

**Prisons &
Probation**

Ombudsman
Independent Investigations

Independent investigation into the death of Mr Peter Baker, a prisoner at HMP High Down, on 24 September 2018

A report by the Prisons and Probation Ombudsman

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 Peter Baker died on 24 September 2018 at HMP High Down from pneumonia and heart disease, with underlying diabetes and blood cancer. He was 70 years old. I offer my condolences to Baker's family and friends.

I am satisfied that Mr Baker's clinical care was equivalent to that he could have expected to receive in the community. However, I am concerned that no care plans were in place to systematically manage and review his longstanding medical conditions, or his cancer care.

There was a delay in requesting an ambulance after Mr Baker was found unresponsive. While it is unlikely that this contributed to his death, a quick response is vital to increase the chances of survival in a medical emergency.

Mr Baker was an older man with limited mobility and in poor health. I do not consider that prison staff appropriately considered this and his other risk factors when deciding to authorise the use of handcuffs for some of his visits and admissions to hospital. The use of restraints is an issue I have repeatedly raised with High Down and the Prison Group Director.

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

May 2020

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Summary

Events

1. On 17 March 2017, Mr Peter Baker was convicted of sexual offences and remanded to HMP High Down. Mr Baker had several longstanding medical problems and two outstanding hospital appointments with specialists. Prison healthcare staff monitored his conditions and facilitated specialist care. Mr Baker also received help from trained social care peer workers.
2. In November 2017, while undergoing investigations in hospital for a facial swelling, Mr Baker was diagnosed with plasma cell myeloma (a form of blood cancer). He had two courses of chemotherapy in 2017 and 2018 and responded well. During 2018, Mr Baker was also treated for other chronic medical problems.
3. Just before 8.30am on 24 September, a prisoner found Mr Baker slumped at the end of his bed. He was breathing, but unresponsive. Healthcare staff and prison officers monitored him until paramedics arrived at 9.13am. While moving Mr Baker to a stretcher, he had a cardiac arrest and attempts to resuscitate him were unsuccessful. The prison doctor confirmed his death at 10.06am.

Findings

4. Overall, Mr Baker's clinical care was equivalent to that he could have expected to receive in the community. However, no care plans were in place to monitor his existing health conditions and his cancer care after his diagnosis.
5. The officer who unlocked Mr Baker's cell in the morning did not conduct a welfare check, as expected. The Governor has since reissued guidance to staff.
6. There was a four-minute delay in calling an ambulance. Although this did not affect the outcome for Mr Baker, it could be critical in future emergencies.
7. We are not satisfied that security risk assessments took sufficient account of Mr Baker's reduced mobility and poor health, and we are concerned that he was restrained for hospital visits and admissions. We have made recommendations about this in previous investigations into deaths at High Down.

Recommendations

- The Head of Healthcare should ensure that all prisoners with serious or long-term health conditions have detailed care plans in place, in line with National Institute for Health and Care Excellence (NICE) guidance.
- The Governor should ensure that control room staff request an ambulance immediately when a medical emergency response code is called.
- The Governor and Head of Healthcare should ensure that all staff completing and authorising 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; are based on the actual risk the prisoner

presents at the time; and are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

- The Governor should revise the risk assessment form for hospital escorts to make it clear that:
 - healthcare staff must provide information on the prisoner's current state of health and mobility; and
 - prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.

The Investigation Process

8. 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.
9. The investigator obtained copies of relevant extracts from Mr Baker's prison and medical records. She conducted a telephone interview with a member of staff on 14 May 2019.
10. NHS England commissioned an independent clinical reviewer to review Mr Baker's clinical care at the prison.
11. We informed HM Coroner for Surrey of the investigation. He gave us the results of the post-mortem examination. We have sent the coroner a copy of this report.
12. The investigator was unable to contact Mr Baker's next of kin.
13. Our investigation was suspended between 2 October 2018 and 18 January 2019 and between 25 April 2019 and 21 January 2020, while awaiting the cause of death and the clinical review. This has delayed the initial report.
14. On 21 January 2019, the investigation was reassigned to another PPO investigator.
15. The initial report was shared with HM Prison and Probation Service (HMPPS). They found no factual inaccuracies and accepted our recommendations.

