Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Derrick Johnston a prisoner at HMP Swaleside on 12 August 2018

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 Derrick Johnston died on 12 August 2018 at HMP Swaleside. He died of a cardiac arrest after choking on his own vomit. Mr Johnston was 43 years old. I offer my condolences to Mr Johnston's family and friends.

Mr Johnston had received a long prison sentence in 2016 and arrived at Swaleside in 2017 with no known health concerns. He was considered to be a responsible prisoner and did not come to the attention of operational staff or healthcare staff regularly. No drugs or alcohol were found in his system after his death and his death appears to have been an unfortunate accident.

When Mr Johnston was found collapsed in his cell, the appropriate emergency procedures were followed but we are concerned about a delay in calling an ambulance. We make one recommendation.

Sue McAllister, CB
Prisons and Probation Ombudsman **March 2019**

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Summary

Events

1. In February 2016, Mr Johnston was sentenced to 21 years imprisonment for kidnap, wounding and drugs offences. He arrived at HMP Swaleside on 23 March 2017 with no significant medical history. He was prescribed an inhaler for mild asthma.

2. Mr Johnston did not access healthcare services in the prison apart from seeing the dentist. He was known to be helpful to staff and there were no documented concerns about his behaviour in prison.

3. On 12 August 2018, an Operational Support Grade saw Mr Johnston collapsed in his cell when he was completing an early evening roll check. He made an emergency call over the radio and officers responded. The control room requested an ambulance.

4. Officers entered Mr Johnston's cell and checked for a pulse. A prison paramedic arrived at the cell and assessed Mr Johnston. He removed vomit from his mouth with a portable suction device and commenced cardiopulmonary resuscitation (CPR), supported by other officers. Ambulance paramedics arrived and continued CPR. This was unsuccessful and Mr Johnston was pronounced dead by paramedics at 8.42pm.

Findings

5. Mr Johnston was considered to be a responsible and helpful prisoner who did not have any health problems and was not well known to healthcare staff.

6. When he was found during the early evening roll check, an emergency call was made appropriately and CPR began without delay. However, there was a delay in calling an ambulance which the prison could not explain, and we make one recommendation.

Recommendation

- The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies and ensure that control room staff call an ambulance as soon as an emergency code is called.

The Investigation Process

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

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

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

10. We informed HM Coroner for Mid Kent and Medway District of the investigation. She gave us the results of the post-mortem examination and we have sent her a copy of this report.

11. Mr Johnston did not name a next of kin and no one could be found to be told of his death or to explain our investigation.

12. The initial report was shared with HM Prison and Probation Service (HMPPS). HMPPS did not find any factual inaccuracies and their action plan is annexed to this report.

Background Information

HMP Swaleside

13. HMP Swaleside, on the Isle of Sheppey, is part of the Long-Term and High Security estate. It houses up to 1,112 men. IC24 Integrated Care provides primary healthcare at Swaleside. There is 24-hour nursing cover, which includes a qualified nurse and a healthcare assistant at night. Minster Medical Group provides GP cover from 9.00am to 5.00pm from Monday to Friday, while Medoc provides an out of hours GP service.

HM Inspectorate of Prisons

14. The most recent inspection of HMP Swaleside was conducted in April 2016. Inspectors reported that only 15% of prisoners were satisfied with healthcare provision. While prisoners had access to an appropriate range of primary care services and visiting specialists, they reported that not all clinics which dealt with long-term conditions ran regularly because staffing was inconsistent.

Independent Monitoring Board

15. 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 30 April 2018, the IMB reported that although the prison was fully staffed, many staff members were young and inexperienced which caused issues with the control and discipline of prisoners. The IMB continued to receive complaints about the treatment and waiting times for healthcare services.

Previous deaths at HMP Swaleside

16. Mr Johnston was the fourteenth prisoner to die at Swaleside since January 2015 and the seventh to die from natural causes. There are no similarities between these previous deaths and that of Mr Johnston.

Key Events

17. On 22 June 2015, Mr Johnston was remanded to HMP Wandsworth for kidnap, wounding and drugs offences. This was not his first time in prison. On 4 February 2016, he was sentenced to 21 years imprisonment. Mr Johnston transferred to HMP Swaleside on 23 March 2017 with no significant medical history. He was prescribed an inhaler for mild asthma.

