

**Prisons &  
Probation**

**Ombudsman**  
Independent Investigations

# Independent investigation into the death of Mr Nigel Embling a prisoner at HMP Warren Hill on 9 January 2017

**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 Nigel Embling died on 9 January 2017 of heart disease while at HMP Warren Hill. He was 58 years old. I offer my condolences to those who knew him.

I am satisfied that Mr Embling received a good standard of clinical care at Warren Hill. The post-mortem found Mr Embling had heart disease, which was not known before he died. Although I am satisfied that there is nothing healthcare staff could have done to predict or prevent his sudden death, the investigation does identify a number of areas for improvement in the conduct of emergency responses.

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**

**July 2017**

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# Summary

## Events

1. On 26 June 2003, Mr Embling was sentenced to an indeterminate sentence for public protection for violent offences. He spent time in several prisons and was moved from HMP Chelmsford to HMP Warren Hill on 3 October 2016.
2. At his reception health screen, Mr Embling expressed concerns about being underweight due to his vegan diet. The nurse recorded a BMI of 22 (Body Mass Index – a BMI of 18.5 to 24.9 is considered a normal weight range). He was a moderate cigarette smoker and accepted smoking cessation advice. Mr Embling had received mental health intervention in the past and although he told the nurse he did not require it, she explained the referral process to him. Mr Embling suffered with psoriasis for which a prison GP prescribed cream.
3. On 6 October, another nurse examined Mr Embling and discussed his history of substance misuse, including using new psychoactive substance (NPS – a range of drugs that have been designed to mimic established illicit drugs) at his previous prison. Mr Embling had received harm reduction advice from a substance misuse worker during his induction, and attended further meetings on 2 and 14 November.
4. The nurse noted Mr Embling's previous episodes of depression, which he explained that he was able to manage himself, and knew how to get support if he needed it. She recorded a blood pressure reading of 130 / 70 (this is slightly high).
5. Mr Embling had epididymo-orchitis (an inflammation of the testicle or duct behind the testicles). On 20 October, a prison GP identified a small cyst and referred him for an ultrasound scan on 6 December. Mr Embling's symptoms improved and he declined the hospital appointment.
6. On 1 November, Mr Embling suffered a seizure having smoked a cigarette containing NPS. A week later, he self-harmed and staff managed him under suicide and self-harm monitoring (ACCT) procedures until 25 November.
7. Mr Embling began taking varenicline (smoking cessation medication) on 24 November and remained largely smoke-free until he died. There were no other significant entries in this medical record.

## Events of 8 to 9 January

8. On 8 January, an officer locked Mr Embling's cell at 7.30pm as usual. Mr Embling appeared to be well. The following morning at 7.50am, an officer unlocked Mr Embling's cell and found him unresponsive. The officer asked prisoners to alert staff while he checked Mr Embling's pulse.
9. Two officers responded and called a code blue emergency (which indicates that a prisoner is having difficulty breathing) over the radio at 7.55am.
10. The officers on the scene were not first aid trained and waited for healthcare staff. Two nurses arrived at 8.00am. They moved Mr Embling to the floor and began

cardiopulmonary resuscitation (CPR). The duty first aider arrived at 8.05am and assisted with CPR. The paramedics arrived at 8.15pm and continued CPR but declared Mr Embling dead at 8.40am.

## Findings

11. We agree with the clinical reviewer that the standard of care Mr Embling received at Warren Hill was equivalent to that he could have expected in the community. His substance misuse and mental health needs were addressed, and he did not display any symptoms of heart disease. His death was sudden and unexpected.
12. The member of staff who unlocked Mr Embling's cell did not carry a radio and had to ask prisoners to alert staff. This resulted in a five minute delay in a code blue emergency being conveyed. In addition, a lack of first aid trained staff resulted in a ten minute delay in administering first aid, and it took ten minutes for the duty first-aider to respond to a code blue emergency call, arriving five minutes after healthcare staff.

## Recommendations

- The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency and are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity.
- The Governor should ensure that staff unlocking prisoners understand how to raise an alarm in an emergency and that key staff are appropriately equipped with radios to enable prompt action.

## The Investigation Process

13. The investigator issued notices to staff and prisoners at HMP Warren Hill informing them of the investigation and asking anyone with relevant information to contact her. No one responded.
14. The investigator visited Warren Hill on 17 January 2017 and obtained copies of relevant extracts from Mr Embling's prison and medical records.
15. NHS England commissioned a clinical reviewer to review Mr Embling's clinical care at the prison.
16. We informed HM Coroner for Greater Suffolk of the investigation who gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
17. Mr Embling had not named any next of kin and had not been in contact with members of his family for many years. Enquiries made by prison staff with several parties, including the police, were unsuccessful.
18. The initial report was shared with the Prison Service. The Prison Service did not find any factual inaccuracies.