Background Information

HMP High Down

16. HMP High Down is a local prison in Surrey which holds up to 1,203 men. Central and North-West London NHS Foundation Trust provides primary health services and in-reach mental health care. The healthcare unit has inpatient facilities with 24-hour staffing.

HM Inspectorate of Prisons

17. The most recent inspection of HMP High Down was in May 2018. Inspectors reported that the prison had failed to meet 47 of the 80 recommendations made after their previous (2015) inspection.
18. Inspectors found that there was a wide range of primary health services, but non-attendance rates were too high. Information was shared appropriately, promoting continuity of care. Older prisoners and those with long-term conditions were well supported by an associate nurse practitioner and further support was being considered to improve the provision. However, the use of care plans for prisoners with long-term conditions was inconsistent. There was effective joint working between the prison, local authority and health provider for social care support and trained prison peer workers provided excellent support.
19. The inspectorate conducted a review of progress in June 2019, to assess progress against selected key recommendations. There were reasonable or good scores in seven of the 12 recommendations reviewed.

Independent Monitoring Board

20. 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 2018, the IMB reported that there was a wide range of primary health services, as well as specialised services provided by visiting consultants. The availability of GP sessions and nurse-led clinics had increased, but a high percentage of prisoners did not attend their appointments.

Previous deaths at HMP High Down

21. Mr Baker's death was the ninth at High Down in two years, eight were from natural causes and one self-inflicted. There have been four subsequent deaths, of which two were self-inflicted. The cause of death has yet to be determined in the other two, but one appears to be drug-related.
22. We have made previous recommendations about provision for prisoners with chronic health conditions; ensuring the wellbeing of prisoners when they are unlocked; and calling an ambulance promptly. We have also made several recommendations about risk assessments and the use of restraints, including two to the Prison Group Director – one before Mr Baker's death and one since.

Key Events

23. On 17 March 2017, Mr Peter Baker was convicted of sexual offences and remanded to HMP High Down. (On 28 April, he received an extended sentence of 11 years, with a custodial term of five years and an extension period on licence of six years.) It was not his first time in prison.
24. A nurse carried out an initial health screen. Mr Baker had several existing medical conditions, including osteopenia (weak bones), an enlarged prostate, sleep apnoea, longstanding back and hip pain, a previous stroke and an ulcer in the small intestine. She noted that Mr Baker had outstanding outpatient appointments with specialists in rheumatology (for joint, muscle and ligament disorders) and otolaryngology (for ear, nose and throat disorders) and he later attended these appointments.
25. The nurse arranged for Mr Baker's existing medication to be re-prescribed. She also referred him to the mental health team, as he had been sectioned under the Mental Health Act when he was 22 years old. (A mental health assessment on 20 March found no existing issues.)
26. On 18 March, a nurse completed a secondary health screen. Mr Baker was a heavy smoker and said he did not want to stop.
27. On 4 April, a local authority social worker assessed Mr Baker as eligible for social care. The next day, a member of staff reviewed Mr Baker in the chronic disease clinic and completed an older persons' assessment. Mr Baker told her that he was able to care for himself and used a walking stick, when necessary.
28. Over the next few months, Mr Baker received his medication daily and staff carried out medication and social care reviews. Social care peer workers helped him to collect his meals and keep his cell clean.
29. On 15 November, Mr Baker reported a swelling on the left side of his face that had started with a sore the day before. A prison GP diagnosed cellulitis and prescribed high dose antibiotics, noting that if Mr Baker did not respond, he would have to be sent to hospital for intravenous antibiotics. The prison GP reviewed Mr Baker later that day and recorded that he was still at high risk. Mr Baker did not attend a follow-up appointment booked for the next day.
30. Mr Baker's condition did not improve. On 17 November, he was admitted as an inpatient to a hospital. On 19 November, a nurse contacted the hospital for an update. A hospital doctor informed him that an ultrasound scan had revealed an abnormality in Mr Baker's renal function and the doctor asked if prison healthcare staff had noted any concerns. The nurse was unaware of any problems. However, the medical record showed that a previous blood test had revealed a raised liver enzyme which required further investigation and a repeat of the test had been requested.
31. Prison healthcare staff kept in touch with the hospital for updates. On 24 November, a ward clerk advised that Mr Baker was due to start chemotherapy that day, but was unable to give any further details as no medical staff were available.

