Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Tariq Dalton, a prisoner at HMP High Down, on 19 November 2018

A report by the Prisons and Probation Ombudsman

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU
Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk
T I 020 7633 4100
F I 020 7633 4141

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 Tariq Dalton died on 19 November 2018 at HMP High Down from an upper gastrointestinal haemorrhage (bleeding from an artery in the gut) caused by an ulcer in the small intestine. Mr Dalton was 46 years old. I offer my condolences to his family and friends.

We had to suspend our investigation while the police investigated the circumstances of Mr Dalton's death and while we waited for the cause of death. This has delayed the production of our report.

Mr Dalton had been at High Down for a month when he died. He had several long-term health conditions and displayed challenging behaviour in prison. He was prescribed anti-inflammatory medication (which can cause gastrointestinal bleeding and ulcers) but healthcare staff did not record whether they considered using a medication to reduce this risk.

In the days before his death, Mr Dalton complained of abdominal pain and said he was coughing up blood. Healthcare staff spoke to him but he was not assessed or reviewed by a GP. On the morning he died, a nurse observed fresh blood in Mr Dalton's cell toilet and informed a GP but no one examined him. Later that afternoon, Mr Dalton was found unresponsive in his cell and died shortly afterwards.

I am very concerned that staff missed several opportunities to assess Mr Dalton's deteriorating condition fully. More comprehensive monitoring on 18 and 19 November might have led to earlier identification of a life-threatening condition.

My investigation also identified several weaknesses in the emergency response. There was a short delay in radioing a medical emergency code and in calling an ambulance. There was also a delay of five minutes before staff arrived with emergency medical equipment. Although these delays are unlikely to have affected the outcome for Mr Dalton, they could make a crucial difference in other medical emergencies.

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 **September 2020**

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Summary

Events

1. On 18 October 2018, Mr Tariq Dalton was remanded to HMP High Down, charged with assault and unlawful imprisonment. On arrival, Mr Dalton said that he had several long-term health conditions, including cystic fibrosis, chronic obstructive pulmonary disease (COPD) and pain from previous leg fractures.

2. On 19 October, a prison GP reviewed Mr Dalton and prescribed medications, including a non-steroidal anti-inflammatory medication. However, there is no evidence that he considered prescribing a proton pump inhibitor (PPI) to reduce the production of acid in the stomach which can be caused by these drugs.

3. On 29 October, a prison officer referred Mr Dalton to the mental health team because of concerns about his strange behaviour. That day, a mental health nurse recorded that Mr Dalton was withdrawing from substances and should be referred to the prison's substance misuse team.

4. On 9 November, a nurse conducted an initial mental health assessment following concerns from prison staff that Mr Dalton's behaviour was not drug-related. On the same day, staff decided to initiate suicide and self-harm prevention procedures (known as ACCT) because Mr Dalton was very low in mood and expressing bizarre ideas. They moved Mr Dalton to the prison's inpatient unit.

5. On 16 November, Mr Dalton reported abdominal pain to a nurse. A GP tried to review Mr Dalton later that day but he was not in the unit. A nurse told us that he asked the GP to see Mr Dalton on 17 November but he said he was too busy. There is, however, no record of this.

6. On 18 November, a mental health nurse noted that Mr Dalton reported internal bleeding and showed him a cup that he said contained saliva mixed with blood. However, there is no record that he examined Mr Dalton or notified a GP.

7. At 10.02am on 19 November, a custodial manager chaired an ACCT case review and noticed that there were dark faeces and blood on the floor and walls of Mr Dalton's cell. She also noticed fresh blood in his toilet and told the nurse who was present. The nurse requested a GP review but did not examine Mr Dalton. At 12.36pm, a GP noted that he had advised staff to obtain a sample of vomit.

8. A mental health nurse told us that he was the only member of healthcare staff in the inpatient unit that afternoon as the nurse who had seen the fresh blood in Mr Dalton's toilet had left the prison without authorisation. He also said that the nurse had not said anything to him about the fresh blood.

9. At 2.19pm, three officers and a supervising officer tried to move Mr Dalton so that his cell could be cleaned. At 2.24pm, Mr Dalton collapsed at the cell door. The mental health nurse attended but did not physically examine him and left to contact a GP.

10. At 2.35pm, the mental health nurse returned to Mr Dalton's cell with a blood pressure monitor. When he failed to get a reading, he asked an officer to call a

medical emergency code at 2.39pm. At 2.41pm, a nurse arrived without any medical equipment. Shortly afterwards, Mr Dalton stopped breathing and staff started cardiopulmonary resuscitation (CPR).

11. At 2.45pm, a nurse arrived with an emergency medical bag. Hospital paramedics arrived at 2.59pm and assisted with resuscitation efforts. At 3.15pm, a GP pronounced that Mr Dalton had died.

Findings

12. The clinical reviewer found that Mr Dalton's clinical care was not equivalent to that which he could have expected to receive in the community.

13. Healthcare staff did not obtain his community medical records, conduct a secondary health screen, record whether a PPI was considered or manage his complex care needs appropriately.

