sent the results of the post-mortem examination. We have given the coroner a copy of this report
6. One of the Ombudsman's family liaison officers contacted Mr Strotten's mother, to explain the investigation and to ask if she had any matters that she wanted the investigation to consider. She wanted to know about the outcome of medical tests in the weeks before Mr Strotten died.
7. Mr Strotten's family received a copy of the initial report. They pointed out some factual inaccuracies and/or omissions. This report has been amended accordingly.
8. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies.

Background Information

HMP High Down

9. HMP High Down is a local prison near Sutton, in Surrey, which at the time of Mr Strotten's death held up to 1,150 men. Virgin Care provides primary health services at the prison, Achor Healthcare the GP services and Central and North West London (NHS Foundation Trust) in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

10. The most recent inspection of HMP High Down was in January 2015. Inspectors reported that health services were good overall, but staff shortages resulted in too many cancelled appointments. Prisoners had prompt access to a range of pharmacy services, which reduced the need for GP appointments, which the inspectorate considered good practice.

Independent Monitoring Board

11. 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 was concerned about the negative effect of low staffing levels, which reduced prisoners' time out of their cells and hampered communication between officers and prisoners. Managerial and system changes had led to improved attendance at healthcare appointments.

Previous deaths at HMP High Down

12. Prior to Mr Strotten's death, where the cause of death was unascertained, there had been four natural causes deaths at High Down since January 2014. We have raised the issue of the inadequately justified use of double handcuffs before.

Key Events

13. On 28 August 2015, Mr Brian Strotten was released from HMP Lewes to an approved premises after serving a 21 month sentence for sexual offences. On 2 October 2015, Mr Strotten's licence was revoked and he was recalled to prison for taking illicit drugs.
14. When he got to HMP High Down, a healthcare assistant completed Mr Strotten's reception medical assessment. Mr Strotten said he had been prescribed omeprazole (for indigestion) and mirtazepine (an antidepressant) in the community. He weighed 78 kg.
15. On 6 October, the prison received Mr Strotten's medical records from the community. A prison GP prescribed Mr Strotten the medication he had been taking in the community. On 20 October, Mr Strotten told a nurse that omeprazole made him nauseous, so she prescribed him lansoprazole (also for indigestion) instead.
16. On 24 November, Mr Strotten told a nurse that he had been sick four times in six hours. The nurse gave Mr Strotten rehydration treatment and advised him to take it until his sickness stopped. On 9 December, Mr Strotten told a nurse that he had abdominal pain and had been vomiting. The nurse advised him to drink plenty of fluid and made a doctor's appointment for the next day.
17. On 10 December, Mr Strotten told a prison GP that he had been sick and had diarrhoea for four days, then he felt better for a week and then the problem returned. She admitted him to the healthcare unit for observation and for blood tests. A nurse asked officers to check Mr Strotten's cell on the wing to find out if he had been taking his medication.
18. On 11 December, officers searched Mr Strotten's cell and found unopened boxes of mirtazapine and lansoprazole, so contacted healthcare staff to alert them. A prison GP saw him later that day and, as he had experienced no more sickness or diarrhoea, she discharged him. She asked for more blood tests, which came back indicating that his platelets were dropping, so recorded that Mr Strotten should have repeat blood tests in January 2016. A nurse recorded that Mr Strotten weighed 78.6 kg in her assessment of him before he was discharged.
19. On 16 December, Mr Strotten told a nurse that he said he was having difficulty opening his bowels. She noted that he looked pale and requested a GP appointment for him. She recorded his weight was 69 kg, a 9.6 kg loss of weight in five days.
20. On 18 December, a prison GP saw Mr Strotten and found him to be short of breath and pale. She noted that had lost weight and had had sickness and diarrhoea intermittently for a month. She told the investigator that Mr Strotten presented with a 'whole collection of generalised symptoms' and she was concerned about him. She suggested that she could admit him to the

healthcare unit again, but he said he would prefer to remain on the wing. The doctor asked for urgent blood tests.

