Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Hamad Jabar a prisoner at HMP Wandsworth on 28 February 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 Hamad Jabar died of coronary heart disease and the effects of psychoactive substances (PS) on 28 February 2018, while a prisoner at HMP Wandsworth. He had a serious pre-existing heart condition and it appears that the effects of the PS he was using at the time of his death, precipitated a heart attack. He was 37 years old. I offer my condolences to Mr Jabar's family and friends.

I am satisfied that the healthcare Mr Jabar received for his various health issues, including his heart condition, was equivalent to that he could have expected in the community.

I am concerned that when Mr Jabar informed an officer that he had chest pain on the day he died, the officer did not use an emergency medical code to call assistance. There was also a considerable delay in paramedics reaching Mr Jabar from the prison's gate, which is unacceptable. The clinical reviewer said that the delay during the emergency response could have affected the outcome for Mr Jabar.

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

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

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Summary

Events

1. On 15 December 2017, Mr Hamad Jabar was sentenced to four weeks imprisonment for robbery and at the same time was also recalled to serve the remainder of a previous sentence. He was transferred to HMP Wandsworth.

2. Mr Jabar suffered from Type two diabetes and had a history of heart disease. Healthcare staff at Wandsworth frequently reviewed and managed his health issues.

3. Mr Jabar had a recorded history of using cannabis and psychoactive substances (PS) in custody. He continued to use illicit drugs at Wandsworth. Prison staff at Wandsworth had virtually no recorded interactions with Mr Jabar during his two months there and were not aware that he was using drugs.

4. On 28 February 2018, at around 1.13pm, Mr Jabar told an officer that he was having chest pain. His cellmate said he was using PS. The officer radioed for healthcare assistance but did not use an emergency code. Around three minutes later, healthcare staff arrived but Mr Jabar's condition deteriorated and he became unresponsive. Nurses started cardiopulmonary resuscitation (CPR).

5. At around 1.39pm, paramedics arrived at Mr Jabar's cell and continued with CPR. At 3.10pm, they took Mr Jabar to a hospital, where he was pronounced dead at 3.37pm.

6. The post-mortem examination found that Mr Jabar died of coronary heart disease in combination with PS intoxication.

Findings

Clinical Care

7. Mr Jabar died because of the adverse effects of PS on his pre-existing heart condition.

8. The clinical reviewer concluded that the clinical care provided to Mr Jabar at Wandsworth was equivalent to that he could have expected to receive in the community. Mr Jabar's cardiovascular risk factors and diabetes were regularly and adequately checked. His heart disease was stable and, although he regularly saw clinicians, he did not complain of chest pain before the day of his death

Substance Misuse

9. Mr Jabar had used illicit drugs during his previous period in custody and it appears that he continued to do so at Wandsworth. Staff were not aware of this. We are concerned that prison staff did not engage with Mr Jabar during his two months at Wandsworth. If they had done so, they might have been aware of his drug use.

Emergency Response

10. The officer who saw Mr Jabar when he was complaining of chest pain did not radio a 'code blue' medical emergency. (This is an urgent call which indicates that a prisoner is unconscious, has difficulty breathing or chest pain and prompts the immediate call of an ambulance.)

11. There was an avoidable delay in paramedics reaching Mr Jabar from the prison's gate. This may have affected the outcome for Mr Jabar.

Recommendations

- The Governor should:
    - ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and in particular, that they call the correct emergency medical code so that there is no delay in calling an ambulance and healthcare staff take the relevant equipment to the emergency;
    - provide the Ombudsman with evidence of the implementation of our previous recommendation on this subject made following the death of a prisoner in October 2017; and
    - review arrangements for paramedics' access to a prisoner to reduce avoidable delays.

The Investigation Process

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

13. The investigator obtained copies of relevant extracts from Mr Jabar's prison and medical records in March 2018.

14. The investigation was suspended between March and October 2018, pending the results of the post-mortem and toxicology reports.

15. The investigator interviewed six members of staff at Wandsworth on 19 November 2018.

16. NHS England commissioned a clinical reviewer to review Mr Jabar's clinical care at the prison. The clinical reviewer conducted three interviews jointly with the investigator.