14. The clinical reviewer also found that more comprehensive monitoring of Mr Dalton's condition on 18 and 19 November might have resulted in earlier identification that he had a life-threatening condition.

15. The clinical reviewer considered that the actions of two prison GPs and a nurse caused sufficient concern to require further investigation. We understand that the General Medical Council (GMC) is investigating the doctors and the clinical reviewer has recommended that NHS England refer the nurse to the Nursing and Midwifery Council (NMC).

16. We are concerned that staff did not radio for additional medical assistance when Mr Dalton initially collapsed on 19 November. We are also concerned that there was a brief delay in calling a code blue when staff were unable to obtain Mr Dalton's blood pressure reading.

17. We are concerned that healthcare staff arrived at Mr Dalton's cell without any medical equipment when responding to the code blue and that control room staff did not call an ambulance immediately.

18. Although the delays in the emergency response are unlikely to have affected the outcome for Mr Dalton, they could make a crucial difference in other medical emergencies.

19. There is no evidence that any action was taken when Mr Dalton's next of kin rang the Safer Custody department on 17 November to express concerns about his welfare.

Recommendations

- The Governor and Head of Healthcare should ensure that a multidisciplinary complex care meeting is held weekly and that a summary of the meeting is attached to the relevant prisoners' electronic medical records.
- The Head of Healthcare should ensure that:
  - healthcare staff routinely request community medical records for newly arrived prisoners;

- healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050;
- there is a suitable system in place to prevent prescribing errors;
- all medical and non-medical prescribers consider the use of a proton pump inhibiter with non-steroidal anti-inflammatory medication and record their decision in the prisoner's medical record;
- healthcare staff do not attempt to administer non-steroidal anti-inflammatory medication to prisoners who have them prescribed;
- there is a process in place to follow up any outstanding actions, such as requests for medical notes and x-ray results; and
- healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners.

- The Governor and Head of Healthcare should ensure that all staff request that a medical responder attends when a prisoner presents as seriously ill but does not meet the criteria for a medical emergency code.
- The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code and take appropriate medical equipment to code blue emergencies.
- Central and North West London NHS Foundation Trust should undertake a review to investigate the concerns raised by the clinical reviewer of the nurse and ensure that appropriate action is taken.
- The Governor should ensure that there is an effective communications gateway in place to enable families to communicate concerns about prisoners' wellbeing in line with the *Strengthening Prisoners' Family Ties Policy Framework*.

The Investigation Process

20. 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 him. No one responded.

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

22. The investigator interviewed nine members of staff at High Down on 13 and 14 March 2019. He also conducted two interviews by telephone on 22 March and 3 April.

23. NHS England commissioned an independent clinical reviewer to review Mr Dalton's clinical care at the prison. She attended joint interviews with the investigator on 13 and 14 March. She conducted two telephone interviews with healthcare staff on 20 March and 6 April, and a joint telephone interview with the investigator on 3 April.

24. We informed HM Coroner for Surrey of the investigation. The Coroner gave us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

25. The investigator contacted Mr Dalton's next of kin to explain the investigation and to ask if she had any matters she wanted the investigation to consider. She wanted to know:

    - whether Mr Dalton had a ruptured duodenal ulcer as a result of an assault by staff or other prisoners;
    - why was Mr Dalton located in the healthcare inpatient unit;
    - if he was he having psychiatric treatment;
    - what medication he was taking;
    - the frequency of staff observations; and
    - more about what happened on 19 November.

    These questions are addressed in this report and in the clinical review.

26. We had to suspend our investigation between December 2018 and February 2019 while the police investigated the circumstances of Mr Dalton's death. We also had to suspend our investigation between April 2019 and April 2020 while we waited for the cause of death. This has delayed the production of our report.

27. Mr Dalton's next of kin received a copy of the initial report. The solicitor representing Mr Dalton's next of kin did not raise any further issues.

28. 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 High Down

29. HMP High Down is a local prison in Surrey, which holds up to 1,150 men. Central and North-West London NHS Foundation Trust (CNWL) provides primary health services and inreach mental health care. Achor Health delivers GP services. The healthcare unit has inpatient facilities with 24-hour nursing cover.

HM Inspectorate of Prisons

30. The most recent inspection of HMP High Down was in May 2018. Inspectors reported that standards had declined since the previous inspection, perhaps because of uncertainty about the prison's future role. Inspectors found that health and social care provision was reasonable and substance misuse services were good. They noted that emergency response arrangements were effective, but the use of care plans for prisoners with long-term health conditions was inconsistent.

Independent Monitoring Board

31. 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 found that the availability of GP and nurse-led clinics had increased but that there was still a large disparity between booked and attended appointments. The IMB noted that the inpatient unit was a challenging environment and that cells were often out of use due to damage caused by prisoners.

Previous deaths at HMP High Down

32. Mr Dalton was the eleventh prisoner to die at High Down since November 2016. Of the previous deaths, eight were from natural causes and two prisoners took their own lives. There have been two deaths since, one self-inflicted and one from natural causes. We have previously identified delays in requesting an ambulance in a medical emergency, most recently following a death in October 2018 (shortly before Mr Dalton's death).