# Background Information

## HMP Warren Hill

19. HMP Warren Hill is a medium secure prison that holds nearly 260 men mostly serving life sentences.
20. Care UK provides healthcare services. Nurses are on duty between 7.30am and 7.45pm during the week, and 7.30am to 5.30pm on weekends and public holidays. Nurses provide regular clinics for chronic conditions, substance misuse and mental health. Doctors consult at the prison from 10.45am to 1.00pm on Monday to Friday.

## HM Inspectorate of Prisons

21. The most recent inspection of HMP Warren Hill was in October 2015. Inspectors reported that prisoners were very positive about the provision of health services, and health staff knew their patients well. However, too few discipline staff were trained in first aid, which could have led to poorer health outcomes in a medical emergency. The inspectorate recommended that sufficient discipline staff should be trained in first aid including in automated defibrillation and all prison staff should know where defibrillators are to ensure a prompt response in emergencies.
22. The substance misuse strategy was comprehensive and information sharing between departments was good. The Rehabilitation for Addicted Prisoners Trust (RAPt) ran substance misuse services and provided all new arrivals with information about new psychoactive substances (NPSs). All prisoners could access appropriate drug and alcohol support services and peer mentoring was available.

## Independent Monitoring Board

23. 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 May 2016, the IMB reported that GPs and healthcare team were embarking on a programme to reduce medication dependency and a range of clinics help men to deal with established problems, including dependence on tobacco. The IMB considers that overall the medical provision in Warren Hill is caringly and carefully provided and at least as good as is on offer by the National Health Service outside the prison.

## Previous deaths at HMP Warren Hill

24. Mr Embling was the second prisoner to die from natural causes at Warren Hill. There have been no deaths since. There were no similarities between the circumstances of Mr Embling's death and previous death at the prison.

## Key Events

25. On 26 June 2003, Mr Embling was sentenced to an indeterminate sentence for public protection for violent offences. He was moved from HMP Chelmsford to HMP Warren Hill on 3 October 2016.
26. At his reception health screen, a nurse noted that Mr Embling chose a vegan diet supplemented by Complan (a nutritional drink). He told her he had concerns about being underweight and she recorded a BMI of 22 (Body Mass Index – a BMI of 18.5 to 24.9 is considered a normal weight range). Mr Embling told her he had received mental health intervention in the past but that he did not currently require any support. She explained the referral process to him if he required it in the future. Mr Embling was a moderate cigarette smoker of 30 years, and accepted smoking cessation advice. He suffered with psoriasis, and the following day a prison GP prescribed cream along with a prescription for Complan.
27. During a second health screen on 6 October, a nurse noted that Mr Embling described himself as an alcoholic prior to his imprisonment, and that he had misused drugs in the past, including heroin. He admitted using new psychoactive substance (NPS – a range of drugs that have been designed to mimic established illicit drugs) at his previous prison but told her that he had learnt from his mistake. She noted that he had received specific advice about the risks of NPS due to the availability of it on the wings and concluded that he appeared committed to progression. Mr Embling received harm reduction advice from a substance misuse worker during his induction, and attended further assessments on 2 and 14 November.
28. The nurse noted that there was evidence Mr Embling had self-harmed and had suffered with depression. He told her he could manage his depression without assistance and explained that he knew how to get support if he needed it. Mr Embling had completed treatment for hepatitis C (a virus that can infect the liver). A blood test on 21 November confirmed the completion of treatment.
29. During the examination, the nurse recorded a slightly high blood pressure reading of 130/70. The systolic (upper) value of 130 is in the prehypertension range (prehypertension is the high normal range, a warning sign of developing high blood pressure in the future). She advised Mr Embling to lead a healthier lifestyle.
30. On 20 October, a prison GP noted Mr Embling had testicular pain from a diagnosed case of epididymo-orchitis (an inflammation of the testicle or duct behind the testicles) but had not taken the medication because he had previously been advised that it would clash with his hepatitis C treatment. Upon examination, the GP noted a small cyst and arranged for an ultrasound scan on 6 December. Mr Embling chose not to attend the appointment on 6 December because by then the symptoms had eased. The GP repeated Mr Embling's prescriptions and noted that although his weight was stable it would be monitored monthly.
31. On 1 November, Mr Embling smoked the end of a cigarette he found on the floor and suffered a seizure. Prison staff suspected the cigarette contained NPS. Mr

Embling said he had picked up the cigarette because he had run out of tobacco and denied taking NPS knowingly.