17. We informed HM Coroner for Inner West London of the investigation. She gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.

18. The investigator contacted Mr Jabar's brother with the assistance of the Nuba Mountains Solidarity Abroad foundation (NMSA) to explain the investigation and to ask whether he had any matters he wanted the investigation to consider. Mr Jabar's brother did not raise any concerns.

19. The investigator sent the initial report to Mr Jabar's brother and informed the Nuba Mountains Solidarity Abroad foundation (NMSA). Mr Jabar's brother did not make any comments.

20. The prison service received a copy of the initial report. They did not identify any factual inaccuracies.

Background Information

HMP Wandsworth

21. HMP Wandsworth is a local prison in London and holds up to 1,628 men in eight residential wings. St George's University Hospital NHS Foundation Trust provides physical healthcare services at the prison. Mental health services are provided by South London and Maudsley NHS Foundation Trust. There is an inpatient unit for up to six prisoners (the Jones Unit) which caters for prisoners with a wide range of general medical, rehabilitative and health-related respite needs.

HM Inspectorate of Prisons

22. The most recent inspection of HMP Wandsworth took place in March 2018, immediately after Mr Jabar's death. Inspectors found that many staff were not engaging well enough with prisoners and appeared to lack confidence. They saw many staff congregating in wing offices and avoiding prisoner contact. They reported that most prisoners were satisfied with the quality of health provision, but lengthy waiting times for appointments were a recurring theme. They considered that the range of primary care services and visiting specialists was appropriate, and external hospital appointments were well managed. Inspectors found that drugs were too accessible, particularly cannabis and PS. They found that the prison's strategy on substance misuse, including supply reduction, was weak.

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 period from June 2017 to May 2018, the IMB reported that illegal drugs, particularly PS, had become increasingly prevalent in the prison. The widespread availability of PS in addition to other drugs and mobile phones was of great concern to the Board.

Previous deaths at HMP Wandsworth

24. Mr Jabar was the fifth prisoner to die at Wandsworth since 2016. Of the other deaths, two prisoners died of natural causes and two deaths were self-inflicted. Since Mr Jabar's death, there have been five further deaths, one from natural causes and the others are still being investigated.

25. In our investigation into the death of a prisoner in October 2017, we were concerned that a support officer did not radio a medical emergency code when he found the prisoner unconscious, and we recommended that the prison remind staff of their responsibilities in an emergency. The prison accepted our recommendation in October 2018.

Psychoactive Substances (PS)

26. Psychoactive substances (formerly known as 'new psychoactive substances' or 'legal highs') are a serious problem across the prison estate. They are difficult to detect and can affect people in a number of ways including increasing heart rate,

raising blood pressure, reducing blood supply to the heart and vomiting. Prisoners under the influence of PS can present with marked levels of disinhibition, heightened energy levels, a high tolerance of pain and a potential for violence. Besides emerging evidence of such dangers to physical health, there is potential for precipitating or exacerbating the deterioration of mental health with links to suicide or self-harm.

27. In July 2015, we published a Learning Lessons Bulletin about the use of PS (still at the time NPS) and its dangers, including its close association with debt, bullying and violence. The bulletin identified the need for better awareness among staff and prisoners of the dangers of PS; the need for more effective drug supply reduction strategies; better monitoring by drug treatment services; and effective violence reduction strategies.

28. HM Prison and Probation Service (HMPPS) now has in place provisions that enable prisoners to be tested for specified non-controlled psychoactive substances as part of established mandatory drugs testing arrangements.

Key Events

Background

29. On 25 January 2013, Mr Hamad Jabar was sentenced to six years imprisonment for robbery. He was a Sudanese national and said that he had been a victim of the conflict in Darfur. Mr Jabar spent time in different prisons and immigration removal centres (IRCs) including HMP Maidstone, HMP Elmley, The Verne IRC and Morton Hall IRC, from which he was released on 15 February 2017.

30. Between January 2013 and February 2017, officers submitted around 38 security intelligence reports on Mr Jabar. Ten related to the use of illegal drugs. Mr Jabar's last recorded drug-related incident occurred on 26 January 2017 at Morton Hall, when officers found he had taken PS.