Key Events

33. On 17 October 2018, Mr Tariq Dalton was remanded to custody, charged with assault and unlawful imprisonment. He was sent to HMP High Down.

34. At an initial reception screen, a nurse noted that Mr Dalton arrived with crutches and said he had recently fractured his left heel and right ankle. He also reported cystic fibrosis (a serious inherited condition where mucus builds up in the lungs and digestive system and can cause life-threatening problems) and chronic obstructive pulmonary disease (COPD – a collection of lung diseases, including chronic bronchitis and emphysema). She printed a copy of Mr Dalton's summary care record (an electronic record of important patient information created from GP records that healthcare staff can access through an NHS web portal) and tasked a GP to prescribe his medication. She also obtained Mr Dalton's consent to request his community GP records.

35. On 18 October, a prison GP prescribed diazepam (to treat anxiety), a seretide inhaler (to treat asthma and COPD) and oxycodone and buprenorphine (opioid-based pain relief). The prison GP told the investigator that it was likely that he read Mr Dalton's summary care record before prescribing his medication, but he could not be certain. He said that alternatively, he would have prescribed the medication using prison records or medication that Mr Dalton had with him.

36. There is no record that healthcare staff conducted a secondary health screen or created care plans for Mr Dalton's serious health conditions.

37. On 19 October, a prison GP reviewed Mr Dalton at a pain clinic and noted that he reported COPD and ankle pain due to previous fractures. He prescribed duloxetine (an antidepressant used to treat nerve pain), meloxicam (a nonsteroidal anti-inflammatory), prednisolone (a steroid used to treat a range of inflammatory conditions) and a decreasing dose of oxycodone. The prison GP also referred Mr Dalton to the asthma clinic and requested an x-ray of his feet, ankles and chest. However, there is no evidence that he reviewed Mr Dalton's summary care record, considered prescribing a proton pump inhibitor (PPI - to reduce the production of acid in the stomach which can be caused by drugs such as prednisolone and meloxicam) or booked him a follow-up appointment.

38. On 20 October, Mr Dalton was placed on the basic regime after receiving numerous warnings for being aggressive and abusive to staff, repeatedly ringing his cell bell and making unprovoked attacks on other prisoners.

39. Also on 20 October, a prison paramedic reviewed Mr Dalton in his cell following a request from prison staff. Mr Dalton requested oxycodone but the tablets had not been delivered. He offered him paracetamol and ibuprofen as an alternative but he declined. Around an hour later, he reviewed Mr Dalton again and recorded that he was still demanding oxycodone. He noted that Mr Dalton said he had "broken every bone in his body and required an emergency ambulance to A&E" but refused to discuss the statement further.

40. On 21 October, a nurse noted in Mr Dalton's medical records that Mr Dalton said he had been punched in the face by another prisoner and had a small cut to his nose. She also noted that he had a black eye which he said was from a previous

injury. (There is no record of Mr Dalton being assaulted in his electronic prison record.)

41. On 24 October, a prison GP reviewed Mr Dalton's summary care records and recorded "meds dealt with already". However, he stopped prednisolone after noticing it had been only been prescribed in the community for 10 days on 24 September. This meant that the course should have finished on 4 October.

42. On 28 October, Mr Dalton collected his morning medication from a nurse and complained about not having diazepam or prednisolone. She told him that his prescriptions had ended and arranged a GP review for 7 November. At this point, Mr Dalton became angry and threw a cup of water at her.

43. On 29 October, an officer referred Mr Dalton to the prison's mental health team because of concerns about his increasingly odd behaviour. He noted that Mr Dalton claimed to be withdrawing from diazepam and had asked to "speak to Special Branch" on several occasions, saying he had information about high profile murders, and appearing to talk to people who were not there.

44. Later that day, a mental health nurse reviewed the referral. She recorded that Mr Dalton was withdrawing from substances and should be referred to the prison's substance misuse team.

45. On 30 October, Mr Dalton attended the respiratory clinic and told a nurse that he was concerned about having his prescription of prednisolone stopped. She noticed that staff had not obtained his community medical records and said she would fax a request to his GP. However, there is no record that healthcare staff requested or obtained this information.

46. On 31 October, a mental health nurse referred Mr Dalton to the substance misuse team. She recorded that his behaviour appeared to be related to substance withdrawal and requested they review him. However, there is no record that a review took place.

47. On 7 November, an officer recorded that several prisoners had approached Mr Dalton and complained about him constantly pressing his cell bell and banging and shouting throughout the night. He recorded that the prisoners said they were losing their patience with Mr Dalton and suggested that he should be moved from the wing as soon as possible. Later that morning, Mr Dalton failed to attend a GP appointment as prison staff decided that he should remain in his cell because of his threatening behaviour. There is no record that healthcare staff booked him another appointment.

48. On 8 November, a prison manager telephoned a mental health nurse, and expressed his concerns about Mr Dalton's odd behaviour. The nurse noted that prison staff did not think that Mr Dalton's behaviour was related to substance misuse.