32. Mr Baker was discharged from hospital on 27 November and returned to High Down. The discharge letter noted that the infection had caused acute kidney injury and that a CT scan and bone marrow biopsy had revealed plasma cell myeloma (a blood cancer arising from the plasma cells). The hospital had prescribed additional medication, including heparin injections (a blood thinner to prevent blood clots) and adjusted the dosage of his existing medication.
33. Over the next few months, Mr Baker had chemotherapy twice weekly as an outpatient. His first course of treatment was successful and his kidney function improved.
34. In February 2018, Mr Baker began to have falls and was provided with a wrist worn falls detector. He was subsequently given a wheelchair and a bed lever to help him get in and out of bed safely.
35. On 12 February, Mr Baker felt unwell and was admitted to a hospital. He was diagnosed with sepsis and a recurrence of acute kidney injury. Mr Baker was discharged on 7 March. On his return to High Down, he refused to be admitted to the inpatient unit and went back to his residential wing. He then had renal dialysis three times a week until June.
36. Mr Baker was due to transfer to another prison, to complete offending behaviour programmes, but the prison suspended this to enable him to finish his treatment. Healthcare staff completed various assessments, including falls; risk of malnutrition; and activities of daily living. They referred Mr Baker to secondary care for severe symptoms. He was admitted to hospital, as an inpatient, four times between April and August for sepsis, testicular problems, cellulitis and fever. Restraints were sometimes used for outpatient appointments and inpatient admissions.
37. On 31 July, a blood test at High Down diagnosed non-diabetic hyperglycaemia, also known as pre-diabetes.
38. Mr Baker had a further round of chemotherapy in August and September. His consultant haematologist described his response to the treatment as excellent and planned to stop and monitor Mr Baker after the next round.

Emergency on 24 September

39. At around 5.30am on 24 September, an operational support grade (OSG), completed a roll check (count) of prisoners. She said that she took extra care when checking the cells of older prisoners, but recalled nothing specific about Mr Baker that day.
40. Due to Mr Baker's mobility issues, a prisoner helped him to get out of bed each day and escorted him around the wing. They were unlocked at around 8.15am and a little later the prisoner went to Mr Baker's cell. (He had last seen Mr Baker at around 6.00pm the previous evening and he had seemed all right.) He found him slumped on the floor at the end of his bed, unconscious but with laboured breathing. He called to another prisoner nearby who had been trained in first aid, and they both tried to support Mr Baker. As he remained unresponsive, the prisoner told an officer.

41. The officer said that a prisoner had shouted that Mr Baker was on the floor, but it did not sound urgent and he thought that he had fallen over, as he had in the past. He unlocked the last three cells on the way to Mr Baker's cell, as he had to pass them anyway. He estimated that it took approximately 30 seconds. While he was unlocking the last prisoners, a nurse joined him and they both went to Mr Baker's cell. The officer thought that Mr Baker was semi-conscious, as he had grumbled when he called out to him. At 8.30am, he radioed a code blue emergency (which indicates that a prisoner is unconscious, or has breathing difficulties).
42. A nurse responded and went to the cell at 8.33am. He found that Mr Baker was unconscious, but was breathing normally and responsive to pain. The nurse placed him in the recovery position and gave him oxygen. He also asked for an ambulance. The control room requested two ambulances at 8.34am, as a code blue emergency had been called for another prisoner at 8.33am. The nurse monitored Mr Baker while waiting for the ambulance and noted that his breathing was normal and he had a good pulse.
43. When the first ambulance arrived at 8.46am, the paramedics said they had been called for the other prisoner, so they were taken to treat him. The second ambulance arrived at the prison at 9.07am and the paramedics reached Mr Baker's cell at 9.13am. At 9.30am, as they were moving Mr Baker onto a stretcher, he went into cardiac arrest. The nurse radioed for all healthcare staff to attend, with all the red emergency bags and suction. Staff and paramedics performed 15 minutes of intermediate life support and 20 minutes of advanced life support.
44. A prison GP attended at 9.50am. The resuscitation attempts were unsuccessful and he confirmed Mr Baker's death at 10.06am.