31. Mr Jabar's medical records also showed that he had suffered adverse effects from the use of PS repeatedly in the past, including one occasion when he had experienced convulsions.

HMP Wandsworth

32. On 15 December 2017, Mr Jabar was sentenced to a further four weeks imprisonment for robbery and was recalled to serve the remainder of his earlier sentence. He was transferred to Wandsworth.

33. Mr Jabar's Person Escort Record (or PER - a document that accompanies prisoners as they move between police stations, courts and prisons) stated that Mr Jabar had no issues related to drug or alcohol abuse, but noted that he suffered from heart disease and Type two diabetes.

34. On 16 December, a nurse reviewed Mr Jabar for his initial health screen. She noted that Mr Jabar suffered from Type two diabetes and had heart disease. Mr Jabar told the nurse that he had not used illicit drugs in the community.

35. The nurse noted that Mr Jabar was taking medication for diabetes, high cholesterol and hypertension. She assessed that Mr Jabar presented well and had no severe symptoms. Mr Jabar was located on B wing, a standard residential unit. His first language was Arabic but staff noted that he communicated well in English.

36. The same day, a prison GP noted that Mr Jabar had a history of coronary artery dissection. (This is a heart condition where a tear forms in a blood vessel and could cause a heart attack.) He prescribed medication to Mr Jabar, including bisoprolol (for high blood pressure) and aspirin and clopidogrel (to prevent blood clots).

37. On 18 December, a prison GP noted during a further health screening that Mr Jabar had Type two diabetes, hypertension and a chronic knee injury. Mr Jabar told the doctor that he suffered from depression for which he was taking mirtazapine. (Mr Jabar had started a treatment for depression in May 2013.)

38. The prison GP concluded that Mr Jabar's mental health appeared to be normal but referred him to the mental health team. The next day, a nurse from the

mental health team, reviewed Mr Jabar and planned to continue monitoring and managing his mental health symptoms.

39. On 27 December, a nurse assessed Mr Jabar's suitability to have his medication in possession. The nurse recorded that Mr Jabar had not concealed or hoarded medication in the previous 12 months. The nurse noted that there was no evidence that Mr Jabar had abused drugs recently or had attempted to self-harm or overdose. The nurse assessed that Mr Jabar was suitable to have his medication in possession.

40. On 28 December, a nurse reviewed Mr Jabar's diabetes. She arranged blood tests, referred him to foot care and for a diabetic eye screening. A week later, a nurse reviewed Mr Jabar again when the blood test results were available. The results showed that Mr Jabar glucose and cholesterol levels had been controlled well. The nurse did not record any concerns.

41. On 1 February 2018, Mr Jabar collapsed and vomited in his cell after lunch. A nurse attended and noted Mr Jabar was alert and oriented. Mr Jabar told the nurse that he frequently had left-sided abdominal pain. The nurse reviewed Mr Jabar, who quickly recovered. She asked Mr Jabar to drink water and to report back if he continued vomiting. (The clinical reviewer considered that Mr Jabar presented with a stomach upset on this occasion that was unrelated to his heart disease and irrelevant to his cause of death. The clinical reviewer raised no concerns about this event or the nurse's actions.)

42. On 5 February, a nurse reviewed Mr Jabar as he presented with symptoms of a urinary tract infection. The next day, a nurse confirmed the infection and prescribed an antibiotic.

43. On 22 February, Mr Jabar moved to K wing, another residential wing. Mr Jabar shared a cell.

44. Officers recorded few interactions or concerns with Mr Jabar on his NOMIS record. There were no entries about Mr Jabar in B or K wing's observation books.

Events of 28 February

45. The investigator reviewed CCTV footage, the control room log and the ambulance service records for 28 February. The prison told us that the CCTV times were around 20 minutes behind the times provided in the logs and ambulance records because of the age of the digital system. We took this into account.

46. At around 12:15pm, the cellmate and Mr Jabar were locked into their cells for lunch. At around 1.13pm, the cellmate pressed the cell bell. Four minutes later, an officer arrived at the cell in response. He spoke to Mr Jabar through the observation panel in the cell door and Mr Jabar told him that he had chest pain.