49. On 9 November, a mental health nurse conducted an initial mental health assessment. He recorded that Mr Dalton presented with bizarre ideas and was putting himself at risk from other prisoners. That day, prison and healthcare staff attended a multidisciplinary team meeting (MDT) and decided to initiate suicide and self-harm prevention procedures (known as ACCT) because Mr Dalton was

'self-isolating' and demonstrating "extreme low mood". Staff also agreed to move Mr Dalton to the prison's healthcare unit for additional support.

50. On 12 November, Mr Dalton flooded his cell and staff, therefore, turned his water off.

51. At 12.12pm on 14 November, a mental health nurse reviewed Mr Dalton in the healthcare unit and created a mental health care plan. At 1.38pm, she recorded that Mr Dalton said he wanted morphine (an opioid-based pain relief) for pain in his ribs, back, legs and arms. She told him that he could have paracetamol, which he had already taken, and that if his pain continued, a GP would review him. At 7.42pm, the mental health nurse recorded that Mr Dalton continued to ask for morphine and threw water at an officer. However, there is no record that healthcare staff requested a GP review.

52. At 11.30am, on 15 November, Mr Dalton failed to attend an appointment with a prison psychiatrist. He reviewed Mr Dalton's prison medical records and noted that in the absence of his community GP records, the concern appeared to be related to substance misuse. He requested an urgent substance misuse assessment and recorded that he would speak to staff about Mr Dalton's GP records. At 1.25pm, a mental health nurse created the third of three care plans and requested a GP review. At 4.00pm, a substance misuse worker reviewed Mr Dalton and recorded that the substance misuse team would offer him support.

53. At 3.40am on 16 November, a nurse recorded that Mr Dalton said he had broken his arm punching the window and needed an ambulance, but that there was no pain, deformity or swelling when his arm was assessed. At 4.10am, he recorded that Mr Dalton had complained of abdominal pain and was suspected of withdrawing from unknown drugs.

54. At 12.28pm, a prison GP attended the healthcare unit to review Mr Dalton but did not see him as prison staff had taken him to the segregation unit for a disciplinary hearing. He recorded that Mr Dalton's problems did not appear to be acute and suggested a review on 19 November.

55. A mental health nurse told the investigator that he asked a prison GP if he could see Mr Dalton on 17 November, but he said he was too busy. The mental health nurse said that as a result, he booked Mr Dalton a GP appointment for 19 November. However, there is no record of their conversation in Mr Dalton's medical record.

56. Also, on 17 November, Mr Dalton's next of kin visited him. The visit took placed in closed conditions because of Mr Dalton's behaviour. She said that Mr Dalton had been very agitated and paranoid and that his behaviour and his mental and physical health had deteriorated noticeably. He told her he had been beaten up by four or five prisoners who had come into his cell and broken his jaw and that a prison officer had given him a 'dig'. (This could mean an insult in prison slang, rather than a physical 'dig'.)

57. She subsequently rang the prison's Safer Custody department to say she was worried about him. She said the person she spoke to had not been very helpful

and had told her she would need to write in as there was no proof she was who she said she was.

Events on 18 November

58. At 6.09am on 18 November, a mental health nurse recorded that Mr Dalton was disruptive overnight and frequently pressed his cell bell. He recorded that Mr Dalton said nobody had attended when he reported vomiting blood the previous day and became verbally abusive when he tried to discuss this with him.

59. At 1.10pm, an officer responded to Mr Dalton's emergency cell bell. He told her that he was bleeding internally and that there was blood all over his cell. The officer recorded that she was unable to see into the cell as Mr Dalton had blocked his cell door observation panel but that she had informed a nurse.

60. At 4.06pm, an officer noted that Mr Dalton had smeared faeces around his cell door, floor and walls. At 4.32pm, a mental health nurse recorded that Mr Dalton's mood had fluctuated throughout the day and that when he was locked in his cell, he complained of pain and demanded to go to hospital. He also noted that Mr Dalton reported internal bleeding and had given him a cup that he said contained saliva mixed with blood, but which appeared to be stains of darkened tea. At 5.32pm, a radiologist emailed the results of Mr Dalton's x-rays (requested on 19 October) to the healthcare administration team.

61. At 5.58pm, the mental health nurse recorded that Mr Dalton had written notes on several complaint forms and posted them underneath his cell door. The notes contained various statements, including, "Why ain't nobody listening to me?", "I'm being slowly murdered and it's wrong", "Staff know I've got information about them and they're trying to kill me. I am dying please help me". The mental health nurse also noted that although Mr Dalton reported spitting up blood, he could see no evidence of this. There is no record that he examined Mr Dalton, took his clinical observations or considered contacting a GP.

Events on 19 November

62. On 19 November at 10.00am, a Custodial Manager (CM) chaired an ACCT review which an officer, a substance misuse worker, a nurse and Mr Dalton attended. The CM noted that although Mr Dalton engaged in the process, he appeared more concerned about an upset stomach. She told the investigator that there was evidence of dark faeces on the floor and walls of his cell and that Mr Dalton said that he had done it to show staff the blood. The CM said she saw fresh blood in the toilet and told the nurse that Mr Dalton needed to see a doctor. The nurse looked inside the cell but did not examine Mr Dalton.