Contact with Mr Baker's family

45. Mr Baker's next of kin was a former partner. The prison's family liaison officer (FLO), and a prison manager, went to the address listed for his next of kin, but she was not there. The FLO tried to locate her by contacting the police, Mr Baker's solicitor and other relatives.
46. The FLO later found out that Mr Baker's ex-partner was in prison at HMP Bronzefield. She therefore arranged for Bronzefield's chaplain, to break the news. When she was informed of Mr Baker's death, Mr Baker's ex-partner said that she had had no contact with him for several years and she was due to be released a few days later. On her release, she agreed to contact the prison if she wanted to receive information, or be involved in the funeral arrangements. She did not make contact.
47. In line with national policy, the prison arranged and paid for Mr Baker's funeral, which was held on 25 October.

Support for prisoners and staff

48. After Mr Baker's death, a prison 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.

49. The prison posted notices informing other staff and prisoners of Mr Baker's death, and offering support.

Post-mortem report

50. The post-mortem report recorded that the cause of Mr Baker's death was bronchopneumonia, caused by left ventricular hypertrophy with ischaemic heart disease. Type 2 diabetes mellitus and myeloma were significant contributing factors.
51. Bronchopneumonia is inflammation of the lungs; left ventricular hypertrophy is enlargement and thickening of the walls of the heart's main pumping chamber; and ischaemic heart disease occurs as a result of narrowed arteries.

Findings

Clinical care

52. Mr Baker had several longstanding and chronic medical conditions when he arrived at High Down. The clinical reviewer found that Mr Baker received appropriate physical and mental health assessments and his conditions were then monitored. Healthcare staff were responsive to his needs. They reviewed and adjusted his medication and pain management, as necessary and promptly sent him to hospital for further investigation when he presented with serious symptoms. Social care assessments were completed and peer workers assisted him with collecting meals and tidying his cell.
53. While an inpatient in hospital, Mr Baker was diagnosed with cancer of the blood plasma cells. (He had not reported any symptoms associated with this condition to prison healthcare staff.) The prison facilitated twice-weekly chemotherapy and he was said to have responded well. Mr Baker was well enough to attend chemotherapy sessions up to 18 September 2018, so there were no signs of infection at that point.
54. Mr Baker reported no new symptoms between his last session of chemotherapy and his death six days later, so prison staff were unaware that he had bronchopneumonia and his death was unexpected. One of the other conditions highlighted in the post-mortem report was diabetes. However, Mr Baker had not been diagnosed with this condition before his death.
55. We are satisfied that Mr Baker's care at High Down was equivalent to that he could have expected to receive in the community. However, we agree with the clinical reviewer that formal care plans should have been in place to manage Mr Baker's chronic conditions and a cancer care plan should have been created after his diagnosis of myeloma. Following High Down's last inspection, HM Chief Inspector of Prisons identified inconsistencies in the use of care plans for those with chronic conditions. We make the following recommendation:

The Head of Healthcare should ensure that all prisoners with serious or long-term health conditions have detailed care plans in place, in line with National Institute for Health and Care Excellence (NICE) guidance.

Unlocking cells and checking the welfare of prisoners

56. Prison Service Instruction (PSI) 75/2011 (revised in January 2020), *Residential Services*, states that there should be systems in place for staff to assure themselves of the well-being of prisoners during or shortly after unlock. Where prisoners are not necessarily expected to leave their cell, staff are expected to check that they are well, for example by obtaining a response during the unlock process.
57. An officer said that he unlocked Mr Baker's cell between 8.10am and 8.15am. Although he said he would usually look into the cell, he did not do so that morning as he was late unlocking. He said that, on reflection, he should have looked in Mr Baker's cell and, since then, he always looks into cells when he opens them, even if he is late unlocking. We do not know whether Mr Baker

collapsed before or after his cell was unlocked and whether the delay in finding him affected the outcome.