47. At around 1.18pm, an officer used the radio to call for "Hotel 3" (the call sign for the emergency response nurse) to assist. He reported that a prisoner was having chest pain. A nurse heard the call and recognised the urgency. She said that she immediately asked the control room over the radio to escalate the call to

a ‘code blue’ emergency. At around 1.20pm, the control room officer called an ambulance, as recorded in the ambulance records.

48. Around 30 seconds later, the officer opened the cell door and went in briefly. He told the investigator that he saw Mr Jabar standing up, leaning on the bed. Mr Jabar looked “uncomfortable” but he was able to talk and said he was going to be sick. His cellmate was agitated and appeared to be under the influence of drugs. The officer said he asked if they had taken anything and they both said ‘no’.

49. The officer said that he told Mr Jabar that a nurse was coming. Mr Jabar then clutched his chest, took a turn for the worse and “keeled backwards”, “his eyes went back in his head” and he was “violently sick”.

50. At around 1:21pm, two nurses arrived. A nurse who went to fetch the emergency response bag, arrived shortly afterwards. A nurse said that Mr Jabar was lying on his back on his bed with his feet towards the cell door. She said that he was breathing with difficulty and was making snoring-like sounds. The nurse placed an oxygen mask on Mr Jabar.

51. Two nurses administered two doses of naloxone to Mr Jabar. (This is an emergency antidote for an opiate overdose.) Mr Jabar’s presentation improved but about a minute later he vomited again and his body became still. Two nurses placed Mr Jabar on the floor and started CPR. They also applied the defibrillator to him. The defibrillator advised that shocks should be delivered.

52. At 1.25pm, the first ambulance arrived at the prison gate. Paramedics reached Mr Jabar’s cell about 14 minutes later, at around 1.39pm. Paramedics took over resuscitation and continued with CPR with the assistance of the nurses.

53. At around 3.10pm, paramedics took Mr Jabar to a hospital where he was declared dead at 3.37pm.

Post-mortem report

54. The post-mortem examination found Mr Jabar suffered from significant coronary disease. The pathologist said that Mr Jabar would have been at risk of sudden cardiac death at any time, given the seriousness of his condition.

55. Toxicology tests found the presence of PS in Mr Jabar’s body.

56. The post-mortem examination found that Mr Jabar died of coronary heart disease in combination with PS intoxication. Both are stated as being the cause of death.

Contact with Mr Jabar’s family

57. On 28 February, a Supervising Officer (SO) the nominated Family Liaison Officer (FLO) for Mr Jabar’s family, was unable to find clear details about his next of kin in his records. Most of Mr Jabar’s family were still living in Sudan and he did not have family in the UK.

58. An officer approached the police, Mr Jabar’s solicitors and the Embassy of Sudan for assistance. Mr Jabar’s brother, who lived in the Netherlands, was the only family member identified. On 1 March, the SO telephoned Mr Jabar’s brother and left a message asking him to call back.

59. On 3 March, Mr Jabar's brother phoned the prison's chaplaincy and asked to be contacted. A SO then returned the call and broke the news of Mr Jabar's death to his brother. On the same day, Mr Jabar's brother flew to London and met the SO with the assistance of staff, from the Nuba Mountains Solidarity Abroad foundation (an organisation that assists Sudanese communities from the Nuba region in the UK). They took Mr Jabar's brother to the hospital where his body was being held for identification.

60. Mr Jabar's funeral was held on 8 March. The prison contributed to funeral costs in line with national policy.

Support for prisoners and staff

61. After Mr Jabar's death, The Head of Security, 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.

62. The prison posted notices informing other prisoners of Mr Jabar'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 Jabar's death.

Findings

Clinical Care

63. The clinical reviewer concluded that the clinical care provided to Mr Jabar at Wandsworth was equivalent to that he could have expected to receive in the community.

    Although Mr Jabar had had had a coronary artery dissection two years before his death, his condition was stable while he was at Wandsworth. There was no evidence that he had developed new cardiac symptoms or that his heart disease was deteriorating. Mr Jabar never complained of chest pain before the day he died. Mr Jabar also suffered from Type two diabetes which healthcare staff frequently monitored and controlled well.