63. At 10.02am, the nurse recorded that prison staff had observed fresh blood in Mr Dalton's toilet and that he had requested a GP review. A prison GP arrived at the healthcare unit shortly afterwards and a mental health nurse advised him to speak to the nurse as he had attended the ACCT review. At 12.36pm, the prison GP recorded, "Discussed with staff – story is not conclusive. Not yet seen – advise staff to supply container and ask him to keep any vomitus for inspection." An officer told the investigator that he was in the unit and that he

overheard the prison GP tell the mental health nurse that he was busy but would try to see Mr Dalton later.

64. The mental health nurse told us that he was the only member of healthcare staff in the unit that afternoon. He said that a healthcare assistant was moved to another part of the prison and that a nurse left at lunchtime saying that he had a family emergency. However, he added that the nurse was not happy that healthcare managers had asked him to cover reception that afternoon and had told them that he would go home if they made him move. He also said that the nurse did not say anything to him about the fresh blood in Mr Dalton's toilet.

65. CCTV footage shows that a Supervising Officer (SO) and three officers went to Mr Dalton's cell at 2.19pm. (CCTV footage provided by the prison was five minutes fast and we have adjusted the timings in this report.) They intended to move him while his cell was cleaned. An officer opened the cell observation panel to ask Mr Dalton if he would like a shower. He said that he would but needed a wheelchair as he could not walk. The SO spoke to the mental health nurse who said that Mr Dalton had walked to collect his medication earlier that morning.

66. At 2.24pm, the SO returned to Mr Dalton's cell and opened the door. CCTV footage shows that as Mr Dalton reached the doorway, he bent forward, clutched his stomach and collapsed. The SO left to get the mental health nurse and returned two minutes later. The mental health nurse looked at Mr Dalton for about 20 seconds but did not physically examine him. He went to the nurse's station and sent an instant message to a prison GP saying that Mr Dalton had collapsed on the floor and that he was about to check his physical observations. He also sent another unrelated message. In the meantime, officers moved Mr Dalton onto the floor in the middle of his cell and locked the door.

67. CCTV footage shows that an officer looked through Mr Dalton's cell observation panel at 2.29pm before posting several pieces of paper through the gaps around the door. In his prison statement, the officer said that Mr Dalton remained in the same position and that he could clearly see him breathing.

68. At 2.35pm, the mental health nurse returned to Mr Dalton's cell with a blood pressure monitor. Officers opened the door and when the nurse entered, he noticed that although Mr Dalton was breathing, he was not responding verbally. He then tried to take a blood pressure reading from one of Mr Dalton's legs (as his arms were wrapped in his dressing gown). At 2.39pm, after checking Mr Dalton's vital signs and failing to get a blood pressure reading, the nurse asked the SO to call a medical emergency code blue (which indicates that a prisoner is unconscious or has breathing difficulties). The SO radioed the code blue while the nurse moved Mr Dalton into the recovery position.

69. At 2.41pm, a nurse responded to the emergency code and arrived without any emergency medical equipment. She found Mr Dalton in the recovery position, with the mental health nurse trying to take his blood pressure. She noticed that Mr Dalton looked very unwell and suspected that he may go into cardiac arrest. At 2.43pm, she left the cell and shouted for a nurse, who she thought was still at work, to bring the crash trolley (containing emergency medical equipment).

Shortly afterwards, the nurse noticed that Mr Dalton had stopped breathing and started cardiopulmonary resuscitation (CPR).

70. At 2.45pm, CCTV footage shows that an associate practitioner arrived with the emergency medical bag and gave it to a nurse. She then left the cell and returned with the crash trolley at 2.46pm. CPR continued while staff attached a defibrillator but it did not detect a shockable rhythm.

71. At 2.59pm, ambulance paramedics arrived and assisted with the resuscitation effort. At 3.15pm, a prison GP pronounced that Mr Dalton had died.

Contact with Mr Dalton's family

72. Later that afternoon, the prison appointed a prison manager as the family liaison officer (FLO), and a CM as her deputy. At 7.10pm, they visited Mr Dalton's next of kin. They broke the news of Mr Dalton's death and offered their support.

73. The FLO continued to support Mr Dalton's next of kin until his funeral, which took place on 14 January. The prison contributed towards the cost, in line with national instructions.

Support for prisoners and staff

74. After Mr Dalton's death, the Governor debriefed the staff involved in the emergency response to ensure that they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support.

75. The prison posted notices informing other prisoners of Mr Dalton'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 Dalton's death.

Post-mortem report

76. A post-mortem examination found that Mr Dalton died of an upper gastrointestinal haemorrhage (a massive bleed from an artery in the small intestine) that had been caused by a large ulcer. Toxicology analysis of Mr Dalton's blood found evidence of meloxicam, but no illicit drugs.

77. The post-mortem report states that the presence of dark faeces in Mr Dalton's cell was consistent with the development of melaena (faeces containing partly digested blood) and an indication that an intestinal bleed had been ongoing for several days. The pathologist also noted that meloxicam has the potential to irritate the intestinal tract and is rarely prescribed without gastro-protective drugs, such as a PPI. He advised that a suitably qualified doctor should review the clinical notes to consider the adequacy of treatment provided to Mr Dalton.