18. Mr Johnston had limited contact with healthcare during his time at Swaleside. In February and March 2018, Mr Johnston saw a dentist and began the process to have a denture fitted. In April and May, Mr Johnston walked out of the dental clinic as he was angry about the service he was receiving.

19. On 17 July, Mr Johnston did not attend a routine NHS health check appointment offered to check for risk of serious illness.

20. Mr Johnston was considered to be a helpful prisoner by officers, with entries in his prison record to show that he volunteered to empty bins on the wing. In July 2018 he alerted staff to an improvised weapon in a cell he was painting. He also attended a weekend training course to become a Listener. (These are prisoners trained by the Samaritans to support other prisoners.)

21. On 12 August, an officer locked Mr Johnston into his cell for the evening. An Operational Support Grade (OSG) was completing the evening roll check when he looked into the cell and saw Mr Johnston collapsed on the floor between his cupboard and sideboard. The OSG immediately radioed a code blue emergency at 7.52pm. (This indicates a medical emergency where a prisoner is unconscious, not breathing or having breathing difficulties.) The control room log records that an ambulance was called at 7.57pm. The ambulance records show that they first received at a call at 8.01pm.

22. A Supervising Officer and two officers responded to the emergency call and entered the cell. The officers moved Mr Johnston to check if he was breathing. Some vomit came out of his mouth. They laid him in the recovery position and tried to find a pulse.

23. A prison paramedic responded to the code blue call and arrived as Mr Johnston was being placed into the recovery position. The prison paramedic said that Mr Johnston had no pulse and minimal breathing. He moved him onto his back and started CPR. Mr Johnston had vomit around his mouth and the prison paramedic used a portable suction device to try to clear the vomit. He inserted an airway and gained intravenous access to administer adrenalin. A Custodial Manager arrived and took over chest compressions, alternating with another Custodial Manager. An officer assisted by giving ventilation. A defibrillator was applied and advised no shocks to be given.

24. The ambulance paramedics arrived at the scene at 8.10pm and continued CPR. They pronounced Mr Johnston dead at 8.42pm.

Post-mortem report

25. The post-mortem found Mr Johnston's cause of death to be the aspiration of gastric contents (choking on his vomit). There was no evidence of any disease to account for this and the toxicology tests found no drugs or alcohol or anything else of significance in Mr Johnston's system. The pathologist concluded it was likely that food had made its way above his windpipe which caused his nervous system to suddenly stimulate his brain and to lower his blood pressure and heart rate to the extent that he had a cardiac arrest.

Contact with Mr Johnston's family

26. A family liaison officer was appointed on the day of Mr Johnston's death. Mr Johnston had no named next of kin and the family liaison officer tried several lines of enquiry to find a family member who could be told the news of his death. Unfortunately, no family details could be established. The family liaison officer arranged the funeral which took place on 18 October 2018.

Support for prisoners and staff

27. After Mr Johnston's death, an operational 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.

28. The prison posted notices informing other prisoners of Mr Johnston'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 Johnston's death.

Findings

Emergency response

29. On 12 August, Mr Johnston was found collapsed in his cell during the evening roll check by an OSG. He appropriately called a code blue emergency which was recorded at 7.52pm. The control log documents the ambulance reference details at 7.57pm and ambulance service records show a call was initially received by them at 8.01pm. An officer was working in the control room when the emergency call was received from the OSG. He has since retired and so cannot explain the reason for the delay in an ambulance being called. Although on this occasion the delay had no impact on the outcome for Mr Johnston, there should be no delays in calling an ambulance and we make the following recommendation:

    The Governor should ensure that all prison staff are made aware of, and understand, their responsibilities during medical emergencies and ensure that control room staff call an ambulance as soon as an emergency code is called.

30. The medical response to the incident was led by a prison paramedic. He described the response as an organised cardiac arrest situation where staff took turns in giving CPR. As a paramedic, he was able to use advance life-saving skills, including gaining intravenous access and administering adrenalin. The clinical reviewer has made a recommendation about the use of advance life-saving skills that the Head of healthcare will want to consider. We agree with the clinical reviewer that the care Mr Johnston received was equivalent to that he could have expected to receive in the community.

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