64. The clinical reviewer said that patients with a cardiac history such as Mr Jabar's do not require regular follow-ups such as ECGs or scans. However, their cardiovascular risk factors need to be managed. The risk factors are blood pressure, cholesterol, weight and smoking. A nurse addressed Mr Jabar's cardiovascular risk factors satisfactorily. She checked Mr Jabar's cholesterol levels and blood pressure regularly, both of which were normal, and she recommended smoking cessation therapy.

65. The clinical reviewer said that, given Mr Jabar's heart condition, the use of PS precipitated a cardiac arrest.

Substance Misuse

66. There is evidence from intelligence reports and his medical records that Mr Jabar used illicit drugs during his earlier period in custody from 2013 to February 2017, and he was found under the influence of PS on a number of occasions, most recently in January 2017.

67. Mr Jabar denied any substance misuse issues when he arrived at Wandsworth at the end of December 2017. However, the evidence suggests that Mr Jabar continued to use drugs during the two months he spent at Wandsworth. His cellmate told the investigator that Mr Jabar took PS on the wing "quite frequently" and the toxicology report found PS in Mr Jabar's body after his death.

68. Staff were not aware that Mr Jabar was using drugs at Wandsworth. No drug-related security intelligence reports were submitted. Officers did not search Mr Jabar's cell because they did not suspect that he was taking drugs, and Mr Jabar was never tested for illicit drugs.

69. The Head of Security, told the investigator that security staff would have had access to Mr Jabar's full intelligence file but that they would not routinely look at the history of someone with no recent drug-related events. We accept that this would not be realistic in a busy local prison.

70. However, we are concerned that Mr Jabar's prison records suggest that staff did not engage with him at all during his two months at Wandsworth. We note that HMIP found a lack of staff contact with prisoners in its inspection in March 2018.

Without such interaction it is difficult for staff to identify or offer support to prisoners who are using drugs.

Emergency Response

71. PSI 03/2013, *Medical Emergency Response Codes*, contains mandatory instructions for efficiently communicating the nature of a medical emergency, ensuring healthcare staff take the relevant equipment to the incident and that there are no delays in calling an ambulance. PSI 03/2013 and Wandsworth's local emergency response code protocol clearly state that officers should always call a code blue emergency over the radio when a prisoner presents with chest pain.

72. When Mr Jabar told an officer that he had chest pain on 28 February, the officer did not call a code blue emergency. Instead, he asked over the radio for "Hotel 3" (the emergency nurse) to attend. It was left to a nurse to realise that this was an emergency situation and to call a code blue.

73. Two nurses told the investigator that officers often used the wrong codes during emergency situations and healthcare staff have to correct them. An officer appeared to be unaware when speaking to the investigator, that the first officer to attend a chest pain situation should call a code blue immediately.

74. Although a nurse swiftly corrected the officer call, we are concerned that there is confusion among staff about which codes should be called, and when, and who should do so. This may have not have had a significant impact in Mr Jabar's case but it could be crucial in future cases.

75. We are also concerned that the ambulance records show that there was a delay of about 14 minutes in the paramedics reaching Mr Jabar's cell from the prison's entrance, although the officer said that it would only take three to four minutes to walk the route. Paramedics recorded in the ambulance records that there was a delay in reaching Mr Jabar because staff at reception could not confirm Mr Jabar's location. If that is the case, it is unacceptable and the delay could have been avoided.

76. The clinical reviewer said that the delay in the paramedics arriving at the cell could have affected the outcome for Mr Jabar, because paramedics are more experienced in managing emergency situations than most nurses. Mr Jabar could have benefited from their expertise earlier. We make the following recommendations:

The Governor should:

- **ensure that all prison staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, and in particular that they call the correct emergency medical code so that there is no delay in calling an ambulance and healthcare staff take the relevant equipment to the emergency;**

- **provide the Ombudsman with evidence of the implementation of our previous recommendation on this subject made following the death of a prisoner in October 2017; and**

- **review arrangements for paramedics' access to a prisoner to reduce avoidable delays.**

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