21. On 23 December, a nurse took a blood sample and on 24 December recorded that the results were normal apart from one result, raised Plasma C-reactive protein test, indicating an infection or inflammation, which needed to be reviewed by a doctor. The nurse sent a message to the GP asking for a review. No one reviewed Mr Strotten before he collapsed two days later.

Saturday 26 December

22. On Saturday 26 December, an officer unlocked Mr Strotten's cell door and told the investigator that Mr Strotten said good morning. He left his cell door open. A nurse recorded that Mr Strotten refused to take his medication that morning. He told the investigator that he could not remember seeing Mr Strotten at the medication hatch and said that he might have either refused to take his medication or did not go to the medication hatch to collect it.
23. Later that morning, Mr Strotten rang his cell bell and told officers that he was not feeling well. An officer responded and thought that Mr Strotten seemed weak but was able to walk. He told the investigator that he asked a nurse who was working on the wing at the time to see Mr Strotten, but she was busy, so he radioed a code amber (a code to request medical assistance for a non-life-threatening situation) at 10.14am.
24. A nurse was responsible for responding to code ambers that day and was working on the other side of the prison. She tried to contact the nurse who was working on the wing to ask her to respond to the code amber instead. The nurse did not answer the call for five minutes and then explained that she was too busy, so the response nurse walked across the prison to see Mr Strotten, about a five minute walk.
25. The response nurse told the investigator that she took an emergency medical bag with her, but no oxygen. She said that when she got to Mr Strotten's cell, she found him pale, cold and said he had problems catching his breath. She had difficulty getting any readings when trying to take his pulse and blood pressure, but found his oxygen level was very low. Shortly after arriving, she asked nearby officers to get some oxygen and another nurse. She asked an officer to radio a code blue (which indicates a medical emergency when a prisoner is unconscious, not breathing or having breathing difficulties), although she could not recall precisely what time she asked this or who she spoke to. An officer radioed a code blue at 10.51am. No one has been able to account for the delay. The control room called an ambulance at 10.52am and it arrived at the prison at 11.00am. The nurse told the investigator that Mr Strotten was talking but was very weak and cold. Paramedics took over Mr Strotten's treatment and decided to take him to hospital.
26. A nurse completed the medical section of the escort risk assessment, the prison has been unable to confirm the identity of this nurse. The nurse recorded that Mr Strotten's condition was not life threatening, that he had a

terminal illness (which was incorrect) and that he was not fully mobile but was awake, breathing and had 'normal orientation'. The nurse did not see Mr Strotten, but did not object to the use of restraints being applied on the basis of his medical record.

27. A prison manager did not see Mr Strotten either, but authorised the use of restraints and specified that Mr Strotten should be restrained using double handcuffs (the prisoner having his hands handcuffed in front of him and then having one wrist attached to a prison officer by an additional set of handcuffs) and an escort chain (a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer) could be used during treatment.
28. The ambulance records show that the ambulance left the prison at 11.49am. Mr Strotten arrived at the Accident & Emergency Department at 12.09pm.
29. The prison manager spoke to Mr Strotten's doctor at 12.35pm and authorised the restraints to be removed for medical treatment. Officers put restraints back on at 2.35pm following another conversation between the doctor and the prison manager. The restraints were finally removed at 3.46pm. Mr Strotten's mother arrived at the hospital at 6.15pm and visited Mr Strotten in intensive care.
30. On 27 December, Mr Strotten was transferred to the intensive care unit at another hospital. On 31 December, Mr Strotten's mother was advised by doctors that there was nothing further they could do to help him and agreed to turn off his life support machine. Mr Strotten died at 1.55pm.

Contact with Mr Strotten's family

31. An officer contacted Mr Strotten's mother at 4.20pm when the hospital told officers that Mr Strotten was critically ill. She met Mr Strotten's mother and her family at the hospital later that day and stayed in touch with her over the next few days.
32. The funeral took place on 1 February and the prison contributed to the funeral costs, in line with national instructions.