78. The pathologist also said that there was no evidence that any form of injury inflicted by a third-party could have caused or have contributed to Mr Dalton's death, and that there was no evidence of any maltreatment while Mr Dalton was in custody.

Events after Mr Dalton's death

79. At 3.27pm on 19 November, a healthcare administrator uploaded Mr Dalton's x-ray results to his electronic medical records. At 4.12pm, a prison GP noted that he had seen the x-ray results at 11.00am that morning and was considering a 'two-week wait' approach (an NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks).

Findings

Clinical care

80. The clinical reviewer found that the clinical care that Mr Dalton received at HMP High Down was not equivalent to that which he could have expected in the community.

Healthcare procedures for newly arrived prisoners

81. Prison Service Order (PSO) 3050 on the continuity of healthcare for prisoners requires that when a new prisoner arrives in reception, prison staff try to obtain relevant information from the prisoner's GP or other health services with which the prisoner has recently been in contact. Mr Dalton took medication to treat several serious conditions, and it was therefore particularly important that healthcare staff should have obtained his community medical record for up-to-date information about his health conditions and treatment. However, despite numerous opportunities, no one requested information from Mr Dalton's GP.

82. PSO 3050 also requires that newly arrived prisoners should be offered a general health assessment in their first week. This assessment is expected to be equivalent to a primary care assessment when registering with a new GP in the community. The Head of Healthcare told us that nurses should have seen Mr Dalton for a secondary health screen but did not explain why they had not done so on this occasion. We are concerned that healthcare staff did not conduct a secondary health screen. This is important for all prisoners but particularly so in Mr Dalton's case as he had said he had cystic fibrosis and COPD.

Prescribing and administering medication

83. The clinical reviewer considered that a prison GP made an error in prescribing prednisolone on 19 October. Mr Dalton's summary care record stated that prednisolone was only prescribed on a short-term basis in the community which meant it should have been stopped on 4 October. We are concerned that the prison GP incorrectly prescribed medication and did not record whether he reviewed Mr Dalton's summary care record.

84. We are concerned that healthcare staff did not prescribe or record whether they considered prescribing Mr Dalton a PPI. The clinical reviewer asked a GP clinical reviewer if there was a requirement to prescribe a PPI with non-steroidal anti-inflammatory drugs which have the potential to cause gastrointestinal bleeding and ulcers. The GP clinical reviewer said that although there was no formal guidance, the fact that Mr Dalton was prescribed meloxicam and prednisolone should have led prescribers to consider using a PPI.

85. A prison GP told us that the British National Formulary (a pharmaceutical reference book containing advice on prescribing and pharmacology) states that although taking non-steroidal anti-inflammatory drugs can increase the risk of gastric bleeding, it is not an absolute indicator for using a PPI. He said that a history of gastric bleeding or use of blood-thinning medications would certainly have meant an increased risk but there was nothing in Mr Dalton's records to suggest he needed a PPI.

86. While we cannot know whether using a PPI would have changed the outcome for Mr Dalton, we consider that healthcare staff should at least have documented the reason why they decided not to use one.

87. The clinical reviewer also considered that as Mr Dalton was already prescribed meloxicam, a prison paramedic should not have offered him ibuprofen on 20 October. Taking two non-steroidal anti-inflammatory medications can increase the risk of gastrointestinal damage. The Head of Healthcare told us that the electronic medical record would have flagged the risk of the two medications interacting if a prison paramedic had tried to administer ibuprofen. However, irrespective of this, we consider that healthcare staff should have been aware of the risks.

Management of complex needs

88. Mr Dalton had complex health needs and often displayed challenging behaviour. He frequently requested pain relief and healthcare staff perceived his behaviour to be drug-seeking. However, the clinical reviewer considered that there was little evidence to support the conclusion that Mr Dalton's behaviour was related to drug misuse and that more should have been done to assess his mental and physical health. We note that prison staff did not think that Mr Dalton's behaviour was drug-related and thought that he had mental health problems. We are also concerned that although healthcare staff made a substance misuse referral on 31 October, Mr Dalton was not seen until a prison GP requested an urgent review on 15 November.

89. The clinical reviewer found no record that healthcare staff discussed Mr Dalton's care or implemented a plan to manage his physical and mental health needs. The Head of Healthcare told us that weekly meetings take place to discuss complex cases but we could find no record of these for Mr Dalton. There was also limited sharing of information between prison and healthcare staff and no lead clinician responsible for Mr Dalton's overall care. This meant that his physical health conditions were not effectively managed.

90. Although Mr Dalton repeatedly reported pain, there is no record that healthcare staff arranged a follow-up appointment at the pain clinic or another GP review after he failed to attend on 7 November. A nurse told the investigator that the focus was on Mr Dalton's mental health and substance misuse needs and that as a result, "the physical aspects might not have been apparent". We agree that healthcare staff appear to have overlooked Mr Dalton's physical health and consider that a more structured, multidisciplinary approach to his care might have led to an improved assessment and identification of his needs.