32. On 7 and 9 November, Mr Embling self-harmed and staff began suicide and self-harm monitoring (ACCT) procedures. A nurse reviewed Mr Embling on 8 November and noted a physical assessment and blood tests were required when he was more settled. On 24 November, a nurse reviewed the ACCT and closed it the following day.
33. On 24 November, during an ACCT review of Mr Embling, a nurse advised him to book a GP appointment to monitor his physical health, particularly his psoriasis and weight. As these were not urgent issues, it was Mr Embling's responsibility to make an appointment. Mr Embling did not request any further GP appointments.
34. On the same day, a prison GP prescribed Mr Embling varenicline (smoking cessation medication). Aside from a regression during the Christmas period, Mr Embling remained smoke-free until he died.
35. There were no other significant entries in Mr Embling's medical record.

#### **Events of 8-9 January 2017**

36. During the evening of 8 January, an officer spoke with Mr Embling and locked his cell at 7.30pm as usual. Mr Embling did not appear to be unwell.
37. On 9 January at 7.50am, an officer unlocked Mr Embling's cell. He greeted Mr Embling and when he did not get a response he spoke to Mr Embling again and entered the cell. He gently shook Mr Embling but he did not respond. He checked his pulse and as he did not carry a radio, told nearby prisoners to alert members of staff.
38. Two officers responded at 7.55am and the first officer called a code blue emergency (which indicates that a prisoner is having difficulty breathing) over the radio at 7.55am.
39. The officers on the scene were not first aid trained and waited for two nurses to arrive, recorded at 8.00am. A nurse felt Mr Embling was warm to the touch but she could not detect a pulse. With assistance from an officer she moved Mr Embling to the floor and began cardiopulmonary resuscitation (CPR). A senior manager and duty first aider arrived at 8.05am and assisted with CPR until the paramedics arrived. The paramedics arrived at the prison 8.15am and continued CPR. Mr Embling was declared dead at 8.40am.

#### **Contact with Mr Embling's family**

40. Mr Embling had not named a next of kin while in prison. After he died, a senior manager identified that Mr Embling had not received any social visits for seven years and that his solicitor and offender manager may have more information. Despite extensive efforts, a next of kin could not be identified.
41. The prison arranged and paid for Mr Embling's funeral, which was held on 21 March 2017.

### **Support for prisoners and staff**

42. After Mr Embling's death, a senior 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.
43. The prison posted notices informing other prisoners of Mr Embling's death, and offering support. Staff reviewed all prisoners assessed as being at risk of suicide or self-harm in case they had been adversely affected by Mr Embling's death.

### **Post-mortem report**

44. The post-mortem report concluded that Mr Embling died of ischaemic heart disease.

# Findings

## Clinical care

45. Mr Embling had been at Warren Hill for three months when he died. In his first few days, healthcare assessments identified that he was a smoker with a history of hepatitis C, epididymo-orchitis, and that he was concerned about his weight. Mr Embling received smoking cessation treatment, and was appropriately referred for a conclusive hepatitis C test, and testicular ultrasound. Although he was not underweight his weight was monitored. Although Mr Embling took NPS, he received appropriate intervention from the substance misuse team before and after the event, and his mental health needs were fully addressed.
46. A blood pressure reading during his initial health screen indicated possible high blood pressure in the future, and a nurse appropriately advised Mr Embling on leading a healthy lifestyle. The process of routinely monitoring a borderline high blood pressure was not in place at the time. However, the Head of Healthcare has reviewed this practice since Mr Embling's death.
47. The clinical reviewer concluded that the standard of care Mr Embling received was equivalent to that he could have expected in the community. Mr Embling was not overweight, he kept fit and chose a vegan diet. He did not display any signs or symptoms of ischaemic heart disease. We are satisfied healthcare staff treated him appropriately. Mr Embling's death was sudden and unexpected and there was nothing that healthcare staff could have done to prevent it.

## Emergency response

48. The member of staff who found Mr Embling did not have a radio in order to call a code blue emergency response and upon calling for assistance, it took five minutes for a code blue to be transmitted over the radio. The officers who first responded were also not first aid trained, and therefore did not attempt cardiopulmonary resuscitation. This resulted in a ten-minute delay administering first aid. In addition, the duty first aider arrived ten minutes after the code blue emergency call, five minutes after healthcare staff. Although the consequence of this delay is not known, the Governor needs to ensure that there is a sufficient distribution of trained staff to ensure a safe environment, as the first minutes for CPR are critical. The Governor also needs to ensure that members of staff conducting morning unlock carry a radio to ensure that an emergency code can be conveyed as soon as possible. We therefore make the following recommendations:

**The Governor should ensure that there are sufficient staff on duty at all times with up to date training to administer basic life support in an emergency and are aware of the importance of starting cardiopulmonary resuscitation at the earliest opportunity.**

**The Governor should ensure that staff unlocking prisoners understand how to raise an alarm in an emergency and that key staff are appropriately equipped with radios to enable prompt action.**



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