Support for prisoners and staff

33. Although there was no formal debrief when Mr Strotten was taken to hospital, or when he died, all staff who responded to his collapse on 26 December and those who escorted him to hospital were offered the support of the prison's care team.
34. The prison posted notices informing other prisoners of Mr Strotten'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 Strotten's death.

Post-mortem report

35. A post-mortem examination recorded that the cause of Mr Strotten's death was unascertained. Blood samples used for the toxicology tests were taken on 27 December and found no illicit substances in Mr Strotten's blood. When he was taken to hospital on 26 December, Mr Strotten told a doctor that he had smoked new psychoactive substances (NPS). The toxicology tests included analysis for new psychoactive substances (NPS), but found none. A toxicologist explained that NPS usually can remain in the body up to 48 hours after use, so it would have been detected if Mr Strotten had taken NPS before he collapsed on 26 December.

Findings

Clinical care

36. On 18 December, a doctor reviewed Mr Strotten and recorded that he had lost weight. Although she asked for urgent blood tests, his blood sample was not taken for five days. The results indicated that Mr Strotten needed to be reviewed because he was likely to have an infection or inflammation, but he was not reviewed before he collapsed two days later.
37. The clinical reviewer concluded that the doctor should have made a follow up appointment to review Mr Strotten the week after the appointment on 18 December, in light of his unexplained weight loss. The abnormal blood result should also have prompted a review. As post-mortem tests have not established what caused Mr Strotten's death, we cannot be sure that further investigation or monitoring would have changed the outcome in this case, but we agree with the clinical reviewer and make the following recommendation:

The Head of Healthcare should ensure that:

- **urgent tests are carried out without delay;**
- **abnormal blood results are promptly and appropriately investigated; and**
- **prisoners reporting weight loss should be properly monitored to determine the root cause.**

Emergency Response

38. On 26 December, an officer radioed a code amber because he did not consider Mr Strotten to be in a life-threatening condition. When the response nurse understood the seriousness of Mr Strotten's condition, she said that she did not use her own radio to call a code blue because she was looking after him. She asked an officer to radio a code blue on her behalf, but there was an unexplained and substantial delay in the code being called.
39. The Head of Healthcare told the investigator that he completed an internal investigation after Mr Strotten's death to examine the reasons for the delay. As a result of that investigation, nurses have been reminded to use their own radio to make an emergency call. An operational manager also reviewed the incident on behalf of the prison. She agreed with the Head of Healthcare's recommendation that nurses should radio emergency calls themselves. She also recommended that the prison should no longer use code amber. Neither investigation established the reason for the delay.
40. We are concerned that there was an unexplained delay in radioing a code blue, and therefore calling an ambulance in this case. The response nurse should have radioed a code blue when she realised that Mr Strotten's condition was serious, but officers should have acted urgently following her request. We make the following recommendation:

The Governor should ensure that all prison staff understand their responsibilities in a medical emergency and that there is no unnecessary delay in calling an ambulance.

Use of restraints

41. 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. 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 judgement 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.
42. Mr Strotten was taken to hospital as an emergency and restrained with double cuffs. Shortly after arrival Mr Strotten's restraints were removed to allow medical treatment. An escort chain was applied at 2.35pm and then removed finally at 3.46pm. The prison manager told the investigator that the decisions to remove and reapply restraints were made by him after a discussion with Mr Strotten's doctor.
43. 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 Mr Strotten, the Prison Service requires that reasons should be recorded in writing. There is no evidence to support this decision and we can see no reason why it would be justified. The risk assessment used was based entirely on the prison's view of his security risk with little evidence that there was any consideration of how his health condition impacted on this risk, as the 2007 High Court judgement requires.
44. 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 on the use of restraints 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. The use of double handcuffs for category C prisoners should be exceptional and fully justified in writing.

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