Recording and reviewing examination results

91. A prison GP requested x-rays of Mr Dalton's legs, ankles and chest on 19 October. The x-rays were taken on 25 October and the results were sent to the prison's healthcare administration team at 5.32pm on 18 November. A healthcare administrator added the results to Mr Dalton's medical records on the afternoon of 19 November. The Head of Healthcare told us that test results were sometimes delayed due to being returned in batches. A prison GP's solicitor told

us that delays in reporting x-ray results were a long-term problem and that the GPs had raised the issue with CNWL on a number of occasions.

92. If the x-ray results had been received earlier, it is likely that Mr Dalton would have been referred to hospital for further investigation

93. At 4.21 pm on 19 November, an hour after he had pronounced Mr Dalton dead, a prison GP noted in Mr Dalton's medical record that he had seen the x-ray results at about 11.00am that morning. He noted that the chest x-ray had shown abnormalities and that he was considering a 'two-week wait' approach (an NHS pathway which requires patients with suspected cancer to be seen by a specialist within two weeks) because of a strong suspicion that Mr Dalton might have a tumour or TB.

94. We recognise that a prison GP would not have been able to review the x-ray results any earlier than the morning of 19 November, but we are concerned that he made a retrospective entry after he knew Mr Dalton was dead. We do not consider this to have been good practice, particularly as he had made an earlier entry at 12.36pm in which he had not referred to the x-ray results or his proposed course of action.

Assessing and monitoring clinical deterioration

95. The clinical reviewer found that healthcare staff missed several opportunities to assess and monitor Mr Dalton between 17 and 19 November, during which time his condition deteriorated significantly.

96. The clinical review considered that a mental health nurse should have tested the cup of fluid that Mr Dalton showed him for the presence of blood. The Head of Healthcare told us that dipsticks were available to test for blood and the nurse accepted that, with hindsight, he could have conducted a test. There is also no evidence that the nurse took Mr Dalton's clinical observations. He told the investigator that Mr Dalton's behaviour often made taking his clinical observations difficult. However, while we recognise the challenges that staff faced, we consider that more should have been done to ensure that Mr Dalton was appropriately monitored.

97. A nurse did not examine Mr Dalton when staff noticed fresh blood in his cell during an ACCT review on 19 November. The clinical reviewer considered that he should have completed a full assessment and requested an urgent GP review. Although the nurse recorded that he had informed a prison GP, he did not indicate how they communicated or whether he specifically told him about the presence of fresh blood.

98. While we cannot know whether the prison GP told nurses that he was too busy to see Mr Dalton, the clinical reviewer considered that he should have examined him, especially on 19 November. The prison GP told us that he did not see the nurse's entry in Mr Dalton's medical records before advising staff to provide a sample of vomit. He said that he would have taken different action if he had known that staff had observed fresh blood. However, we note that he had seen Mr Dalton's x-ray results, showing an apparent abnormality in the lung, earlier that morning.

99. The clinical reviewer was concerned that a nurse left the prison during a shift without authorisation and without updating the mental health nurse about Mr Dalton's condition. She noted that the Nursing and Midwifery Council (NMC) code expects staff to "make a timely and appropriate referral to another practitioner when it is in the best interest of the individual needing action, care or treatment". Information sharing is vitally important and we consider that the nurse should have updated the mental health nurse or another appropriate member of staff.

100. We consider that healthcare staff failed show a suitable level of enquiry when faced with symptoms suggestive of internal bleeding and should have conducted a thorough assessment. Although we cannot be sure if earlier intervention would have prevented Mr Dalton's death, taking observations, testing fluid for blood and a GP review might have led to earlier identification of a life-threatening condition. We make the following recommendations:

The Governor and Head of Healthcare should ensure that a multi-disciplinary complex care meeting is held weekly and that a summary of the meeting is attached to the relevant prisoners' electronic medical record.

The Head of Healthcare should ensure that:

- **healthcare staff routinely request community medical records for newly arrived prisoners;**
- **healthcare staff offer all prisoners a full general health assessment within a week of their arrival, in line with PSO 3050;**
- **there is a suitable system in place to prevent prescribing errors;**
- **all medical and non-medical prescribers consider the use of a proton pump inhibitor with non-steroidal anti-inflammatory medication and record their decision in the prisoner's medical record;**
- **healthcare staff do not attempt to administer non-steroidal anti-inflammatory medication to prisoners who have them prescribed;**
- **there is a process in place to follow up any outstanding actions, such as requests for medical notes and x-ray results; and**
- **healthcare staff receive training to help detect and treat early warning signs of deterioration in prisoners.**

101. The clinical reviewer considered that as the Directors of Achor Healthcare Ltd, two prison GP's were responsible for the overall quality of medical services provided. She noted that there was no evidence that anyone in the organisation reviewed Mr Dalton after 19 October and that they failed to comply with several criteria set out in the General Medical Council (GMC) document entitled "Good Medical Practice". The clinical reviewer concluded that there was enough concern for the matter to be referred to NHS England.