58. The Governor reissued High Down's Governor's Information Notice 143/2018, *Ensuring Prisoners' Safety at Unlock*, on 12 December 2018. It reiterates the expected procedures for unlocking cells, notably that it is essential for staff to satisfy themselves that the prisoner in question is alive and well. As well as setting out the expectations, the Governor included a strong message instructing staff that following this practice would make High Down a safer environment and potentially save a prisoner's life, and that failure to do so could contribute to further deaths.
59. In view of the steps taken by the Governor to address this issue since Mr Baker's death, we have not made a formal recommendation.

Emergency response

60. PSI 03/2013, *Medical Emergency Response Codes*, and High Down's Governor's Order 3/2017, *Medical Emergency Codes*, set out the actions staff should take in a medical emergency. The instructions contain mandatory instructions on efficiently communicating the nature of a medical emergency and stipulate that if an emergency code is called over the radio, an ambulance must be called immediately and that it is not a requirement for a member of healthcare team or a prison manager to attend before this is done.
61. The officer called a code blue emergency promptly when he arrived at the cell and saw that Mr Baker was semi-conscious. However, there was a delay of four minutes before the control room requested an ambulance. An entry in the control room log noted that an ambulance was required, which suggests that this had to be requested separately. There was a further delay when the first ambulance crew arrived, as they were diverted to another medical emergency which was considered to be more urgent. At that time, Mr Barker was stable.
62. While it is unlikely that the delay in calling an ambulance affected the outcome for Mr Baker, in other circumstances it could be critical. We make the following recommendation:

The Governor should ensure that control room staff request an ambulance immediately when a medical emergency response code is called.

Risk assessments and the use of restraints

63. 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.
64. A judgment in the High Court in 2007 made it clear that prison staff need to distinguish between a 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 judgment indicated that medical opinion about the

prisoner's ability to escape must be considered as part of the assessment process and kept under review as circumstances change.

65. Mr Baker was a category C prisoner, on the standard level of the prison's incentives and earned privileges scheme. He frequently attended hospital for treatment as both an outpatient and inpatient. He was fully compliant and courteous to staff. Generally, healthcare staff noted on the escort risk assessments that Mr Baker was not fully mobile and a wheelchair user, yet stated there were no medical objections to restraints and he could remain cuffed for treatment. Operational staff recorded on the forms that there were no escape alerts and that his risk factors for escape, risk to the public and other security issues were 'normal' (on a scale of low, normal and high).
66. Mr Baker was always escorted by two prison officers. For some appointments between June and August 2018, no restraints were used and prison managers annotated the risk assessment form to indicate that this was due to his poor physical health, taking account of the medical assessments. However, for others in August and September, he was restrained with single handcuffs.
67. On 6 August, Mr Baker was admitted to hospital as an emergency. He received intravenous antibiotics and required surgery. The next day, a prison manager stipulated that his handcuffs should only be removed after he was sedated for surgery. A nurse asked for the restraints not to be replaced immediately after the operation, but an escort chain was applied later that evening. (An escort chain is a long chain with a handcuff at each end, one of which is attached to the prisoner and the other to an officer.)
68. A risk assessment completed for chemotherapy on 18 September, required Mr Baker to be restrained with double handcuffs, with single handcuffs for treatment. (When double cuffed, a prisoner has his hands handcuffed in front of him and then has one wrist attached to a prison officer by an additional set of handcuffs.) No reason was given for this level of restraint and the decision-maker noted that there was no intelligence to suggest that Mr Baker was a heightened risk.
69. We are not satisfied that staff appropriately assessed Mr Baker's risk. He had reduced mobility and several chronic conditions, including cancer, and received intravenous treatment in hospital. The input from healthcare staff was variable, some prison managers took little or no account of how his medical condition affected his risk of escape, as the High Court judgment requires, and decisions about the use of restraints were inconsistent. We make the following recommendation:

The Governor and Head of Healthcare should ensure that all staff completing and authorising 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; are based on the actual risk the prisoner presents at the time; and are not used during serious or invasive treatment, unless there are exceptional reasons for doing so.

The Governor should revise the risk assessment form for hospital escorts to make it clear that:

- **healthcare staff must provide information on the prisoner's current state of health and mobility; and**
- **prison managers must confirm that they have read and taken into account the healthcare information about the prisoner's current state of health and mobility in determining the level of security needed.**

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