102. The clinical reviewer also concluded that a nurse's actions and omissions on 19 November raised enough concern for NHS England to refer this matter the NMC. It is not clear whether this has been done and we, therefore, recommend:

Central and North West London NHS Foundation Trust should undertake a review to investigate the concerns raised by the clinical reviewer of the nurse and ensure that appropriate action is taken.

Emergency response

103. Prison Service Instruction (PSI) 03/2013, *Medical Response Codes*, requires prisons to have a two-code medical emergency response system. High Down's local policy instructs staff to use a code blue to indicate when a prisoner is unconscious or having breathing difficulties, and a code red when a prisoner is bleeding. Calling an emergency medical code should automatically trigger the control room to call an ambulance, and healthcare staff to attend with the appropriate emergency equipment. If a prisoner's symptoms do not correspond to the definition of an emergency medical code, staff are instructed to contact the control room and ask for an emergency healthcare responder to attend.

104. When Mr Dalton collapsed on 19 November, a mental health nurse left the cell without physically examining him and sent an instant message to a prison GP. While Mr Dalton's collapse did not meet the criteria for a medical emergency code blue, we consider that the mental health nurse should have checked his vital signs and asked for an emergency responder to attend. At interview, the mental health nurse told us that he could see Mr Dalton was breathing normally and asked staff to put him back in his cell until he returned with the equipment to take his observations. While we recognise that he was on his own and had not received a handover from a nurse, we consider that he should have acted more swiftly and radioed for assistance.

105. We are satisfied that an officer responded promptly to the mental health nurse's request and appropriately called a medical code blue. However, we consider that a code blue should have been called as soon as he found he could not get a blood pressure reading rather than waiting until he had tried to get a reading from Mr Dalton's leg.

106. We are concerned that when a nurse responded to the code blue, she arrived without any emergency medical equipment. This meant that she had to leave Mr Dalton's cell and shout for a nurse to bring the crash trolley. The nurse told the investigator that she did not take an emergency medical bag with her as everything was normally in the unit. We are also concerned that the nurse did not get the crash trolley when she failed to get a response from a nurse. She said that she went back into the cell as was a mental health nurse and she did not want to leave him on his own. This meant that the emergency medical equipment was not available until five minutes after the emergency code had been called.

107. While asking for a medical responder to attend when Mr Dalton first collapsed and quicker access to emergency medical equipment was unlikely to have changed the outcome for Mr Dalton, in other emergency situations, it could be crucial. We make the following recommendations:

The Governor and Head of Healthcare should ensure that all staff request that a medical responder attends when a prisoner presents as unwell but does not meet the criteria for a medical emergency code.

The Governor and Head of Healthcare should ensure that all staff are made aware of and understand PSI 03/2013 and their responsibilities during medical emergencies, including that staff promptly use an emergency code and take appropriate medical equipment to medical emergencies.

108. We are concerned that an ambulance was not called immediately after the code blue. The control room log shows a code blue was radioed at 2.36pm, and an ambulance was called at 2.38pm. An operational support grade (OSG) told the investigator that he had to notify staff and gather more information before calling an ambulance. This was not in line with PSI 03/2013. When a code blue is called over the radio network, this automatically notifies the staff who need to attend and control room staff should call an ambulance immediately. While it is unlikely to have affected the outcome for Mr Dalton, a delay of even a few minutes may make a crucial difference in a medical emergency.

109. In an investigation into another death at High Down in October 2018, we found that there was also a delay calling an ambulance. We made a recommendation in that case to ensure that control room staff call an ambulance immediately. The prison accepted the recommendation and told us that the medical code guidance would be refreshed and re-issued to all staff through a notice to staff, a full staff meeting and a bulletin by April 2019. They also said that quality assurance checks would take place to monitor the timeliness of calls and be reviewed at a monthly safety meeting. We therefore make no recommendation.

Safer Custody

110. Prison Service Instruction (PSI) 64/2011, *Safer Custody*, requires staff who receive information from concerned family members to communicate those concerns to the relevant staff and consider opening an ACCT.

111. We are concerned that there is no evidence that anyone from the Safer Custody department took any action when his sister rang on 17 November to express concern about the deterioration in his physical and mental health. We appreciate that staff cannot give information out about prisoners to anyone who calls, but we consider that someone should have checked his welfare in response to her call and should have reassured her that they would do so.

112. Since Mr Dalton's death, HMPPS's *Strengthening Prisoners Family Ties Policy Framework*, introduced in 2019, states that 'Governors will establish a process that enables family members and/or other people with concerns about a prisoner's safety to contact an identified member of staff without delay' and that 'the process must include prompt feedback to the person who raised the concerns'. We recommend:

The Governor should ensure that there is an effective communications gateway in place to enable families to communicate concerns about prisoners' wellbeing in line with the *Strengthening Prisoners Family Ties Policy Framework*.

Prisons & Probation Ombudsman
Independent Investigations

Third Floor, 10 South Colonnade
Canary Wharf, London E14 4PU

Email: mail@ppo.gov.uk
Web: www.ppo.gov.uk

T I 020 7633 4100
F I 020 7633 4141